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Approved Mental Health Professionals: Teamwork, 'Safety Nets' and 'Buckling Under'

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ABSTRACT

In England and Wales, Approved Mental Health Professionals (AMHPs) have the ultimate responsibility, based on doctors' medical recommendations, for deciding to detain a person, without consent, under the Mental Health Act (1983). The work can be traumatic, yet its emotional impacts are often unacknowledged. Consistent themes include erratic levels of supervision and an overdependence on peer support, despite the longstanding recruitment and retention difficulties arising from high levels of stress and burnout. This article draws on findings from two research projects with AMHP services: one a national study using questionnaires and focus groups, and the other a doctoral research study using ethnography. Findings suggest that a lack of peer support, teamwork and debrief opportunities, exacerbated during the COVID-19 pandemic, intensified stress and burnout ('buckling under') as well as undermining socialising opportunities for trainees. AMHPs used metaphoric language to articulate their difficult experiences. Workplace environments including hot-desking and lone working may undermine casework discussions, social relations, informal peer support and supervision. Overall, AMHPs perceive their teammates as an essential source of support (a 'safety net') without which there are negative implications for practice. Ultimately, stress is exacerbated when there is no space to reflect and no team to do this with.

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In England and Wales, Approved Mental Health Professionals (AMHPs) have the ultimate responsibility, based on doctors' medical recommendations, for making the decision to detain (which can involve enforced treatment), without a person's consent, under the Mental Health Act (1983) (MHA). The AMHP has overall responsibility for coordinating the process of assessment (Department of Health, 2015 para. 14.40). This entails navigating complex inter-agency arrangements (DHSC, 2019) across different environments (including community-based scenarios) and across diverse groups of people with lived experience including, but not limited to, children, older adults, people with learning disabilities and so on. In keeping with statutory Guiding Principles (DoH, 2015), AMHPs should always consider whether there are less restrictive alternatives to

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detention (DoH, 2015 para 14.7). The role is, as a matter of statute, independent and autonomous where 'nothing [...] shall be construed as authorising or requiring an application to be made by an AMHP' (s.13(5) MHA 1983).

The AMHP role was created with the 2007 amendments to the 1983 Act, replacing the Approved Social Worker (ASW), and it is no longer limited to social workers. Instead, AMHPs can be registered social workers, mental health or learning disability nurses, occupational therapists or chartered psychologists. However, in England, registered social workers continue to make up the vast majority (95%) of the AMHP workforce (Skills for Care, 2024). In keeping with this background, AMHPs are required to apply a social perspective and a value base aligned with social work (HMSO, 2008). In many respects, particularly in the research and literature bases, the roles are unchanged.

The AMHP workforce

There have been longstanding recruitment and retention difficulties within the AMHP workforce, understood to arise from high levels of stress and burnout and low morale (CQC, 2018; Department of Health and Social Care, 2019; Huxley et al., 2005; Mental Health Act Commission, 1999; Stevens et al., 2018). In fact, the creation of the AMHP role via the 2007 revisions was understood to be a response to this (Hudson & Webber, 2012).

Stress and burnout

The work has long been experienced as emotionally difficult and mentally draining with stress, low morale and emotional exhaustion being continually cited as a core problem (Barnes et al., 1990; Evans et al., 2005; Huxley et al., 2005; Stevens et al., 2018). The lack of resources (including the availability of ambulances, police and doctors) has led to delays and late working, and the lack of beds, the preponderance of out-of-area beds and a lack of community alternatives to hospital continues to be the most problematic area (Gregor, 2010; Hemmington et al., 2021; Morriss, 2016). AMHPs have felt forced to compulsorily detain people in the absence of a less restrictive option (BASW, 2016; Hemmington et al., 2021), which is entirely contrary to the professional role and value-base.

AMHPs experience guilt and anxiety from having to 'walk away' (Morriss, 2016), identified more recently as moral injury arising from their inability to do the job they are there to do (Hemmington, 2023b). 'Rewarding' work has included the one-off, contained nature of interventions and, with it, a degree of professional discretion with scope to exercise independent judgement with the authority and opportunity to resolve crises for individuals and their families using social perspectives, therapeutic skills and crisis intervention techniques to avoid hospitalisation (Huxley et al., 2005; Quirk et al., 2000; Watson, 2016).

AMHP service settings and teams

In England, AMHP services have been undergoing transition and reorganisation leading to an increasingly wide variation in the models of delivery. These reorganisations have also been understood to be in response to ongoing recruitment and retention difficulties (CQC, 2018; Stevens et al., 2018). Service models now include teams dedicated only to

statutory work from daytime (with support from Emergency Duty Teams (EDT) outside these hours) through to 24-hour services. Some 'hub and spoke' models have mixed-role AMHPs who support an AMHP rota alongside their substantive role (ADASS, 2018). The latest survey data (Skills for Care, 2024) suggests that half of the national Local Authority AMHP services have an AMHP duty system covering 24-hours 7 days of the week, indicating a range of different delivery models. It also suggests that around two-thirds of AMHPs combine their role with another role. Around a third of AMHPs solely perform the role of an AMHP and the remainder was not primarily working or regularly working as an AMHP.

Sources of support and supervision

Consistent themes in the literature have been around absent leadership and management, erratic levels of supervision, a lack of opportunity for debriefing, and an over-dependence on peer support to sustain AMHPs in the role (Furminger & Webber, 2009; Hudson & Webber, 2012; Huxley et al., 2005; Social Services Inspectorate SSI, 1991). Peer group discussion within teams is one way in which ASWs and AMHPs have been sustained (Hemmington et al., 2021; Quirk et al., 2000) since the emotional demands, stress and anxiety of carrying out statutory work are often otherwise unacknowledged and unrewarded (Gregor, 2010). This is despite the fact that feeling valued is associated with better mental health, less emotional exhaustion, less depersonalisation and higher job satisfaction (Huxley et al., 2005).

AMHP practice is often viewed as a solitary concept, arguably contributing to the lack of attention to the systems in place to support it. The role has been experienced as being misunderstood by service users and colleagues leading to a perception of a lack of support from others (CQC, 2018; Evans et al., 2005; Skills for Care, 2018; Stevens et al., 2018).

Beyond a legal role

The focus has tended to be on the processual, bureaucratic or legalistic aspects of the role, but it has been acknowledged that the work can be traumatic and overwhelming. Compulsory admission to hospital is, usually, a frightening experience for service users who can feel stripped of their rights and self-respect, but 'it is often traumatic for ASWs too, if they have any sensitivity' (Thompson, 1997, p. 11). The emotional dimensions have been acknowledged, usually in relation to the concept of emotional labour (Hochschild, 1983), used to illustrate the ways in which the role involves processing intensely powerful emotions and feelings, whilst also managing and containing individuals' and families' stress and trauma, as they co-ordinate and oversee complex assessments and risky situations often requiring them to wait for support from other colleagues (Allen et al., 2016; Vicary et al., 2019).

Emotional labour

Emotional labour can be part of face-to-face or voice-to-voice contacts with the public, and it is the management of emotion and expression in order to conform to organisational display rules and emotional expressions (Grandey, 2000). In practice, it consists of paying attention, maintaining a neutral tone, understanding the person's feelings, considering

their affective needs, showing concern and sympathy and suppressing feelings of fear or irritation even in the face of provocation (Mercadier, 2002).

Managing others' distress without appearing to be affected by it oneself can also be understood as acting as a 'container' for unmanageable feelings. This is derived from Bion's (1967) description of the ways in which a caregiver processes their child's difficult feelings and returns them in a more digestible format. Gregor (2010) drew parallels with ASWs' unconscious processing of a wealth of powerful emotions and feelings for service users, their families and sometimes other professionals. There are challenges attached to the need to continually project authority and control over a crisis situation, including managing the anxious projections of colleagues (Hemmington et al., 2021; Thompson, 2003). If unable to do all this, however, they may experience the distress and anxiety of the situation as their own, taking it home with them at the end of an emotionally draining shift. A further pressure is found through the 'social fantasies' that can operate in respect of the perceived remit of the role, where it is assumed that 'once we turn up . . . we can perform miracles' (Gregor, 2010, p. 438) and where this is society's way of keeping extreme mental distress out of the public eye and safely contained within private homes and institutions (Hinshelwood, 1998).

Yet the emotional aspects of the work are often not discussed (Dwyer, 2012). AMHPs may even be unaware of the emotional labour that they undertake, may not necessarily acknowledge the containment of anxieties as part of the role or, in fact, see emotional labour as something negative rather than a skilled aspect of the work (Gregor, 2010; Mann, 2004). Research exploring this further is outlined below, within the context of AMHPs' experiences of support, or otherwise, derived from their team structures and peer presence.

Research project

Two research projects with AMHPs and AMHP services are outlined below. One was part of a doctoral research study using ethnographical research with AMHPs (Hemmington, 2023a), and the other a national research project using questionnaires and focus groups (Hemmington et al., 2021). Empirical research, as part of the former, was interrupted by the global COVID-19 pandemic. At the same time, a national online project studying AMHPs' experience of the role was undertaken, and findings from this project are presented to augment the ethnographical study.

The ethnographical study was undertaken within a relatively large Local Authority in terms of staff numbers and geographical area. It has a comparatively broad and diverse population, as well as a combination of rural and urban areas. Significantly, it had recently introduced a 'hub and spoke' model of service delivery (introducing full-time AMHP teams to work alongside the traditional mixed-role AMHPs).

For the national project, a survey was cascaded through national networks of professional AMHP Leads. The survey findings represented 258 practicing AMHPs. This was followed with four focus groups with 21 AMHPs in total. There was a mix of types of service or team structures that the participants worked within: 36% were full-time AMHPs and mixed-role AMHPs made up 64% of the sample. Where AMHPs were not full-time, they outlined a range of other responsibilities including

Care Act (2014) activities, safeguarding, case management, duty or triage work and care coordination.

Ethnography

Ethnography is the study of people's interactions, behaviours and perceptions in natural settings, including groups, teams, organisations and communities (Reeves et al., 2013). Essentially, it is 'the art and science of describing a group or culture' (Fetterman, 1998, p. 1). As a means of studying social phenomena and human society, and as typically face-to-face direct research, it values the idea that to know other people the ethnographer must 'do as others do, live with others, eat, work and experience the same daily patterns as others' (Madden, 2010, p. 16).

Findings: ethnography

The ethnography phase of the study brought into view areas of interest that had not yet been apparent within the literature. Firstly, the setting and environment were significant. Full-time AMHPs were based in a central urban 'hub' comprising a large, open-plan office which also hosted other services, including generic frontline social workers, some police operatives and the Emergency Duty Team (EDT). Their team's area was noisy, with tightly packed desks, and had been likened to a call centre. The AMHP team had a hot-desking arrangement, undermining a sense of permanence. Indeed, once the work was allocated, AMHPs would quickly leave their team-base to travel around the county. The pace seemed fast, and AMHPs even appeared to speak more quickly and with greater urgency. They did not sit down for very long. Language was congruent with a sense of vernacular urgency: for example, 'I haven't got time for this' and 'I just crack on'.

Mixed-role AMHPs, who were rostered less frequently, worked from community mental health team-bases spread around the county in both urban and rural settings. They had their own assigned desks which were more spaced out, and they often sat alongside colleagues from different professional backgrounds and non-AMHPs with whom they might discuss aspects of casework or general team-work and, as such, they appeared to operate from within a broader organisational framework and organisational identity (rather than just within the confines of a specific or more narrow AMHP role). These spatial dynamics appeared to have a bearing on the way in which they engaged with their organisation and their workplace social relations more broadly. There was a noticeable team identity characterised, for example, by a shared responsibility for referrals which were discussed openly, with discussions including whether a request for a statutory assessment even needed to be 'escalated' to the duty AMHP at all or whether there were alternative responses that could be considered. By way of contrast, these AMHPs also used language such as 'I need to stop and think about this', 'I won't be rushed', 'we all need to slow down' and 'I just need to press the brake pedal for now'.

In ethnographic research, Marcus (1995) recommends 'following the people' and 'following the thing' (p. 32). In applying this, the importance of location and environment as sites where the action took place became clearer. There were emerging different

organisational and individual identities and perspectives within the AMHP service and teams, and these illustrated territorial and professional attachments, identities and narratives.

Communication, meaning and the use of metaphor

AMHPs' difficulties and conflicts came into being through the ways in which they conveyed their experiences and emotions. A recurring observation was of their use of metaphor and figurative language. 'Following the metaphor' enabled a deeper understanding of what was happening, including the ways in which language changed across ethnographic sites and teams (Marcus, 1995). AMHPs used metaphorical language as a way to articulate difficult or controversial experiences.

There were unanticipated difficulties and perceptions of power and hierarchy between full-time and mixed-role AMHPs and their teams (see Hemmington, 2023b). Lakoff and Johnson (1980) speak of 'orientational metaphors', which are ones with an up-down orientation, for example, where spiritual is up and mundane or material is down, and these can also convey aspects of hierarchy and power. Similarly, in this research, AMHPs used language related to interpersonal power, control and boundaries: full-time AMHPs were described by mixed-role AMHPs as having achieved a position in the 'lofty heights of hub', and the former also referred to their own 'heightened awareness' of and sensitivity to what was going on across the service. Mixed-role AMHPs, however, indicated that they were at the 'bottom of the pile' when it came to influence and status.

A further metaphorical theme was apparent with the use of military language, where full-time AMHPs were seen to 'pull rank', indicative of discipline and battle, where (wounded) part-time AMHPs were 'up in arms' about this. It could be part of an antagonistic scenario in team meetings, but it could also mean more generally surviving a combative experience. There was also a language of pain, where part-time AMHPs talked about being 'burned' by their experiences of a 'stinging' encounter with colleagues. Discussions around recruitment to address the shortage of AMHPs was described in pessimistic terms of 'putting more logs on the fire'.

AMHPs used metaphoric and figurative language as a way of articulating the unsaid, particularly where it was linked with organisational identity and conflict. It is 'a fundamental characteristic of how people categorise and make senses [sic] of their experience' (Gibbs, 1992, p. 572). Yet it was also evidence of AMHPs developing new and unanticipated *team* identities, within the AMHP service itself, as they found themselves belonging to (full-time) 'hub' teams or (mixed-role) 'locality' teams. As a consequence of separation, they were using metaphor to communicate a complex, patterned set of experiences in a shorthand that was understood by the members of their AMHP community who could share their mutual knowledge and experiences (Glucksberg et al., 1992).

Metaphor and figurative language in group settings

In group settings, figurative language served to both contain and expand upon emotional experiences, with metaphors creating familiarity and allowing individual group members to form their own connections to it (Ettin, 1994). It enables groups to bond and share

complex experiences in a safe way and it enables people to achieve distance from emotionally charged or distressing situations (Young, 2008). Metaphor can create a fictitious experience which can be used to restore lost certainty and reduce dissonance (Oehrle & Fadely, 1992). It was, at times, difficult for AMHPs to communicate their sense of the complex interactions within their work and their language helped to capture its overwhelming, unspeakable and hazy aspects (Markman, 2011).

Findings: national research project

Many themes from the ethnographical study were reinforced within the national research project. Certainly, there was evidence of stress and burnout. AMHPs described frustration, anxiety, mental strain and fatigue, particularly around having to leave situations which felt unsafe, incomplete or where they had not been able to 'get the required outcome' (p.40). The strain is clear from one AMHP, where:

> 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 upset family members affects my wellbeing [. . .] My family often tell me that after an AMHP shift I come home 'spaced out' and detached. (p. 39)

This was also reinforced by observations of AMHP colleagues' burnout whereby 'some have no feelings behind their eyes' (p. 66) albeit acknowledging that this could happen to anyone due to the trauma involved in the work. Yet, significantly, one AMHP manager observed that this was not acknowledged or discussed within supervision when AMHPs:

> . . . will describe law and processes but avoid their own psyche that brought them into the work. (p. 66)

Some AMHPs spoke of the emotional impact of the role and the ways in which it is 'raw', 'traumatic' and an 'emotional battering'. Some AMHPs believed that engaging with your own feelings makes you a better AMHP but, paradoxically, this is at a cost since:

> people who make the best AMHPs have the highest toll on them [. . .] [there is] nothing in the system which protects them and emotionally, I think it has a major toll. (p. 66)

Yet they described having little to no time for debrief or to process the emotional impact of their decision for themselves or the service user.

Support and supervision

Generally, AMHPs in both studies spoke of feeling unsupported and undervalued and this was compounded by poor or absent supervision opportunities, which led to anger and frustration. In the national study, AMHPs were asked if they received professional AMHP supervision. Overall, 69% stated that they did, but 25% did not and 6% did not answer the question. AMHPs were asked which were the most welcome or effective support strategies that they have available to them and, consistent with the literature, the majority found their AMHP peers and colleagues to be the most welcome and effective source of support. One clear, shared experience, however, was that the lack of peer

support, teamwork and debrief opportunities had been exacerbated and intensified by the COVID-19 pandemic and the isolation that this created. It was clear that many AMHPs had been badly affected by the lockdown. They spoke of isolation and stress to the point where:

> . . . it's only because of colleagues that I could carry on. The pandemic meant that there was no time spent together sharing, supporting . . . that for me was the final straw. I buckled under and had to take time off. (p. 68)

Overall, again, the indications were that peer support, and with it the sharing of knowledge and opportunities for team reflection, sustained many AMHPs, with one describing their team as offering them an emotional 'safety net'. Teams and colleagues were described in a way that was indicative of a form of supervision, mitigating against stress and, for some, burnout and so the isolation of the pandemic meant that they had lost essential protection.

AMHP teams united and divided

The ethnographic study had produced unexpected findings: that full-time and mixed-role AMHPs did not work together in the way that the service intended. Similarly, within the national project, there was an emerging suggestion that, contrary to longstanding ideas of team support as essential, team dynamics and cultures could also create barriers.

In an environment that was seen as being increasingly 'macho' (see Hemmington, 2023b), solidarity was lost. In contrast with perceptions of peer support and 'comrades', some AMHPs' colleagues were simultaneously an essential source of support but also 'our own worst enemies', compromising 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 [independent] 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 prepare]. 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 . . . we don't do ourselves justice.

Arguably, this invites consideration as to how the architecture of AMHP service models and teams should be carefully designed, constructed and maintained to ensure that teams operate in a way that is conducive to support and, ultimately, offer a 'safety net'.

Discussion

Research with ASWs and AMHPs has long suggested that it is the motivation and support from peers, including its containing aspects, that has enabled them to carry on even if this is merely to have someone to 'run things by' (Gregor, 2010). This was reinforced by the AMHP, above, whose isolation during the COVID-19 lockdown led to them ultimately 'buckling under'.

Teams can be a significant source of social support and have even been perceived as a secure base (Schofield & Beek, 2014) where, as an extension to Bowlby's (1969/1982) Attachment Theory, relationships with available, accepting, sensitive, reliable others offer a safe haven to return to when life is stressful. In the context of emotionally demanding occupations, teams and supervisors may provide a work-related secure base giving

a sense of being valued and helping to sustain workers' self-worth (Biggart et al., 2016; Schofield & Beek, 2014). They provide emotional containment through 'holding environments' (from Bion, 1967) offering empathic acknowledgement and an enabling perspective (Kahn, 2005). Yet to achieve this secure base, teams need good leadership and conducive workplace environments with opportunities to meet, reflect and have confidential conversations. The ethnographic work with AMHPs described above suggested that hot-desking arrangements and open-plan offices compromised this, compounding feelings of uncertainty and isolation and heightening stress.

Attention has been paid to the weight of emotional labour inherent in the AMHP role, albeit somewhat surprisingly with less focus on managing this in practice or reconciling it with the long-term recruitment and retention difficulties. Some theoretical models of emotional labour do, however, focus on the moderating and regulating role provided by colleagues and teams, not least as a means of sharing or 'venting' the emotional experiences and workers' feelings and reactions with others (Niven et al., 2013; Rimé et al., 1998). Some AMHPs conveyed what appeared to be emotional dissonance, or a discrepancy between their felt emotions and the emotional display that is required of them in their work contexts (Van Dijk & Brown, 2006). Using militaristic metaphor, they described ways in which they protected themselves. They were also observed to 'avoid their own psyche' that brought them into the work, indicative of observable internal role conflicts whereby, on the one hand, they could not express their authentic feelings at the risk of acting unprofessionally (or being seen as weak) but, simultaneously, they could not express the emotion required by the display rules of their organisation without threatening their own values. This can lead to an unpleasant state of tension, which may be emotionally exhausting (Hülsheger & Schewe, 2011) and reduce self-confidence, self-efficacy and lower self-esteem (Rimé, 2009).

Yet this type of emotional dissonance has a clear and direct relationship with burnout (Andela et al., 2015). Burnout has been described as a form of emotional exhaustion with feelings of being depleted, overextended and fatigued and with depersonalisation resulting in negative and cynical attitudes towards, and reduced empathy with, service users (Holmqvist & Jeanneau, 2006). Organisational measures of burnout are difficulty recruiting and retaining staff (Gilbody et al., 2006), reduced commitment (Burke & Richardsen, 1993), high absenteeism and turnover (Stalker & Harvey, 2002) and job dissatisfaction (Maslach et al., 2001). Significantly, given the above, isolating work practices and entrenched patterns of uncommunicative social interactions in the workplace are indicative of burnout (Cherniss, 1980). Of particular note is that burnout can be contagious within teams: it can damage colleagues' morale (Stalker & Harvey, 2002).

Given the longstanding recruitment and retention problems, as well as high levels of stress and burnout, greater attention needs to be paid to AMHPs' social contexts. Team reflexivity, or the extent to which teams reflect upon and modify their functioning, provides personal and social moderating effects (Andela et al., 2015). The loss of meaning and role clarity arising from burnout and emotional dissonance can be buffered by a team that works to elaborate, restructure or consolidate the core professional knowledge and value base through awareness and discussion. This is particularly the case with a profession founded on independence and autonomy that has long described its 'invisibility' and feelings of being misunderstood, traditionally by non-AMHP colleagues but, as this research suggests, increasingly by AMHP colleagues themselves, depending on service or team function.

In teams with a climate of authenticity, employees can take a break from actively monitoring their self-presentation. They can express suppressed emotions such as frustration or sadness around co-workers (Vohs et al., 2005). Affiliation with team colleagues directly contributes to a reduction in anxiety and the sharing of emotion can facilitate assistance and support, reassurance, legitimisation, the production of advice and solutions (Rimé, 2009), social sharing (i.e. talking about emotionally stimulating work) and it can attenuate the residual distress lingering after a taxing episode (McCance et al., 2013). It is concerning, then, if service and team restructures are bringing about a new disaffiliation for AMHPs, compounding their existing sense of isolation and lack of support.

Policy perspectives

The first National Workforce Plan for AMHPs was published in 2019 (DHSC, 2019). This considered the 'national drivers' affecting the AMHP role in terms of workforce requirements, tools and organisational structures that could consolidate, stabilise and support AMHPs. It introduced service standards which, together with the regulations and competencies (HMSO, 2008) and education/training guidance (Social Work England, 2020) provide the framework for support and development. Standard Four pertains to AMHPs' 'personal, professional, physical and psychological safety' (p. 33) whereby AMHP service arrangements should 'ensure that AMHPs' safety and well-being are at the forefront of operational considerations' (4.1). Additionally:

> AMHP services should support the independence of decision-making and ensure that AMHPs have access to individual, peer and professional support, can explore their working practices in a safe manner and are provided with timely de-brief sessions ... Supervision should be viewed as the 'cornerstone of quality AMHP practice'. (4.3)

Yet the national research project outlined above indicated that debrief rarely, if ever, happens in AMHP practice despite it being one way to achieve social sharing, reflective practice and deliberative, guided reflection-on-action.

This needs further consideration. There is very little empirical data as to what happens during debriefing (Sawyer et al., 2016) and, further, evidence suggests that when we do try to debrief we often default to processes, policies and law at the expense of more meaningful content and, also, that groups often wait until late in a discussion before they bring up unshared information (Jaffrelot et al., 2012). This seems particularly pertinent for AMHPs who are wont to default to laws and processes, 'avoiding the psyche that brought them into the work' or seeing the emotional labour as something to avoid in the context of a 'macho' environment (Hemmington, 2023b). Yet the high levels of stress, burnout and recruitment and retention difficulties would suggest that this is addressed sooner rather than later. Further, teams are places for professional learning and socialisation where AMHP trainees learn through modelling, presence and a process of 'osmosis' (McGarvey-Gill, 2023). Service restructures, which result in an increase in lone-working, create risks for future AMHPs, exacerbating recruitment and retention difficulties. AMHPs were able to describe sophisticated ways in which engaging with our own feelings makes you a better AMHP (albeit at a cost where support and supervision are lacking) but for a less experienced worker or trainee it would be very easy to adopt a distant, dissonant, bureaucratic or functional approach to the work (Gregor, 2010). This has to be avoided at all costs.

Conclusions

The findings above outlined emerging new models of service delivery and AMHP teamwork and, with it, changing modes of practice and experiences for AMHPs. It highlighted the potentially fragile architecture of the system where AMHPs had identified cracks and fissures (albeit often expressed in hazy, figurative ways). Some identified emotional difficulties and estrangement, alienation and, at times, described a new-found, fundamental destabilisation of the system. Overall, AMHPs perceive their teammates as an essential source of support (a 'safety net') without which there are negative implications for practice, including the ability to share emotions and fears. Ultimately, stress is exacerbated when there is no space to reflect and no team to do this with.

AMHP work is emotionally charged work and, arguably, should be explicitly seen as such. Understanding AMHPs' stress and burnout may need a deeper look at the ostensibly mundane aspects of the environment, such as hot-desking or other temporary surroundings which, in fact, may be undermining or removing essential peer support (Biggart et al., 2016). AMHPs appear to need opportunities to make sense of and challenge situations of ambiguity and moral complexity with their colleagues as illustrated by those who found that isolation and lone work from the COVID-19 pandemic lockdown was a final straw (Hemmington et al., 2021). There were complex transactions between AMHPs from different parts of the service (and, with them, emerging sub-cultures) and these need to be further understood within the context of stress, burnout, recruitment, retention and role clarity more broadly. Ultimately, if local authorities wish to improve their retention rates of existing and future AMHPs, then a supportive and containing environment needs to be fostered in order to offer AMHPs the opportunity to process their emotional responses to their work. The container needs containing, and acknowledging and supporting this as part of an essential team function needs to be a deliberate part of any future restructuring.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Notes on contributor

Dr Jill Hemmington is the Course Leader for UCLan's qualifying and post-qualifying AMHP education and training. Jill has worked within mental health services for over thirty years, from in-patient and community settings to Mental Health Social Work (MHSW) and MHSW integrated CMHT management. Jill qualified as an ASW in 2000 and acted as Practice Assessor, and she continues to practice as an AMHP. Jill developed UCLan's AMHP programme which she leads along with a suite of post-qualifying AMHP refresher events, all of which are delivered nationally and are tailored according to local workforce needs. Jill is an external panel member for a Local Authority's qualified AMHP reapproval panel and an Education and Quality Inspector for AMHP and BIA programmes for Social Work England. She has completed a PhD relating to the variables (organisational and environmental) influencing AMHP decision-making, with a particular focus on Shared Decision-Making (SDM), AMHPs' independence, power and communication dynamics and the Empowerment and Involvement principle. She is developing training materials to look at SDM, linking to the principles of service user involvement and co-production underpinning policy developments. More recently, research and training interests have been in AMHPs' experiences of moral distress and moral injury and how to manage this challenging aspect of practice. Jill is

a founder member of the AMHP Research Group (ARG), a group co-opted to the national AMHP Leads Network, and she supports current national AMHP Workforce Development initiatives including the modernisation of AMHP programmes and ways in which universities can support the recruitment and retention agendas. Jill is a Specialist Lay Member in the Mental Health Tribunal service.

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