APPROVED MENTAL HEALTH PROFESSIONAL (AMHP)

SERVICE DELIVERY REVIEW

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Dated: 01.10.14
Purpose: Review of weekly AMHP rota

Introduction:

This paper is brought to the JMG for information. Although the AMHP service is outside the scope of the Section 75 agreement the management and functioning of that service has a direct impact on the service delivery of the partnership due to both a shared agenda and staff who work in the CMHTs as well as performing AMHP duties.

Background:

Nationally there has been an increase in Mental Health Act(MHA) activity by about 4-6% over past decade. This has been during a period of resource changes and decreasing numbers of Approved Mental Health Professional (AMHP) practicing in UK.

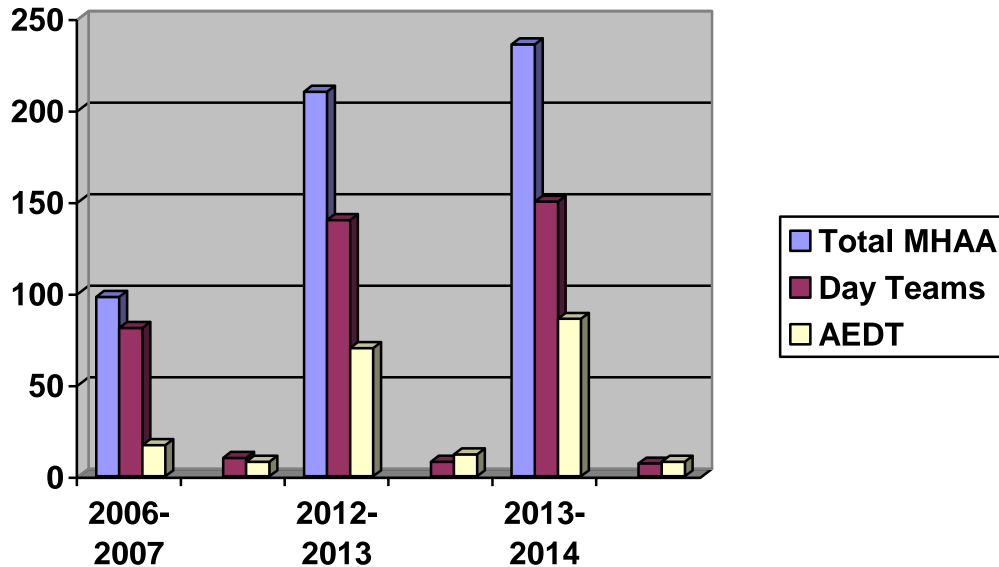
The 2007 updated MHA was hoped to address the issue of an ageing AMHP population and the implications in the future for the delivery under this legislation. The role was extended to other disciplines within Mental Health to be able to train and practice as AMHPs. However the reality is that after 6 years there has been a minimal increase from other disciplines nationally, and none with the Borough of Richmond. As a result we have seen a decrease again in the numbers of AMHPs whilst meeting an increasing demand of 60+% rise in MHA work since 2007.

The 5 year House of Commons Scrutiny Report 2013 making the following observations:

'Over the course of this inquiry the committee learnt of severe pressure on beds, with some wards running at over 100% occupancy. It is now acknowledged that there appears to be an inverse relationship between the number of available beds and rate of detention….. Being detained is the ticket to getting a bed.'

The committee were 'very concerned by the suggestion that some clinicians may resort to use of sectioning powers to secure hospital access for some patients who would otherwise have been voluntary patients. Such behaviour would represent a serious violation of the civil rights of the patient- as well as an abuse of the professional obligation of the clinician.'

1. LOCAL STATISTICAL OVERVIEW



**Figures taken from statistics gathered through AMHP report submissions*

1.1 **2006 – 2007** 98 MHA assessments document in LBRUT
81 by day teams – 10 ASWs
Averaging 8.1 assessments per worker
17 by AEDT – 8 ASWs (4 Boroughs covered)
Averaging 2.13 per worker for LBRUT only

1.2 **2012 – 2013** 210 MHA assessments document in LBRUT
140 by day teams – 8 AMHPs
Averaging 17.5 assessments per worker
70 by AEDT – 8 AMHPs (4 Boroughs covered)
Averaging 5.8 per worker for LBRUT only

1.3 **2013 – 2014** 236 MHA assessments document in LBRUT
150 by day teams - 7 AMHPs
Averaging 21.4 per worker
86 by AEDT - 8 AMHPS (4 Boroughs covered)
Averaging 10.8 per worker

1.4 Average assessment taking 5 hours 10 minutes.

1.5 Trust figures demonstrate discrepancy in recorded statistics from AMHP reports.

2013-2014 MHA office for SWLSTG-TR recorded:

- 416 uses of MHA which were constituted of
- 231 detentions
- 23 s17(a) CTOs
- 44 s5(2)
- 7 s5(4)

- Fewer than 5 s135(1)
- 108 s136

1.6 From these figures AMHPs should have submitted 254 reports solely upon the applications made under MHA.

Based upon LBRUT figures there were at least 39 informal admissions and 61 assessments that did not lead to any admission.

1.7 Therefore there should have been a minimum of 354 reports submitted.

1.8 This has evidenced the previous hypothesis that some AMHPs were not submitting reports in regard to all MHA activity. AMHPs have stated that the contemporaneous full report expected by their employer or the Local Authority are not always completed or in due time as a result of having to prioritise other competing tasks once the assessment is completed.

It should be noted that this is specific to day services as AEDT staff have to ability to handover additional referrals to day services in order to complete their reports.

1.9 Data demonstrates that not all activity is being recorded, in particular abandoned assessments, work to gain warrants, peer support/reflections, occasional doubling up of staff in complex situations, legal consultation, consultations with colleagues and considerations of referrals that do not lead to interview.

This has been raised at AMHP Forums and with Trust Leads.

1.9 Total use of the MHA 1983 for the SWLSTG Trust: April 2011 – March 2012 compared to April 2013-– March 2014. These figures include section 136 and all holding powers. **(Figures provided by SWLSTG MHA Office)**

BOROUGH	TOTAL SECTIONS 2011/2012	TOTAL SECTIONS 2013/2014	Population	Total Area Covered km²
Kingston	273	326	160,400	37.25
Richmond	**275**	**416**	**187,500**	**57.41**
Merton	342	356	200,500	37.61
Sutton	228	219	191,100	43.85
Wandsworth	651	758	307,700	34.26
Specialist	190	181		
Others	55	121		
TOTAL	**2014**	**2277**		

1.10 It is evident that Richmond is one of the least densely populated Boroughs covered in the Trust, but serving the largest area meeting greater pressures in

view of mobility and time requirements as all admitting beds are located in out of Borough hospitals.

1.11 According to Department of Health Community Mental Health Profile 2013, Richmond does not have a significantly high psychiatric morbidity rate. Overall the profile taken from national statistic collation showed that Richmond has a

- 'significantly lower' rate for numbers of contacts with mental health services per 1000 population in comparison to rest of England;
- Number of people per 1000 population on Care Programme Approach 'significantly higher' than rest England
- Rates of depression in over 18 year olds 'significantly better'
- And both rates of recovery and rates of suicide as 'not significantly different' to rest of England.

1.12 Richmond has seen a disproportionately significant increase in use of MHA from the previous annual period compared to the other Boroughs in the Trust.

2.0 REVIEW OF WEEKLY AMHP ROTA

2.1 The previous system of teams 'consuming their own smoke' worked well for many years, but had been widely reported by AMHPs , teams, managers and all referrers that the system no longer suited the changes in service delivery and demand for MHA work.

2.3 AMHPs had not been evenly spread between teams leading to difficulties for managers covering off work in their teams and referrers from teams that had been unpopulated with AMHPs. As such on 28.10.13 Richmond went to a centralised weekly AMHP service.

2.4 AMHPs are not an adult mental health specific resource. Requests for MHA assessments can come from any referrer. MHA assessments will cover service users of Eating Disorders, other specialist services, Learning Disabilities, Older Persons and CAMHs.

There is no upper or lower age limit to the application of MHA.
AMHPs need to be available to offer suitable information and advice to a range of referrers. As such to maintain their warrants, AMHPs have to do a minimum of 4 assessments per annum; minimum of 18 hours specialist training & 5 day refresher every 3-5 years. This is monitored and maintained by the AMHP Lead.

2.5 Managing AMHPs within teams can be challenging. AMHPs are required to prioritise their statutory MHA work over any other duties. With reduction in service provision without reduction in demand for mental health services, this poses a dilemma at times in needing to deliver on the range of duties required.

2.6 Previously AMHPs had been 'on call' every day to cover off team assessments as well as having spot days out for AMHP duty. Managing their caseloads on a daily basis was incredibly challenging. AMHPs repeatedly expressed concern about having to cancel arrangements with service users

without notice to respond to a MHA assessment request on the same day. Remaining in the team environment had not allowed for any demarcation in roles and duties both for teams, managers and individual AMHPs.

2.7 In response the service has been centralised. A short survey to review this service has been undertaken. One to AMHPs and another to in-house referrers. It was a unanimous response that the AMHP rota should remain dedicated centralised service in Richmond.

.3. FULFILLMENT OF AMHP ROLE & BED MANAGEMENT

3.1 The AMHP service sits outside of the s75 agreement and is operationally managed by LBRUT AMHP lead which is the responsibility of the ADSW reporting to the Head of Learning Disabilities and Mental Health and in turn the Assistant Director of Adult Social Care.

3.2 Code of Practice (4.33 – 4.51) set out the Responsibilities of the LSSA and AMHPs. These in brief, are to ensure 'sufficient AMHPs are available to carry out their roles under the Act' 24 hours every day. Under s13MHA there is a duty for an 'AMHP to consider' any request for a MHAA. This could constitute as information gathering then sign posting, implementing a 'less restrictive' alternative to admission or full MHAA.

3.3 AMHPs act on behalf of the LSSA but 'cannot be told by LSSA or anyone else whether or not to make an application.' The independence of the role as AMHP is central to the responsibilities and decision making.

3.4 The s75 agreement states that the Trust will release AMHPs to undertake their duties and for AMHP training. The Trust will work in Partnership with the Council to enable sufficient AMHPs to be available from the integrated health and social care services managed under the agreement.

3.5 In summer 2014 it became evident that there were not sufficient numbers of AMHPs to undertake the responsibilities and that an emergency joint plan with the Trust was required to address the release of AMHPs to undertake their duties in the absence of the rota being sufficiently covered. The review of requirements of staffing and management of rota became highlighted as essential within this review.

3.6 It was envisaged that there would be a need for 10 – 12 AMHPs to cover the level of work in Richmond. Two AMHPs on rota each week with understanding of need for sickness cover or additional work on a given day from AMHPs not on duty were it so required

3.7 Due to loss of 3 further substantive AMHPs and release of two longer term locum AMHPs the numbers were not sufficient to manage in this way. It was agreed for a locum AMHP to be dedicated to the AMHP rota and other AMHPs to participate on rota about every 6 weeks.

3.8 Trust requested that another locum to dedicate to AMHP rota on 2/3 day split whilst the re-design work was completed. Then latterly to have a dedicated AMHP service with two locums on duty. Managers have reported

feeling unable to release staff from their teams for a week at a time due to either being small teams or not having sufficient cover in the teams when AMHPs are on statutory duties.

3.9 It has been opportune to review the variety of ways in which a rota could be managed in Richmond, and this consolidated that weekly dedicated should be re-instated and maintained.

4.0 OPTIONS

4.1 It has been unanimously received that the AMHP service be a centralised service.

4.1 Management of this service:

- continue from senior AMHPs being on rota weekly as manager for consultation, advice and co-ordination
- combination of AMHP seniors and non AMHP managers undertaking the role – may require consideration of expert peer legal advise
- AMHP co-ordinator role be developed to oversee the co-ordination of AMHP service, consultation and advice on day to day basis, as per previous AMHP Lead post piloted in Richmond
- ADSW post to continue to oversee the functioning of AMHP work and support AMHP managers with more complex scenarios

4.3 Staffing of rota

- 2 AMHPs coming out of teams for week at time to manage rota
- 4 AMHPs coming out of teams on 2/3 day split of a week
- Combination of above two options
- Centralised dedicated team. Staffing levels from through put of activity observed over past year would require 2 AMHPs and 1 AMHP senior
- Combination of a dedicated AMHP and 1 AMHP coming onto rota on weekly basis with AMHP co-ordinator overseeing duty

All options would require back up provision from qualified AMHPs in teams to cover leaves and days where there is exceptionally higher volumes of requests.

4.4 It would not be advisable to have a stand-alone AMHP service for a number of factors:

- Requirement for back up
- Requirement to ensure that sufficient numbers can always be made available as a statutory requirement
- Risk of ‘burn out’ is documented as much higher in stand-alone teams
- Risk of over representation of single views upon responding to MHA work clinically and Borough not big enough to justify greater numbers of AMHPs in the team than 3
- CPD opportunities for workforce – Richmond does not limit access to AMHP training unlike many Boroughs
- Sufficient number of trained AMHPs outside of dedicated service in longer term – no incentive to hire nor train AMHPs if not in dedicated team

- Loss of additional knowledge and skills from AMHPs in non-dedicated team, such as enhanced level training in risk assessment and management
- Loss of incentive for staff to be released, without backfill, to undertake such training as equates to 6 months
- Issues around leave, particularly unplanned such as sickness/compassionate
- Risk of isolation from main referring MH services that is known to increase MHA activity

5.0 SERVICE REVIEW

5.1 A survey was carried out of Richmond AMHPs in June 2013 to gather views of workers locally. It was repeated with subsequent survey in June 2014 to understand any difference to the service and role since centralising. Both services had 11 AMHPs canvassed with 100% response rate.

5.2 The surveys were loosely based around the work of J.Hudson, Kent County Council & M.Webber, Reader in Social Worker at York University who carried published on their survey – Stress and the statutory role: Findings of the 2012 AMHP Survey.

5.3 2013 When asked what three things may help you in doing work as an AMHP the response was almost unanimously around wanting clearer distinction to the role away from other duties and greater support in role.

5.4 Rating how well AMHPs felt able to balance their AMHP work against other duties the majority of workers indicated that AMHPs do not feel able to manage the demands that they reflected upon as 'competing'.

5.5 Most AMHPs felt either reasonably satisfied or unsure about how they felt about AMHP role, whilst only 9.1% felt the AMHP role is well understood. The majority of AMHPs felt it was either sometimes or not well understood, with comments highlighting a feeling that both the complexity, significant time demands and autonomous status were not understood.

5.6 The survey was carried out again in June 2014 to understand if there had been any changes in the delivery of this service and conditions for AMHPs in their practice in order to support the review of the weekly dedicated service.

5.5 Prioritise three things that assist you in doing your work as an AMHP:

70% stated support and peer supervision of being on duty with other AMHPs
60% stated being centralised away from usual team of work
50% stated time to properly consider a referral, plan and undertake the MHAA
40% stated supervision and AMHP forum
Other comments included:
Availability of AMHP manager
Regular refresher training
Co-working with other agencies particularly CHTT
Accurate information

5.6 From the perspective of the AMHPs, the change to a centralised service has demonstrated considerable improvements to their working conditions and ultimately outcomes for the service provision:

How well do you feel current AMHP rota is working?	2013	2014	Referrers
Extremely well		**63.64%**	16.67%
Well	9.09%	27.27%	**33.33%**
Ok	9.09%		16.67%
Not so well	**27.27%**		**33.33%**
Awful	9.09%		
N/A	27.27%	9.09%	

5.7 In house referrers were also surveyed. The response rate was very low at 6/105 recipients, despite repeating the mail shot. Thus the response should not be deemed as a truly representative view of all the services targeted that included inpatient, CHTT, CAMHS, and older persons services. 68.65% of the referrers gave positive feedback in relation to centralising the service. When asked what they would recommend for Richmond service 100% of referrers stated centralised AMHP service either weekly, monthly or dedicated. No referrers wished to see the service return to a daily rota.

How well do you feel you are able to balance demands for AMHP work against other tasks?	2013	2014
10. FANTASTICALLY	0.0%	
9. EXTREMELY WELL	0.0%	9.09%
8. VERY WELL	0.0%	**27.28%**
7. WELL	0.0%	**36.36%**
6. PRETTY WELL MOST DAYS	0.0%	18.18%
5. OK MOST DAYS	0.0%	
4 NOT WELL	**27.3%**	
3 NOT WELL AT ALL	18.2%	
2 NOT AT ALL	18.2%	
1 INCREDIBLY DIFFICULT	18.2%	9.09%
0 HOPELESS	0.0%	
N/A	18.2%	

5.8 The change in outcome to this question was summarised by the only additional comment to this question as “much easier to manage workload in a planned way – neither intrudes on the other meaning both sides of my work get my work get my full attention and best practice.” Colleagues at AMHP Forum on 25.09.14 said that they would all agree with this as a statement.

5.9 It has been established by management that greater links between teams, CHTT and AMHP service could support bed management difficulties more effectively. AMHPs on a weekly rota have been able to plan and ‘case manage’ referrals that did not worked on the daily rota. This would be the most effective way of responding to the concerns raised by the House of Commons scrutiny committee.

5.10 Passing cases between workers led to reports of loss of information; duplication of tasks; confusion in liaising; and a lack of clarity of plan at times. Consistency in worker following through referral has enabled better communication and risk management of cases, whilst either a MHAA is being set up or ‘least restrictive alternatives’ such as community teams or CHTT are being utilised.

5.11 It is hoped that the CHTT and AMHP service may be able to share some office space going forward, in order to further develop this worker relationship and practice, as is the current service provision in Merton that has been reported positively.

5.12 Further work is required between ADSW and Operations Manager to overview staffing and consideration of an AMHP co-ordinator to oversee the day to day running of the service. This has been developed in Merton where they are also co-located with CHTT and report this assists in reduction of bed usage and crisis of access to bed in emergencies. Merton have a higher population but a lower detention rate.

5.13 By comparison the service in Wandsworth is managed by a mix of ‘consume own smoke’ and 3 separate AMHP duty service covering one GP surgery and then a split in the Borough. There is no way to compare numbers of AMHPs at any time undertaking MHAAs in this regard, but they have 3 AMHPs on duty daily to cover any unknown service users.

5.14 Kingston currently run a non-centralised daily duty service for unknown service users, as per Richmond previously. We have shared data to support the review of their service, which is proposed to also centralise upon some evidence founded from the review.

5.15 Both AMHPs and referrers in majority considered that there was an improvement to the service and the consistency of AMHP throughout week was highlighted as the biggest positive for referrer, service user and their families.

5.16 It was envisaged that the main challenge of this rota would be management of AMHPs caseload whilst away from their usual team. It was acknowledged that this is challenging and there has been some tension from other professionals in this regard which came out in the survey.

5.17 AMHPs felt that there absence could be better managed when planned in this way rather than previously when they would not know when a statutory assessment would be required to take precedence over their day. AMHPs generally believed that this was a more positive way of working for the service users on their own caseload, as they no longer have to cancel appointments without notice in this regard.

5.18 Anecdotally the MIND carers lead reported that whilst there have not been any specific comments from carers about the change to a centralised AMHP service, she could report that since commencing there have not been concerns or complaints raised which was the case previously.

6.0 Appendix

6.1 Staffing during the period of review:

- 2 permanent experienced AMHPs have left the service
- All AMHPs are also BIA qualified creating further complication and restriction to availability for AMHP duty requiring further negotiating
- 2 trainees have successfully completed placement and warranting
- 1 qualified AMHP due to return from maternity leave at end of year and will be supported to work toward warranting early next year
- No current candidates suitable to recommend for AMHP training
- 1 locum AMHP currently (2 recently left)
- 2 further locum AMHP required for sufficient cover
- 3 AMHPs that had left service completed survey having worked during this period
- Richmond requires 12 AMHPs to ideally cover 1 in 6 weeks on rota
- Average assessments take 5+ hours up to several days depending on nature of referral and associated matters (can be several attempts before concluded)
- ALL respondents from both surveys wanted a continued Centralised dedicated AMHP Service.