Research Square

Preprints are preliminary reports that have not undergone peer review.
They should not be considered conclusive, used to inform clinical practice,
or referenced by the media as validated information.

Approved Mental Health Professionals' (AMHPs) lived experience of the roleand factors that could support improved recruitment, retention, and wellbeing: a qualitative study

Francesca Mazzaschi

MazzaschiFI@cardiff.ac.uk

Cardiff University https://orcid.org/0000-0001-7947-6906

Abubakar Sha'aban

Cardiff University https://orcid.org/0000-0002-5491-9851

Rebecca Roberts

Cardiff University

Muawiyah Sheraz

Cardiff University

Anthony Cope

Cardiff University

Adrian Edwards

Cardiff University https://orcid.org/0000-0002-6228-4446

Natalie Joseph-Williams

Cardiff University https://orcid.org/0000-0002-8944-2969

Research Article

Keywords: Approved Mental Health Professionals, recruitment, retention, well-being

Posted Date: July 8th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-10280515/v1

License: This work is licensed under a Creative Commons Attribution 4.0 International License.
Read Full License

Additional Declarations: The authors declare no competing interests.

Approved Mental Health Professionals' (AMHPs) lived experience of the role and factors that could support improved recruitment, retention, and wellbeing: a qualitative study

Authors: Francesca Mazzaschi[1], Abubakar Sha'aban[1], Rebecca Roberts[2], Muawiyah Sheraz[2], Anthony Cope[1], Adrian Edwards[1], Natalie Joseph-Williams[1]

1. Health and Care Research Wales Evidence Centre, Cardiff University, United Kingdom
2. School of Medicine, Cardiff University, United Kingdom

Abstract: Approved Mental Health Professionals (AMHPs) are specially trained and authorised under the Mental Health Act to undertake necessary duties needed to determine whether an individual must be compulsorily admitted and detained in a psychiatric unit. The AMHP must consider both medical recommendations and the law in making the final decision in these situations. The AMHP role is vital within both mental health care and legal systems in England and Wales, ensuring the safety, rights, and care of individuals experiencing mental health crises. However, the AMHP workforce is facing increasing challenges related to recruitment, retention, and wellbeing. To ensure the continuity of this critical workforce, we must understand the lived experiences of AMHPs and the factors contributing to these challenges.

The aim of this study was to explore the lived experiences of AMHPs in Wales to identify the factors that impact their recruitment, retention, and wellbeing, and to make recommendations for supporting and sustaining the workforce. The objectives were to explore lived experiences of AMHPs in Wales, key factors that influence the recruitment of AMHPs, the retention of AHMPs, the role's impact on practitioner wellbeing, perceived impact of regional, legal, and policy contexts in Wales, and AMHP recommended changes to improve recruitment, retention, and wellbeing. We conducted a qualitative study, using semi-structured online interviews (October 2025-March 2026) to explore these objectives. Data underwent framework analysis based on the Job Demands-Resources (JD-R) theory.

We recruited 23 participants with experience of working in 20 of 22 local authorities in Wales. Participants identified key demands of the role including workload, unpredictability of tasks and finish times, gravity of decisions and organisation of logistics. Participants described both role-based and personal resources available to support them. All participants discussed their experiences working with other services such as hospital staff and the police.

Mutual respect and understanding of roles and responsibilities was essential in creating a positive working environment. Implementation of the Right Care Right Person (RCRP) policy still requires improvement to be valuable to all involved. The demands of the role and limited resources affected staff wellbeing. Participants suggested aspects of the role that need to be improved.

This study identified both within AMHP teams and system level recommendations to improve recruitment, retention and wellbeing of the workforce. These derived from both AHMPs' suggestions and our analysis, and included i) shift design and staffing, ii) support, supervision and role management, iii) interagency working, iv) service infrastructure, and v) training and professional development.

Funding statement: This work was funded by the Health and Care Research Wales Evidence Centre, itself funded by Health and Care Research Wales on behalf of Welsh Government.

Health and Care Research Wales Evidence Centre
Canolfan Dystiolaeth Ymchwil Iechyd a Gofal Cymru

Approved Mental Health Professionals' (AMHPs) lived experience of the role and factors that could support improved recruitment, retention, and wellbeing: a qualitative study

June 2026

Health and Care Research Wales Evidence Centre
Canolfan Dystiolaeth Ymchwil Iechyd a Gofal Cymru

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

Ariennir gan Lywodraeth Cymru
Funded by Welsh Government

Report Contributors

Health and Care Research Wales Evidence Centre Research Team

Dr Francesca Mazzaschi (Research Associate), Dr Abubakar Sha'aban (Research Associate)

Rebecca Roberts (Student)

Muawiyah Sheraz (Student)

Prof Adrian Edwards (Health and Care Research Wales Evidence Centre Director)

Dr Natalie Joseph-Williams (Associate Director and Reader in Improving Patient Care)

Public Partner

Anthony Cope

Stakeholders

Judith Rheade (Social Care Wales)

Dr Jeremy Dixon (Reader in Social Work, Centre for Adult Social Care Research (CARE) Cardiff University)

Evidence need submitted to the Evidence Centre: April 2025

Initial Stakeholder Consultation Meeting: 4th June 2025

Final Report issued: July 2026

The report should be cited as: Mazzaschi F, Sha'aban A, Roberts R, Sheraz M, Cope A, Edwards A, Joseph-Williams N. Approved Mental Health Professionals' (AMHPs) lived experience of the role and factors that could support improved recruitment, retention, and wellbeing (PR0050). June 2026

Disclaimer: The views expressed in this independent report are those of the authors, not necessarily Health and Care Research Wales or Welsh Government. The Health and Care Research Wales Evidence Centre and authors of this work declare that they have no conflict of interest.

© 2023 Health and Care Research Wales Evidence Centre.
Material contained in this document may be reproduced under the terms of the Open Government Licence (OGL) www.nationalarchives.gov.uk/doc/open-government-licence/version/3/ provided it is done so accurately and is not used in a misleading context. Acknowledgement to Health and Care Research Wales Evidence Centre to be stated. Copyright in the typographical arrangement, design and layout belongs to the Health and Care Research Wales Evidence Centre.

Approved Mental Health Professionals' (AMHPs) lived experience of the role and factors that could support improved recruitment, retention, and wellbeing: a qualitative study

Executive Summary

(Report number: PR0050, June 2026)

Background

Approved Mental Health Professionals (AMHPs) are specially trained and authorised under the Mental Health Act to undertake necessary duties needed to determine whether an individual must be compulsorily admitted and detained in a psychiatric unit. The AMHP must consider both medical recommendations and the law in making the final decision in these situations.

The AMHP role is vital within both mental health care and legal systems in England and Wales, ensuring the safety, rights, and care of individuals experiencing mental health crises. However, the AMHP workforce is facing increasing challenges related to recruitment, retention, and wellbeing. To ensure the continuity of this critical workforce, we must understand the lived experiences of AMHPs and the factors contributing to these challenges.

The aim of this study was to explore the lived experiences of AMHPs in Wales to identify the factors that impact their recruitment, retention, and wellbeing, and to make recommendations for supporting and sustaining the workforce.

The objectives were to explore:

- lived **experiences** of AMHPs in Wales (including day-to-day roles, responsibilities, interactions with other services).
- key factors that influence the **recruitment** of AMHPs
- what affects the **retention** of AMHPs within local authorities and health/social care systems
- the role's impact on **practitioner wellbeing**
- perceived impact of **regional, legal, and policy contexts in Wales**
- **AMHP recommended changes** to improve recruitment, retention, and wellbeing

Methods

We conducted a qualitative study, using semi-structured online interviews (October 2025-March 2026) to explore the lived experiences of AMHPs across Wales to understand the demands of the role, resources available and recommendations suggested by AMHPs for improving retention, recruitment and wellbeing of the workforce. Interviews were recorded and transcribed, and data underwent framework analysis based on the Job Demands-Resources (JD-R) theory.

Key Findings

We recruited 23 participants with experience of working in 20 of 22 local authorities in Wales. Experience ranged from those still training, to those with over 20 years of experience.

Participants identified key demands of the role including workload, unpredictability of tasks and finish times, gravity of decisions and organisation of logistics. Participants described both role-based and personal resources available to support them. This includes support from line managers and peers, training, building confidence over time, alignment with personal beliefs and finding personal value in the role. However, most described that overall demands outweigh available resources.

All participants discussed their experiences working with other services such as hospital staff and the police. Mutual respect and understanding of roles and responsibilities was essential in creating a positive working environment. Implementation of the Right Care Right Person (RCRP) policy still requires improvement to be valuable to all involved.

The demands of the role and limited resources affected staff wellbeing. This was often described as increased anxiety, challenges of navigating work-life balance and experiences of moral injury.

Participants suggested aspects of the role that need to be improved, although most were unsure as to what practical changes can be made to achieve this.

Recommendations

This study identified both within AMHP teams and system level recommendations to improve recruitment, retention and wellbeing of the workforce. These derived from both AHMPs' suggestions and our analysis:

	Within AMHP Team	**System / Policy Level**
Shift Design & Staffing	-≥2 AMHPs per shift -Cross-local authority collaboration -Overlapping/sharing shifts	-Regional/shared AMHP service models
Support, Supervision & Role Management	-Structured supervision (line, reflective, peer) -Reduced dual-role caseloads & clear boundaries -Debriefing and protected time	-National workload guidance -Supervision standards -Prioritisation of staff wellbeing
Interagency Working	-Promote role understanding -Escalate RCRP misapplication	-Improved communication pathways -National guidance (roles, thresholds, RCRP) -Joint multi-agency training
Service Infrastructure	-Shared use of resources across authorities	-Access to patient places of safety as a minimum standard -Standardised pay and incentives
Training & Professional Development	-Increased assessment exposure -Early-career support	-Expanded training provision -Reduced barriers to entry

Contents

Executive Summary ***3***

Abbreviations ***6***

1. Background ***7***

2. Aims and Objectives ***9***

2.1 Aim 9

3. Methods ***10***

3.1 Study population 10

3.2 Recruitment 11

3.3 Data collection 12

3.4 Data Analysis 13

4. Results ***14***

4.1 Participants 14

4.2 Key findings 16

5. Discussion ***36***

5.1 Workload 37

5.2 Organisation of logistics 39

5.3 Impact on Staff Wellbeing 42

5.4 Strengths and Limitations 44

6. Recommended areas of improvement ***44***

7. References ***46***

8. Additional Information ***49***

8.1 Information available on request 49

8.2 Conflicts of interest 49

8.3 Acknowledgements 49

Abbreviations

SMREC	School of Medicine Research Ethics Committee
AMHP	Approved Mental Health Professional
MHA	Mental Health Assessment
JD-R	Job Demands-Resource
PGCert	Postgraduate Certificate
RCRP	Right Care Right Person
THRIVE	Threat, Harm, Risk, Investigation, Vulnerability and Engagement model
RAVE	Resistance, Aggression, Violence or Escape

1. Background

Approved Mental Health Professionals (AMHPs) play a vital role within the mental health care and legal systems in England and Wales, ensuring the safety, rights, and care of individuals experiencing mental health crises [1]. However, the AMHP workforce is facing increasing challenges related to recruitment, retention, and wellbeing [2, 3]. Research has also identified how AMHP recruitment and retention are shaped by organisational pressures, workload and limited training capacity [4]. To ensure the continuity of this critical workforce, it is essential that we understand the lived experiences of AMHPs, and how these demands contribute to these challenges.

AMHPs are specially trained professionals who are warranted under the Mental Health Act 1983 (and under the newly enacted 2025 Act) [5] to carry out a range of statutory duties relating to people with mental health needs. AMHP are warranted under local councils to hold specific legal authority within the council jurisdiction. Their role is both person-centred and legal, with a strong emphasis on safeguarding the rights, autonomy, and wellbeing of individuals. AMHPs operate in high-pressure, emotionally demanding, and ethically complex situations [1]. They are responsible for Mental Health Act (MHA) assessments, particularly regarding whether a person needs to be detained in hospital for assessment or treatment [5]. Within this role, they must balance legal considerations and the rights of the individuals, coordinate hospital admission or appropriate community-based care, liaise with relevant services and families, and importantly see the person through a social care model of mental health.

Although AMHPs report pride in their emotionally and ethically complex work, these professionals often remain an “invisible” workforce [6, 7]. Public visibility typically only arises when serious incidents occur and are reported in the media [8]. The challenges they face are compounded by systemic pressures, such as limited hospital bed availability, delayed ambulance or police responses, insufficient community mental health resources, complex multi-agency coordination, and financial constraints within local authorities [9]. An ageing workforce [10], and limited role-specific incentives [11] further exacerbate workforce sustainability issues.

AMHPs will be affected by forthcoming legislative and policy developments, including the gradual implementation of the Mental Health Act 2025 [5], the ‘Right Care, Right Person’ (RCRP) and the implementation of the Welsh Wellbeing and Mental Health Strategy 2025-2035 [12]. The Mental Health Act 2025 has now been enacted, although its provisions will be implemented in stages.

The Mental Health Act 2025 introduces reforms that increase the complexity of the AMHP role. In particular, the Act replaces the ‘nearest relative’ with a ‘Nominated Person’ and strengthens their

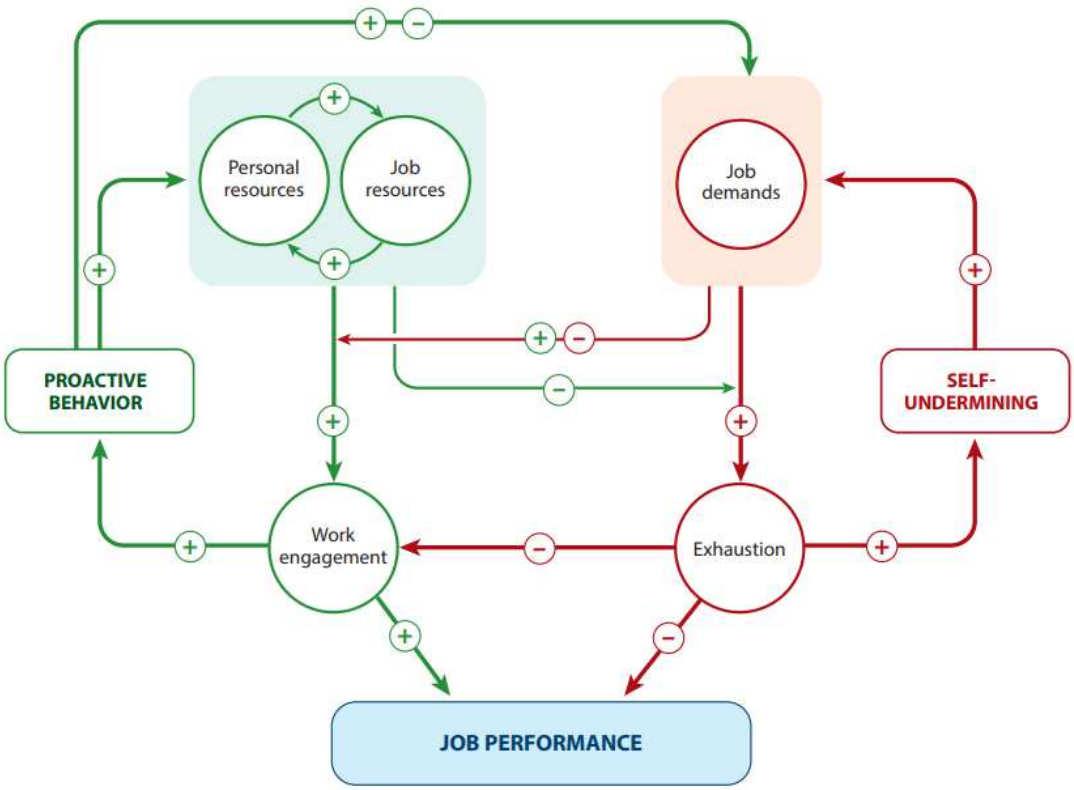
role within the detention process. While AMHPs are now under a duty to consult the Nominated Person, the legislation allows an application for detention to proceed despite an objection where specific criteria are met, including where there is a risk of harm [13]. This effectively places greater responsibility on AMHPs to justify decisions that override the wishes of the patient's representative, increasing the likelihood of scrutiny and potential legal challenge. These changes, alongside wider reforms such as tighter detention criteria and new duties, point to an increasingly complex and legally demanding role for AMHPs, with corresponding implications for professional risk and stress.

In addition, workforce function is constrained by ongoing operational issues, including the limited availability of MHA Section 12-approved doctors, which contributes to assessment delays. Only two Health Boards in Wales currently have Section 140 bed policies in place, despite the requirement that these policies specify beds to be used in emergency situations. Delays in arranging safe and timely ambulance transport also continue to pose significant risks for both practitioners and individuals in crisis.

AMHPs are essential professionals at the intersection of mental health care, social justice, and the law. They protect vulnerable people, ensure ethical and legal practice in compulsory mental health interventions, and help uphold the rights of individuals while ensuring public and personal safety. A deeper understanding of AMHPs' lived experiences is urgently needed to inform sustainable workforce planning and support mechanisms tailored to the Welsh context. The estimated total AMHP workforce in Wales is approximately 295 individuals, of whom a significant proportion are aged 50 or above. This demographic context makes the issue of recruitment, retention, and wellbeing particularly urgent and relevant for study.

The Jobs Demands-Resource (JD-R) theory is often used to understand, explain and make predictions about employee wellbeing and job performance [14]. This is done using the JD-R model, which proposed that job characteristics consist of two categories; Demands (physical and mental efforts) and Resources (factors which motivate and mitigate stress). Figure 1 shows how both demands and resources contribute to job performance. It is proposed that high demands may lead to burnout, while high resources promote positive engagement. As we know the AMHP workforce is currently experiencing challenges around recruitment and retention, the demands and resources of the role will be explored in this study to better our understanding of key areas of stress and gain a better understanding of what resources are currently available.

Figure 1: The job demands-resource model. Bakker et al 2022



2. Aims and Objectives

2.1 Aim

To explore the lived experiences of AMHPs in Wales to identify the factors that impact their recruitment, retention, and wellbeing, and to generate recommendations for supporting and sustaining the workforce.

2.2 Study Objectives

1. Understand the **personal and professional lived experiences** of AMHPs in Wales (focusing on how they navigate their day-to-day roles, responsibilities, interactions with other services).
2. Understand **key factors that influence the recruitment of AMHPs**, including key motivations to enter the role, perceived barriers, and enablers.

3. Examine the **challenges and enablers affecting the retention of AMHPs** within local authorities and health/social care systems.
4. Understand how the role of AMHP impacts practitioners' **wellbeing**, including emotional, psychological, and professional aspects.
5. Explore **perceived impact of regional, legal, and policy contexts in Wales** (including upcoming legislative changes).
6. Generate **co-produced recommendations**, informed by AMHPs' lived experiences, for improving recruitment, retention, and wellbeing support, aimed at supporting and sustaining the AMHP workforce in Wales.

3. Methods

This was a qualitative study using semi-structured interviews to explore the lived experiences of AMHPs across Wales to gain a better understanding of the demands of the role and the resources available.

Favourable ethical opinion was granted by Cardiff University School of Medicine Research Ethics Committee (SMREC 26/16). The study protocol, recruitment processes and public facing documents were developed with our Public Partner (AC) to ensure they were feasible, understandable, and relevant.

3.1 Study population

The study population comprised Approved Mental Health Professionals (AMHPs) in Wales, including those who:

- Are currently practising, in training, or have recently left the workforce (within the past two years)
- Are employed on a full-time, part-time, or sessional basis
- Come from any professional background
- Represent different career stages, including newly qualified AMHPs and those approaching retirement or recently retired

3.1.1.1 Inclusion Criteria

- Currently practising as an AMHP in Wales
- Currently undertaking AMHP training
- AMHPs not currently practising (e.g., on extended leave or recently retired within two years) but willing to participate
- Willing and able to provide informed consent

3.1.1.2 Exclusion Criteria

- Individuals with no prior or current experience in the AMHP role or training

3.1.2 Sample

The study aimed to recruit between 20 to 30 AMHPs from across the 22 Welsh Local Authorities. A maximum variation sampling strategy [18] was employed to ensure diversity in participant characteristics, including geographical region, gender, age, length of time qualified as an AMHP, proximity to retirement, professional background, and employment setting (e.g., full-time AMHP role vs. dual role with other social work responsibilities, AMHPs currently in training, and those who have recently left the role).

Representation from different regions and local authorities was particularly important to capture geographical and organisational variation. This is critical, as a significant part of the perceived challenges in the AMHP role stem from the wide variability in local practices, remuneration structures, professional recognition, and support across different areas.

3.2 Recruitment

Recruitment was conducted using purposive and snowball sampling strategies to ensure variation in region, professional background, and years of experience.

3.2.1 Recruitment Process

1. Initial Contact via Gatekeepers

The research team collaborated with key stakeholders and gatekeepers, including:

- Welsh Local Authority AMHP leads
- The All-Wales AMHP Community of Practice, facilitated by our stakeholders

These individuals were asked to share an ethically approved secure online screener form link and a brief study advert via internal communication channels (e.g., email, newsletters, staff meetings) to the estimated 295 relevant staff in Wales.

2. Expression of Interest

Interested participants filled in a secure online screener form to make sure they met the study inclusion criteria. Respondents accessed the Participant Information Sheet (PIS) on the screener form, to understand the study objectives. Once this had been completed, interview participants were purposely sampled from the pool of interested individuals.

3. Snowball Sampling

Participants were invited to recommend other eligible AMHPs who may be willing to take part. These referrals were followed up with a similar recruitment and consent process.

3.3 Data collection

Semi-structured interviews were conducted via virtual call on Microsoft Teams between October 2025 and January 2026. Interviews were conducted by FM and were audio-recorded. An interview schedule was used to guide discussion to ensure key topics were explored. This was developed with stakeholders, including our public parter (AC), to ensure questions were accessible, accurate and facilitated open discussion.

A summary of key topics covered in the interview guide is included in Table 1.

Table 1: Key topics covered in the interview guide

TOPIC	DESCRIPTION
BACKGROUND INFORMATION	Looking at what led participants to train as an AMHP.
DAY-TO-DAY EXPERIENCES	Exploring what a typical day look like, what challenges do they face and what do they find meaningful.
INTERAGENCY WORKING	Discussion around how they find working with other services and how have recent policy changes affected that.
WELLBEING	Exploring the impact of the role have on AMHP wellbeing and what helps promote wellbeing in the role.

RETENTION	Looking at what may impact an AMHPs discission to stay in the role or leave.
REGIONAL VARIABILITY	Exploring experiences and perceptions around how practice varies across Wales.
RECOMMENDATIONS FOR IMPROVEMENT	Asking participants what changes could be made to support recruitment, retention and wellbeing of the workforce.

3.4 Data Analysis

Interviews were transcribed verbatim for analysis using a Cardiff University authorised third-party transcription service ('Transcribe This Ltd'). Transcripts were imported into NVivo 15 pro Qualitative Analysis Software (Lumivero, 2017) for analysis.

A framework analysis approach was used to systematically analyse the interview data. This method allowed for both deductive coding aligned with predefined themes (specifically the JD-R model) and inductive coding to capture new, emergent themes from the participants lived experiences. The analysis followed these key stages:

- **Familiarisation** – Transcripts will be read and re-read to gain an in-depth understanding of the data.
- **Coding** – Data will be coded according to the key domains of the JD-R Theory (e.g. job demands, job resources, outcomes) and other emergent areas of relevance to the research aims.
- **Charting** – Data will be summarised and organised into a matrix to facilitate comparison across cases and thematic categories.
- **Interpretation** – Patterns, differences, and relationships within the data will be explored to generate meaningful insights and inform recommendations.

Coding was led by the study lead (FM), with at least 20% of transcripts double coded by a second researcher (MS and BR) to enhance reliability. Any discrepancies in coding were discussed and resolved collaboratively. Emerging findings and theme development was reviewed iteratively with NJW and the wider study team.

4. Results

4.1 Participants

We recruited a total of 23 participants. Overall, 65% (n=15) of participants identified as female;35% identified as male (n=8). Full summary of demographic data can be seen in table 1.

4.1.1 Local Authority Representation

Local authorities were represented either by those currently hold a warrant with them, or those who had previously been warranted with them. Twenty local authorities were represented in the interviews, only excluding Denbighshire and Isle of Anglesey. While we were unable to interview participants currently warranted with Blaenau Gwent or Bridgend, we were able to interview participants who had previously been warranted with them (See table 2).

Table 2: Number of participants currently or previously warranted under each Welsh local authority

Local Authority	Number of participants currently warranted	Number of participants previously warranted
Blaenau Gwent	0	1
Bridgend	0	1
Caerphilly	1	0
Cardiff	2	1
Carmarthenshire	1	0
Ceredigion	1	0
Conwy	1	0
Denbighshire	0	0
Flintshire	2	0
Gwynedd	1	1
Isle of Anglesey	0	0
Merthyr Tydfil	2	0
Monmouthshire	1	1
NPT	2	1
Newport	1	0
Pembrokeshire	1	0
Powys	1	0
RCT	2	1
Swansea	1	1
Torfaen	1	0

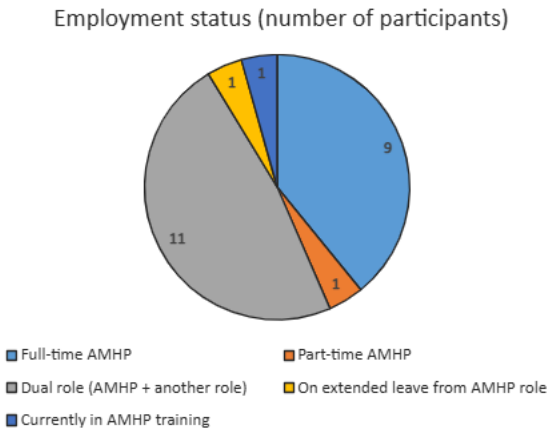
VoG	1	0
Wrexham	1	0

4.1.2 Employment status and setting

Participants interviewed included full-time AMHPs (n=9) and part-time AMHPs (n=1) as well as those in dual role positions(n=11), on extended leave from the AMHP role (n=1) and current trainees(n=1). The most common employment status was those in dual role positions, undertaking AHMP duties alongside their caseload as a social worker (See fig 2).

Whilst most participants were employed under their local authority, other employment settings included within the police and NHS teams.

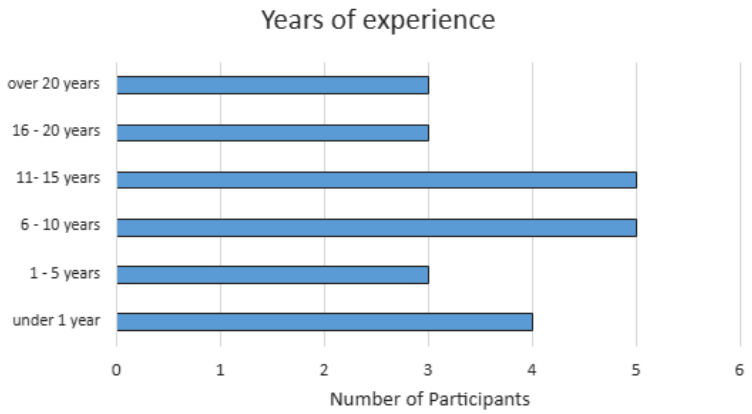
Figure 2- Employment status



4.1.3 Years of Experience

There was a wide range of years of experience in the participants interviewed. This ranged from those still training to those with over 20 years of experience in the role (see fig 3). Those who started prior to November 2008 qualified as Approved Social Workers (ASWs) and moved into the AMHP role when the provisions of the Mental Health Act 2007 replaced the ASW role with the AMHP role.

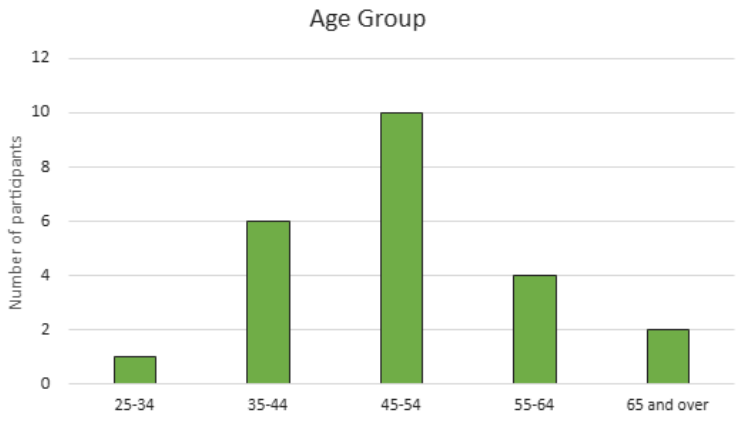
Figure 3- Years of Experience



4.1.4 Age

Participants age groups raged from 25-34 years to 65 years and over, with the most frequently reported age group being 45-54 years (See fig 4)

Figure 4- Age Groups of Participants



4.2 Key findings

Overall, seven key themes emerged from the interviews. These themes are summarised in Table 3 below. A detailed list of themes, sub-themes and exemplar quotes is provided in Appendix B and is discussed in detail below. Due to the workforce size in some local authority areas, detailing where individual participants were based may lead to participant identification. As a result of this, we have analysed the data collectively rather than highlighting specific examples of practice.

Table 3: Themes and Sub-themes

Themes	Sub-themes
Job Demands (from JD-R theory)	Workload Gravity of Decisions Organisation of Logistics Unpredictability
Job Resources (from JD-R Theory)	Line Management Peer Support Training
Personal Resources (from JD-R theory)	Personal Beliefs Confidence Finding Value in the Role
Impact on Wellbeing	Anxiety Work-life Balance Moral Injury
Variability Across Wales	Case Complexity Procedures Staffing Structure Resources
Interagency Working	Mutual Understanding Policy and Legislation Mutual Respect
Recommendations	Improvements to Recruitment Improvements to Retention System Level Changes

4.2.1 Job Demands

This theme covers key aspects of the role that may prove to be challenging or demanding. Four sub-themes were identified including workload, emotional impact and gravity of decisions, organisation of logistics and unpredictability.

4.2.1.1 Workload

One workload demand mentioned by many participants related to dealing with multiple referrals. In some areas, this is alleviated by having multiple AMHPs on duty at once. However, this is not standard practice across all local authorities. This was seen in some cases as leading to an unmanageable workload.

> ***"one person on the rota, and you could get three assessments, which is, you know, it's really hard going." (P12)***

Although this is a key issue for areas with only one AMHP on the rota, it is still reported as a challenge in areas with two AMHPs in times of high demand.

> ***"I've logged on and discovered that there are three assessments waiting for us. Two AMHPs, three assessments and, that's really difficult to manage." (P23)***

This high workload impacted those working in dual roles. A particular problem highlighted by several participants was their caseload in their other role not taking into account the time needed to do their AMHP role.

> ***"People who are working in the community teams, they're always promised that they will be given a lower caseload and protected time to do their AMHP work and, and to do their day-to-day care coordination roles. But it rarely works that way, because there is such a high demand." (P08)***

When asked about how they balance both roles, some participants reported that whilst those in dual roles see their AMHP role as an integral part of their work, it is can be regarded as a separate additional stressor.

> ***"I think it is core work. And I think the difficulty we often have is that it's othered, so then people see it as this additional stress, rather than part of their job." (P01)***

Further to this, people in dual roles faced specific challenges depending on the teams they were based in. Those based in mental health teams often felt that whilst some saw the benefit in being managed by those who had understanding and experience in the AMHP role, as they felt more supported in taking time away from their core caseload, some felt this made it difficult to maintain boundaries.

> ***"…I think the focus is more on AMHP. So even if I've got three visits booked in a day, if the AMHP on duty is having a hell of a day, I will get a call and say you need***

to cancel your visit, this takes priority, and then everything else gets kind of shunted back then." (P12)

Workload challenges were exacerbated in authorities that were understaffed. Participants noted unsustainable conditions that had a knock-on effect on their core role

"what happens then is people leave, services change, people go off sick and I think by the time I finished, we were doing, I was doing one week in three or four because there weren't many of us plus I always kind of mentor it to colleagues now, plus a kind of a caseload of 40 odd people plus one week in four or five on the office duty rota as well. So it became kind of unmanageable really."(P15)

4.2.1.2 Gravity of Decisions

Participants all expressed a clear understanding of the impact of their decisions. The responsibility of deciding if an individual should be detained is something that all participants commented on and it was clear that most participants saw this as a challenge of the role.

"I think we, you know, we are, we are making massive decisions that affect, can potentially affect the course of the rest of somebody's life on almost every occasion."(P04)

4.2.1.3 Organisation of Logistics

The organisation of logistics was reported to be one of the most demanding aspects of the role.

"Dealing with, with people is the easy part. That's, you know, sadly, the reality of it. It's all the navigation."(P06)

Issues related to limited resources included transport, police and doctor availability; however the most frequently reported issue was with bed availability. This often led to the assessment process taking longer which increases risk in community settings as well as having an effect when organising other services.

"When you're sat there, either waiting for an ambulance or, you know, the St John's Ambulance, or while you're waiting to see if there's a bed. And then what do you do if you can't make the application? It's a lot of, there's a huge amount of

stress you carry and risk trying to manage that risk it's down to the health board. Unfortunately, if there's no beds, we can't magic up beds, but it's you still carry it."(P03)

4.2.1.4 Unpredictability

When asked to describe a typical working day as an AMHP, all participants expressed that, due to the nature of the role, there was no way to predict exactly how the day will go. While some more predictable elements were reported, such as the assessment of those already admitted to hospital, it was generally expressed that the role is unpredictable at its core.

> ***"There will be work that you do which is more predictable. You may go and assess somebody who's in hospital already under the Mental Health Act…So yeah, but we do that as well. So that's slightly more predictable work. And you can kind of predict when that, you know, you've got a date when that ends."(P01)***

One of the key issues reported surrounding the unpredictability of the role was the uncertainty around working day end times. Most participants reported that they would be expected to work past their scheduled shift if a request comes through towards the end of the day.

> ***"I think in terms of, like, you will get a call at five to five, end of the day, and you're just expected to run with that. So, you know, there are days where I've worked from nine o'clock in the morning to three o'clock the next day, and I haven't had a proper break. You know? I haven't eaten well."(P12)***

Overall, participants generally expressed the key demands of the role to be the elements outside of their control. While the gravity of decision-making was widely acknowledged as an inherent challenge, the key stressors were more frequently linked to managing high and sometimes unmanageable workloads, navigating unpredictability in daily tasks and working hours, and coordinating complex logistics with limited available resources. These demands are further exacerbated in understaffed services and dual-role positions, where competing responsibilities and unclear boundaries intensify pressure. Collectively, this suggests that, although some level of demand is accepted as part of their role, their combined impact may

negatively influence staff wellbeing and may contribute to ongoing challenges in workforce retention.

4.2.2 Job Resources

This theme covered the experiences and opinions of participants surrounding resources available to them to carry out their work. This includes three sub-themes; line management, peer support and training

4.2.2.1 Line Management

Throughout these interviews, it was clear that participants' experience with line management played a substantial role in determining their job satisfaction. When facing the challenges of the role, it was expressed that having a manager who understood the challenges faced and had experience in the role was appreciated.

> ***"I've always felt supported because I've always been supervised and managed by AMPHs, so they've always had that kind of understanding and they either did or are currently still doing the role."(P05)***

However, in some situations, having the same manager for the AMHP role and a different role sometimes led to situations where participants felt unable to maintain boundaries. Participants explained how they were sometimes expected to take on AMHP duties when not scheduled on the rota.

> ***"In some cases, we've had an email out to the other AMHPs just to say, "look, the AMHP is really busy. Can anyone kind of step up?" but that's really difficult to manage, because you've got to do your other work." (P12)***

It was also reported that some participants felt that they lacked an adequate amount of formal supervision. When asked if they felt they were able to go to their supervisor for support, one participant highlighted that although they felt their supervisor provided as much support as possible, they recognised that their workload and was conscious of this when seeking support.

"I do. But, again, we work in a system that is so overloaded. And she's probably overloaded with other things. And she's, you know. Yeah. We are overwhelmed."(P20)

Others expressed dissatisfaction with the level of support provided by managers. One participant recalled an instance where they received follow-up support from the police officer working on an assessment but no follow up from their line manager.

"the phone rang and it was the police person who I was liaising with asking me, you okay, you finished? Just make sure you're safe. I said, yeah, thank you for ringing. Really, you know, really thoughtful. Never heard from my managers. Not a, you know, they didn't even ask me on Monday morning."(P10)

Being able to have clear communication channels with supervisors or line managers was valued amongst participants, as it provides opportunities to be able to debrief after facing challenging situations or decisions.

"I think my management, they, they are really supportive. Yeah, they are. And, you know, you can have robust conversations with them about stuff, there's no, no problem with that, but they are really supportive."(P19)

4.2.2.2 Peer support

Peer support was often the primary source of support for staff. Participants said that a support team provided a vital sense of community and allowed for informal debriefing.

"we're a good, close-knit team, so there's always somebody at the end of the phone, if you ever needed to debrief a bit. We have, because there's generally, always two of us on, we make sure that we're supporting each other and keep in check with each other. Make sure everything's going okay."(P06)

While participants appreciate the autonomous nature of the role, having someone to talk through ideas and decision making both improved confidence in decisions and helped to alleviate feelings of isolation when working in stressful situations.

"It means that I can be challenged on it by somebody else who knows what our roles [and] responsibilities are, who understands the legal framework. Someone

can go, I'm not sure that was quite right. Or, you know, you can have that in the moment feedback, which I think is really important."(P08)

Good peer support also contributed to participants feeling a sense of responsibility to their peers. This resulted in some to remain in the role in order to support their peers.

"you want to be there for your peers, your fellow AMHPs as well. You keep going." (P12)

4.2.2.2 Training

Many participants were pleased with the level of AMHP training provided. Training for the role is currently a Postgraduate Certificate (PGCert) in AMHP practice and in Wales is exclusively delivered by Swansea University. It was seen that they found the course to be informative and generally enjoyable.

"But I really enjoyed it. I felt it was pitched well. The content was good. It was clear. It was a lot of work, but I enjoyed it."(P05)

Although course satisfaction was fairly high amongst participants, some expressed that they felt that training opportunities and resources were limited, with mention of the Swansea based course being the only one based in Wales.

"I may be speaking out of turn here, but I think it's a bit of an issue in Wales, isn't it, is that - I, I know the Swansea of course is still going, but I'm not - the opportunities to train are not far and wide, I don't think."(P19)

Further to this, one participant highlighted challenges surrounding entrance requirements to the course being unattainable to those not working within a mental health team.

"I think it's very discouraging when it's opened up to other people and they're told that they can't do it because they haven't got the experience. I mean, that's ridiculous."(P09)

Overall, it can be seen that the availability and quality both line management and peer support are critical in shaping staff experience, influencing both retention and wellbeing. Supportive and knowledgeable line management can positively impact staff satisfaction, but inconsistencies in supervision, unclear boundaries, and system pressures may serve to

undermine this. It is also clear that peer support is a clear factor in the retention of staff and is a valued resource, mitigating isolation, strengthening decision-making, and fostering a shared sense of responsibility that promotes the retention of the workforce. While initial training is generally viewed positively, these findings acknowledge that limited opportunities and barriers to those outside of mental health teams may impact recruitment.

4.2.3 Personal Resources

This theme highlights personal skills and traits that participants attributed to both wanting to join and helping them remain in the workforce. Three sub-themes emerged from the data; personal beliefs, confidence, finding value in the role.

4.2.3.1 Personal Beliefs

The most frequently reported benefit of the role was that participants felt that it aligned with their personal beliefs. Almost all participants mentioned that they found it meaningful to be able to advocate for and help those in need.

> ***"I've always viewed it as a privilege. You know, it can feel uncomfortable at times. But seeing people in that moment and feeling that you can do something to make it a little bit less shit, not necessarily better, but if you can make their experience a little bit less awful, then there's value in that."(P05)***

4.2.3.2 Confidence

Having confidence in decision making played a vital part in determining job satisfaction. Many participants expressed how their confidence had grown as they gained more exposure to the role. This enabled participants to feel better equipped to challenge other professionals to advocate for the person undergoing assessment.

> ***"So it wasn't like a single assessment where I thought, I can do this now. It was a gradual sort of shift where there's times I look back and think I actually quite enjoy doing this work now as opposed to really dreading it when I first started."(P05)***

This was reinforced by participants reflecting on how they felt as newly qualified AMHPs and the apprehension experienced when trying to make those challenges.

> ***"Have no anxiety about making this statement, but if you were a newly qualified AMHP, as I was many years ago, so speaking from experience, would I have made that challenge now? I wouldn't be confident in saying to you that I would have, that I would feel confident in making that challenge. So it's only the years of experience, of becoming more confident."(P11)***

4.2.3.3 Finding Value in the Role

As well as the appreciation for how the role helps those in need, participants mentioned several other elements of the role that they find valuable. Many of those who worked in dual-role positions expressed how the AMHP training and being continuously involved in the role helped them in their other role.

> ***"I mean obviously I had a caseload then, I was using my AMHP skills. I needed those skills really to manage that caseload, because most of that work was really complex." (P16)***

Others also mentioned the pace of the role being rewarding often finding it stimulating and having the satisfaction of seeing the work through to the end.

> ***"I did enjoy the, the quickness of the role, maybe the intensity and the complexity of some of the work that was undertaken."(P07)***

Several participants mentioned enjoying learning and researching the law and enjoying the problem solving element of the role.

> ***"I enjoy using that kind of legal aspect, having to make some decisions. It's quite a nice kind of process of you kind of run through a bit of a checklist in your head. So I enjoy, I enjoy the kind of legal, formal process a bit, I suppose."(P11)***

These findings suggest that sustaining the workforce depends not only on attracting individuals with strong value alignment, but on maintaining the conditions that allow this motivation to translate into confidence, competence, and ongoing job satisfaction. While the role's meaning, challenge, and variety have been expressed as benefits of the role, this may be

dependent on the quality of support provided. Particularly in newly qualified AMHPs who have not build up confidence through experience.

4.2.4 Wellbeing

Through discussions surrounding the demands and resources of the role, it was clear that the imbalance between the two often impacted staff wellbeing. Wellbeing was reported to be affected by way of increased anxiety, reduced work-life balance and instances of moral injury.

4.2.4.1 Anxiety

Anxiety was most commonly reported with regard to the unpredictability of the role, more specifically the uncertainty around when they would finish for the day.

> ***"I think that's probably one of the most like anxiety provoking things. You don't know if you're going to be really late. You don't know if you're going to have a really difficult one," (P12)***

Many also expressed that anxiety would worsen throughout the day due to an understanding that they would need to complete an assessment regardless of how late in the day it came through.

> ***"the closer you get to your working day finishing, the more stressed out you are. The thinking, oh, my God, if something comes in, it's four o'clock. And rather than thinking, oh, I've only got an hour left, you're thinking, oh, my God, if something comes in now."(P04)***

4.2.4.2 Work-life balance

Most participants reported having to often work extra hours, with some working well into the night in order to complete an assessment. This often led to challenges around maintaining a sustainable routine and was reported to have a negative impact on their work-life balance.

> ***"I've worked days when I've got home three o'clock in the morning, and then you're in work the next day. Or you can go in a little bit later, but you can't take the day off because you've got things to do, you know, I might have a meeting at nine o'clock in the morning, so I've got to go in for that. So I think there's not, sometimes there's no balance there."(P14)***

One participant expressed how this had deterred them from applying for other AMHP roles where they were required to be on the rota more frequently.

> ***"to be honest, has put me off applying for AMHP roles that would mean I was on the rota more, because I would not want to compromise my kind of work-life balance in a way"(P18)***

It was also highlighted by one participant that this can be an issue in balancing work and family commitments, especially when AMHPs have dependents.

> ***"You can't rely on a nursery or anything like that because there's no guarantee that you will be there at 6:00 to pick a child up." (P23)***

4.2.4.3 Moral Injury

Multiple participants described situations akin to the concept of moral injury. In some instances this was related to a lack of resources and not being able to carry out their work to the standard they feel is appropriate for the individual requiring assessment.

> ***"I think that can be quite a common experience, of potentially feeling overwhelmed, whether it's by the demand or the demand on your service or the demands of the particular situation. Again, feeling that thing about going back to that feeling of powerlessness, feeling that you need to do something, and you can't, or can't do what it is that you want to do."(P04)***

This was further emphasised by one participant who expressed that AMHP's do not hold the power to conduct their responsibilities.

> ***"You have to beseech the police to get help, you often have to beseech ambulance drivers to get help, even in compromised dangerous positions, and sometimes you get the police ones saying we're not going to come until the ambulance come and the ambulance will tell you we're not coming till the police come. And you're there holding the metaphorical baby, meaning a very unwell, sometimes very dangerous person. So yeah, I always put, it's the AMHP role is responsibility without power."(P10)***

All participants appreciated the emotional distress faced by people undergoing mental health assessments. Most participants reported that this can also impact the AMHPs. One participant

expressed that they felt a lack of sense of purpose after seeing multiple people detained without a positive outcome.

> ***"I thought all we've done is lock this person up for a length of time and they're now here, having lost their liberty and they're exactly the same. What are we doing here? We're failing everyone."(P05)***

It was also reported that the continuous exposure to such scenarios often causes a gradual build of emotional stress.

> ***"it's the slow atrophy that AMHPs feel. Because it might not be one instance. It might be, you know, just that number of crisis situations and the events that happen there. You know, whether it's just the repetition of very sad stories or whether it's being threatened, assaulted, because that does happen."(P08)***

The findings shown in this theme further emphasise the impact of the role demands excessing available resources. The anxiety, poor work-life balance and experiences of moral injury highlight the potential for AMHPs to experience high levels of emotional strain related to their role which would not only impact staff wellbeing, but may lead to challenges with workforce retention.

4.2.5 Variability Across Wales

Most participants identified areas in which practice and procedures in their current local authority differed from others. This includes four sub-themes; case complexity, procedures, staffing structures and resources.

4.2.5.1 Case Complexity

Case complexity was reported to differ across different areas. It places with higher population turnover (i.e. University towns and city centres) cases are more complex as AHMPs are often supporting with people who are further from home.

> ***"you get a lot of people who come for a weekend away and then have their crisis here, actually they're quite a long way away. There's also that to negotiate. You know, establishing where the person's ordinary residence, should they return to that area and be treated in their own home? Do they have a home?" (P08)***

Participants also mentioned that there are additional considerations when working with those who speak Welsh as their first language. This tends to be the case in more rural areas, and as such beds may need to be located out of area, leading to patients not having access to treatment in their own language.

> ***"Well, if they need to be in hospital, if it's available for them in English, then we've just got to go with that,' and I can see why that is the, the kind of the way it goes. But it's, it's, you know, it's really sad"(P18)***

In addition to this, one participant also reported that they had heard of colleagues in rural areas having to navigate through challenges unique to that environment, such as dealing with livestock.

> ***"you hear people who have had to deal with a herd of sheep because the person was a farmer. And you know, whereas here we maybe have to deal with the odd cat or dog, but I've, I've never had to kind of ring Defra and say, we've got a herd of sheep here that we don't know what to do with. So there's different challenges."(P01)***

4.2.5.2 Procedures

While general requirements for the assessments are standardised across Wales, several differences in the process were highlighted. This included referral processes, where in some areas AMHPs were phoned directly and in others request forms were emailed to AMHPs to review.

> ***"you get a phone call from whoever it is that's requesting one or a doctor may come and see you to discuss it. It's usually a discussion around what they're asking for, what the sort of rationale is."(P05)***

> ***"we've got the email process. There's more communication between us AMHPs."(P10)***

There were also differences regarding to the amount of paperwork required and some places having additional systems in place for organising transport.

> ***"They are different, even just down to things like paperwork can be different. So I was with an AMHP colleague from [PLACENAME] the other day, and if somebody isn't admitted to hospital, they were showing me the form they started, the doctors have to fill in if they're not detained, yet, there's nothing like that here."(P14)***

"So it has to be approved by the health board. Then it goes off to this platform, and they have, like, a bidding system, basically, and whoever's the cheapest transport supplier will win the bid. But then they could be, you know, two, three hours away, so you're still having to wait for them to, to arrive."(P06)

4.2.5.3 Staffing Structure

Differences in staffing structures was the most frequently reported difference. Differences included number of AMHPs on rota at a given time and how the AMHP role was embedded in the local authority. Looking at AMHPs on rota, all participants reported either one or two AMHPs on the rota at any given time. It was seen that those who have two AMHPs on duty have a more balanced workload and better peer support.

"AMHP 1 will take whatever comes in first. And if there's something else that comes in, then me as AMHP 2 will take that… I think it's a really good– because we, you know, speak to each other in the mornings, we're on together, right, you know, this is, I'm here, let me know if you need anything, if you need another body I'll be there."(P09)

This is further emphasised by those who work in isolation feel more pressure in the role.

"There's one AMHP on duty. So that one AMHP is under pressure. They've got a lot of plates in the air that they're trying to manage."(P11)

Regarding how AMHPs are embedded in the local authority, this was either seen in the form of AMHP hubs, where there is a dedicated AMHP team (full time AMHPs) or AMHPs working within other teams and having days in which they are on duty (dual-role AMHPs). There were mixed preferences among participants, with some showing preferences for the dual-role position, due to not wanting to work as an AMHP full time.

"I know they have hubs elsewhere. That's something I really wouldn't like personally, because I wouldn't want to do this role five days a week. So I like the fact that we can do our normal job and then do the AMHP role."(P06)

However, those working as full time AMHPs appreciated not having an additional caseload and being able to focus only on their AMHP work.

> ***"I was doing the rota while I had my caseload, while I had duty in the office, while I had assessments as well going on clinical assessments.***
> ***It was crazy and it was draining and loads of people couldn't, couldn't keep on doing it and they left because it was too much."(P22)***

4.2.5.4 Resources

The availability of resources also differed across Wales. It was reported that there are several areas in Wales with very few to no designated places of safety. These are places in which people are detained and managed safely while assessments are undertaken. This was seen to place a higher burden on AMHPs as it sometimes led to assessments not being conducted in an appropriate and safe setting.

> ***"So you're kind of faced with a potential situation why people could be just waiting for beds in the emergency departments. And my experience taught me, you know, it's not good to leave agitated patients in those types of units because there's quite a high risk of absconding."(P16)***

A few participants expressed that they felt that there were more resources and investment in cities. One participant explained that this led to urban areas being better equipped to deal with complex cases.

> ***"They have a better medic group and better teams around them in terms of size and to be honest knowledge. So the ability to be able to cope with complex things is higher... I think that in everything is under the microscope in a city, so people see what's going on."(P20)***

While many participants were reluctant to comment or speculate on potential pay discrepancies, those who did, believed that there is a difference across local authorities.

> ***" I mean, I think an incentive would be that, you know, in terms of how much we get paid, I think that should be across the board. I don't think there should be all these differences in pay."(P22)***

Overall, this shows that variability in AMHP practice is experienced in a range of different ways. Although some of the reported variation reflects local context, such as rurality, population turnover and language needs, inconsistencies can lead to unequal pressures on staff. These findings reflect the need for consistency in key areas, alongside sensitivity to specific local challenges in order to support the wellbeing and retention of the workforce across all regions of Wales.

4.2.6 Interagency working

A key aspect of the AMHP role is working with other services such as doctors, police and transport providers. Throughout the interviews participants highlighted how mutual understanding of role and responsibilities, policy and legislation, and mutual respect can impact AMHPs and affect their wellbeing at work.

4.2.6.1 Mutual understanding of roles and responsibilities

Participants often reported situations in which they felt other services were not fully informed about the AMHP role. This often led to unrealistic expectations being placed upon AMHPs, which has the potential to lead to situations of conflict.

> ***"…really struggled with that over the years to understand that just because the AMHP, you know, organises it or arranges for it, that doesn't mean to say that we are responsible for it. So we don't have to commission transport, we don't have to find the bed. We're not supposed to find the bed." (P20)***

4.2.6.2 Policy and Legislation

When asked about the proposed changes put forward in the Mental Health Reform Act, all agreed that AMHPs should not be granted power to detain individuals. This was due to a lack of training, protective equipment and how this authority may adversely alter the dynamic between the AMHP and the individual being assessed. Many felt that the change was proposed without proper planning.

> ***"they've got body armour, they've got cameras, they've got pepper spray, they've got handcuffs. We are there just in, in, you know, our cardigans, with our diaries,***

do you know what I mean? It's kind of, I think they often don't appreciate that." (P01)

The Right Care Right Person policy was also discussed. Most agreed with the principles, agreeing that poor mental health should not be criminalised. However, they felt that it is not currently being used as intended. It was reported that AMHPs often felt dismissed with police quoting the policy when it should not apply to the situation.

"we've got scenarios where people are being threatened by, with weapons and the police are saying because that person's got a mental health need, that's not, that's not a police responsibility, which, which is wild, that makes staff feel that they are, they're not, you know, that they are, their safety is not valued."(P01)

4.2.6.3 Mutual Respect

Upon reflecting on the challenges faced regarding understanding of the role and policy changes, it was clear that having mutual respect in these challenging situations was the best way to establish teamwork and come to reasonable solutions.

"I must admit, I've been very lucky, but I think it's more about my personality, and it should never be about personalities, and it should be about mutual respect for one another's role and own risk assessments." (P03)

One participant also highlighted how in their own situation, a lack of respect experienced from health colleagues negatively impacted their wellbeing and resulted in them taking extended leave.

"I hit burnout about 18 months ago. And had six months out of work and that was very much related to the AMHP role in terms of the challenges that I was facing. I was I was bullied by health colleagues and a lot of that was around the AMHP role" (P20)

Overall, it can be seen that effective interagency working is a critical element of the AMHP role and can have a direct impact on of job satisfaction. These findings highlight the importance of clear and respectful communication, joint training, and shared accountability across services to support staff wellbeing and promote effective collaboration.

4.2.7 Recommendations

Throughout the interviews, participants made several recommendations for changes to the role and the systems surrounding it. This included ways to improve recruitment and retention as well as system level changes which would help improve working conditions for AMHPs.

4.2.7.1 Improvements to Recruitment

When asked for suggestions on how to improve recruitment, a recurring recommendation by participants was to make AMHP roles more accessible. Almost all participants agreed that the workforce would be strengthened by making the role more accessible to those outside of social services to join.

> ***"I would say broadening it out from just adult mental health service, sort of, you know, because predominantly, you know, I know there are other occupational sort of, you know, qualified people who can become AMHPs, but, but generally they aren't, you know? Yeah, I haven't come across any psychologists who become AMHPs. I haven't come across any occupational therapists who become AMHPS."(P02)***

It was also expressed that those healthcare workers becoming AMHPs may help embed the role within healthcare.

> ***"I think there's value in non-social workers doing it and because it can, it helps the social model become more ingrained in the medical field rather than it being, you're all medical, we're all social and we'll work together, but we're not really going to work together, yeah?"(P05)***

Improving the perceptions of the role was also suggested. More specifically, making sure that the positive and rewarding aspects of the job are visible and celebrated beyond the AMHP community to make the role more appealing.

> ***"It needs to be, you know, this is something you really want to have, you know, it's something to aspire to as opposed to, you know, people just trawling out their bad stories being called out and being out all hours, you know. I think, it's how it's marketed has to change."(P09)***

4.2.7.2 Improvements to Retention

To help keep people in the AMHP role for longer, participants highlighted several areas of improvement. Firstly, was the prioritisation of work-life balance. While most were unsure of how this would be feasible, the unpredictable end times of shifts and being called in for additional assessments when not on the rota were key contributors to poor work-life balance.

> ***"You can't commit to that and I think that's probably for me. If I thought that the AMHP role was a nine to five then I would just continue in that role."(P23)***

As mentioned previously, one of the main challenges faced by newer AMHPs is a lack of confidence in decision making. It was suggested by more experienced AMHPs that increased exposure to the role during training may help to improve this.

> ***"I think the more that you're exposed to situations, and every situation is very unique, and very different, I think obviously just having that wide variety of assessments to go on"(P16)***

It was also suggested that an increased financial incentive would also be helpful in encouraging AMHPs to stay in the role.

> ***"Yeah, maybe doubling the salary would just, well, do you know what I mean, but I don't want it to sound trite, but in, you know, like, you know, I don't, I don't know is, you know, is the short answer."(P02)***

4.2.7.3 System Level Changes

In terms of system level recommendations, many suggested that it would be beneficial to encourage collaborative working across local authorities. This would help with knowledge transfer and help to build and maintain an AMHP community, further building on good peer support.

> ***"It would be nice to have AMHPs from all over. I get the logistics of meeting up but it would be nice if we could have regular forums across Wales because sometimes we have people from North Wales who arrive here and vice versa, you know, so it***

would be good to maintain some links so people know what's going on across Wales." (P14)

Another suggestion was to enhance capacity of the service, ensuring that all local authorities have more than one AMHP on the rota. It unanimously agreed that working environment was better due to their availability and workload was more manageable when there was more than one AMHP on the rota at a time. This made AMHPs feel more part of a team and more confident in their role.

"And it's not about making, making decisions by committee. But actually, I always think there are benefits to kind of like working with somebody else and supporting one another."(P04)

It was also mentioned that a direct access to police and transport services would be beneficial. Many expressed frustrations at having to go through 101 (the official non-emergency telephone number used to contact the police) and 111 (the non-emergency telephone number for the NHS) routes.

"But that would be better, is access to the people that know, rather than expecting everyone up to a level where they know, because that's unrealistic, having direct access to people who do know, is easier. It's like asking all the call handlers in social care to understand the Mental Health Act, it's ludicrous, isn't it? So it's better they have a direct number to us, so we can have a direct number to them to discuss, is my dream." (P05)

Overall, participants were able to highlight several areas of recommended improvement, both on a within team and system level. However, participants were unable to identify specific changes that can be made to implement these.

5. Discussion

This study explored the lived experiences of AMHPs across Wales, with a focus on better understanding the challenges they face and how they are supported. This was done to further understand how recruitment, retention and wellbeing of the workforce can be improved. The findings of this study show

the AMHP workforce as highly dedicated, often working through stressful situations independently and finding value in their work. However, the demands of the role and limited resources is leading to what many experience as an unsustainable workload. These findings align with national workforce reports, which consistently highlight increasing demand, staffing shortages and systemic pressures impacting AMHP services [15, 16].

Although recommendations for change were suggested by participants regarding recruitment, retention and system level changes, many participants felt unsure as to how an improvement of a key stressor, work-life balance, would be feasible.

In the context of this study, job demands are defined as characteristics of a role that require ongoing physical and mental effort, contributing to the risk of work fatigue [17]. The job demands reportedly faced by AMHPs included workload, organisation of logistics and the emotional impact of the role. These categories broadly reflect those already identified in AMHP and social care literature, where high workload, co-ordination of resources and emotional strain are recognised aspects of the role [18].

Below we consider the key demands of the role, how resources available influence them and how these highlight areas to be considered in improving retention, recruitment and wellbeing.

5.1 Workload

When discussing the workload associated with the role, participants highlighted elements contributing to an unsustainable workload. The identification of high workload has been repeatedly identified as central pressures within the AMHP role

Areas of importance surrounded balancing dual-role positions and dealing with understaffing.

As a large proportion of participants worked in dual-role positions, those in these positions were asked how they balanced both roles. It was clear that there is a need to balance both carefully, making the most of the benefits (i.e. knowledge transfer), whilst also maintaining time boundaries to prevent one role negatively impacting the other. We can see from this study that this is not always achieved. This reflects wider evidence that workforce pressures and structural constraints are a key contributors to AMHPs limited ability to maintain clear role boundaries, specifically with regards to increasing service demand and limited staffing capacity [19].

Participants described how the nature of their core role impacted their ability to balance the two, with those in roles not managed by AMHPs finding it easier to create and adhere to boundaries. However, those managed by AMHPs also often appreciated having a manager who understood the additional responsibilities of the role. These findings raise an important question regarding whether dual-role practitioners may benefit from dual or shared management arrangements, rather than being situated within a single line-management structure. While this was not a consistent finding within the present study, wider literature suggests that dual-management or "matrix" management models (where staff are accountable to more than one manager) may support collaboration, knowledge sharing and flexible use of expertise [20]. Such models have also been explored in health and social care through co-leadership approaches, which can strengthen integration by combining complementary expertise and shared responsibility [21].

However, this brings additional challenges including conflicting priorities and a subsequent increase in pressure. This reflects the conflicting opinions of the participants in this study. This suggests that whilst dual-management structures may be beneficial to some, further work would be needed to ensure clear boundaries and communication between managers.

A study by Kuusisto (2025) looking at navigating dual roles mirrored this requirement of boundaries by highlighting how a clear separation of roles can improve wellbeing and efficiency [22]. **These findings highlight the importance of non-AMHP managers to have an appreciation for the commitment of the AMHP role, and AMHP managers to promote having clear time boundaries regarding AMHP versus other duties.**

In many cases, the high workload and a feeling of unsustainable working was heightened when participants reported understaffing in their area. Several studies have been conducted into the impact that understaffing and overburdened working environments have on social workers, with results indicating a higher risk of experiencing burnout, psychopathology and other mental health problems [23-25]. **The problem of understaffing can therefore be seen as an example of how a decline in recruitment may be causing a decline in retention.** This issue is not unique to Wales. Despite a rising number of assessments required, the number of AMHPs in England dropped by 3% between 2020 and 2022 [3]. Participants suggested that **making the role more accessible to those working outside of social care would work towards improving recruitment.** This is a logical suggestion as psychiatric nurses, occupational therapists and psychologists are all eligible for the role [7]. However, 95% of Wales AMHP workforce is made up of social workers, with currently only approximately 17 to 18 AMHPs

employed outside of the sector, including nursing, occupational therapy and psychology sectors [5]. In order to better understand the extent to which the workforce needs to be expanded, further work is needed to establish a reasonable number of assessments for AMHPs to carry out in a given shift with consideration to their varying durations. Furthermore, a deeper understanding of the barriers to access to the role experienced by those outside of social care is required to make feasible change to access.

Further to this, participants working as the only AMHP on rota, often felt additional pressure when trying to manage multiple assessments. **It was clear from the results of this study, that AMHPs experienced high job satisfaction when the workload was shared by two AMHPs.** This reflected that the reduction in workload enabled staff to carry out their role to the best of their ability as they had sufficient time for a more thorough assessment and decision making. This reduction in workload may also lessen the requirement to work beyond standard working hours.

Participants also reported that this provided additional peer support when on duty by enabling AMHPs to discuss their decisions with one another. This would therefore contribute to a better working environment, leading to better retention and recruitment of the workforce. While standardising this two AMHP model may not be feasible for all local authorities, it may be of value to explore how collaboration between local authorities may help to facilitate this. Further research is therefore needed to consider whether implementing collaborative systems could be feasible.

5.2 Organisation of logistics

Organisation of logistics is a fundamental part of the AMHP role. However, several factors were reported in this study which make this a highly demanding part of the job. These include a lack of resources and challenges with interagency working. **Our findings show that participants felt that navigating their role with a lack of resources was a key stressor**. The lack of mental health unit beds was a frequently reported issue, which often led to situations where assessments were prolonged or delayed which increased risk to both patients and AMHPs. The issue regarding bed availability has been a recognised burden on the AMHP workforce for some time [9, 26]. When navigating prolonged assessment procedures, designated places of safety help to alleviate risk. Designated places of safety aim to provide an environment with minimal exposure to hazards and potential threats [27]. However, it was found that access to such places is inconsistent across Wales. This was seen to result in assessments being conducted in accident and emergency (A&E) departments. A 2024 systematic review focussed on

experiences of those attending A&E for mental health support and found that A&E is often unable to adequately meet mental health needs, in many cases enhancing patient distress [28].

These findings suggest that consistent and timely access to designated places of safety should be considered a core service requirement rather than a variable provision. From a perspective prioritising patient and staff safety, prolonged waits for assessment or safe placement may represent a significant system failure. **Ensuring reliable access to places of safety across regions may therefore be critical not only for reducing risk and improving patient experience, but also for supporting AMHPs to work safely and effectively**. While bed availability is a factor born out of the increasing pressures on the NHS, places of **safety should be provided as a minimum standard**.

The core element of organising a mental health assessment, is navigating, accessing and engaging colleagues in other services. This study highlights how the success (or otherwise) of these working relationships can directly impact AMHP wellbeing. In addition to the above issue surrounding bed availability, the coordination of schedules is another factor contributing to longer assessments. Several elements were seen to contribute to the demand experienced by AMHPs. **A central issue surrounding this was a lack of understanding of the AMHP role by others.** This aligns with wider mental health service research which suggests that differences in professional perspectives and unclear role boundaries can hinder interagency collaboration within mental health services [29].

Our findings indicate that AMHPs are frequently put in situations where they are expected to carry out work not within the boundaries of their role. This is often due to a lack of understanding from other professionals. Linking back to the suggestion posed of making the AMHP role more accessible to those outside of social care; doing this may also help to better embed the role within a healthcare setting, thus facilitating knowledge transfer between the two fields. In addition to this, **our findings support the idea that raising awareness / educating relevant disciplines of the scope of AMHP role would be beneficial to interagency working relationships.**

Participants expressed consistent views of the Right Care Right Person (RCRP) policy. This policy was first adopted in 2023 and enforces the process of 101 call handlers triaging incoming calls and diverting them away from police services, back to the AMHP, unless there is a crime in progress or a risk to life or of serious harm [30]. While participants mostly appreciated the need only to use the police when needed, many felt that this was not currently being implemented as intended.

Our study found that AMHPs felt that in practice, the policy may be misunderstood or applied in ways that result in **police disengagement from mental health-related incidents, even where the threshold for risk appears to be met from the perspective of the AMHP.** Participants described situations where the police refused to attend, leaving AMHPs to work through complex and potentially unsafe cases without appropriate support. This has significant implications for both the safety of the AMHP, but also the individual being assessed and those around them.

Police interventions within mental health contexts are typically premised on structured risk-assessment frameworks such as THRIVE (Threat, Harm, Risk, Investigation, Vulnerability and Engagement), which support decision-making and prioritisation under the National Decision Model [31]. In practice, decision-making may also be informed by locally used criteria such as “RAVE” (Resistance, Aggression, Violence or Escape), which are used to determine the immediacy and nature of risks requiring police involvement during Mental Health Act assessments [32]. These frameworks are explicitly concerned with assessing the immediacy and severity of risk in order to justify police deployment.

However, there is evidence to suggest that police interpretations of immediacy may not fully align with established legal standards. In Rabone v Pennine Care NHs Foundation Trusts (2012), the Supreme Court clarified that “real and immediate” risk to life is one that is present and continuing and importantly may extend over hours, days or longer, rather than requiring an instantaneous threat [33]. This legal interpretation contrasts with the policing approaches that may prioritise acute, imminent harm when applying THRIVE and RAVE criteria.

Implementation issues have previously been reported by AMHPs. A 2024 study based in England looking at health and social care perspectives of RCRP highlights similar concerns regarding clarity of thresholds and different perceptions of risk. In cases where this ambiguity occurs may cause increased stress for AMHPs, contribute to poorer interagency relationships, and ultimately result in delays or gaps in care for individuals in crisis.

The participants in this study suggest a need for national guidance, co-produced by health, social care and police authorities [34]. The findings of this study report the impact of this policy on the AMHP workforce. Therefore, **the AMHP workforce should specifically also be included in this proposed guidance co-production.**

Overall, participants felt that interactions with other services are heavily influenced by interpersonal relationships between AMHPs and other teams. **When participants did not feel respected by external**

colleagues, other challenges were made harder to navigate. Research has shown that an individual's motivation and engagement in work is significantly influenced by the quality of interactions amongst colleagues [35]. **This both reiterates the benefit of promoting understanding of the AMHP role among other teams and highlights a need for multiprofessional learning to improve working relationships between teams.**

5.3 Impact on Staff Wellbeing

The impact of the AMHP role on staff wellbeing was clear throughout this study. Wellbeing was seen to be impacted through a lack of work-life balance and the emotional and psychological demands of the role.

The workload faced by AMHPs was reported to have a direct impact on AMHP work-life balance. A key contributor to poor work-life balance was the overspill of working hours. Having no clear end time to the working day was seen to cause anxiety, with participants highlighting how late referrals, could lead to assessments extending well into the evening. This, in some cases, prevented basic needs such as sleep and healthy eating being prioritised, and led to challenges with balancing family responsibilities. The importance of work-life balance in maintaining job satisfaction is widely recognised [36] and the association between the pressures faced by those working in social care roles and the experience of stress and burnout has been previously recognised [37]. This has been further emphasised with the changing nature of employment with an increasing number of younger employees prioritising work-life balance when seeking employment and a lack of this contributing the job dissatisfaction and reason for wanting to resign [38]. This indicates that pressures are not solely a matter of volume, but also of timing and predictability. In particular, late-day referrals appear to have a considerable impact on wellbeing, as they are more likely to extend beyond standard working hours.

This highlights a potential need to reconsider the organisation of AMHP shifts. One possible approach may involve **introducing clearer cut-off points for routine daytime referrals, alongside potentially introducing overlapping shift patterns with out-of-hours services**. Such models could help distribute workload more evenly and reduce the likelihood of individual practitioners becoming overburdened late in the day.

In addition, **improving awareness among referring agencies regarding the impact of late referrals may be beneficial.** Encouraging referrals earlier in the day, where possible, could support more timely assessments and reduce the risk of extended working hours. Taken together, these measures may help

to improve work–life balance, enhance staff wellbeing, and contribute to improved recruitment and retention within the AMHP workforce. However, further research is needed to evaluate the feasibility of these changes.

Emotional and psychological demands of the role were often reported in reference to vicarious trauma and moral injury. Most participants identified the importance of being aware of the impact of repeated exposure to traumatic situations and situations where the outcome of an assessment did not lead to positive change for the individual. Although vicarious trauma and moral injury within AMHP practice remain under-researched, it has previously been considered a work hazard in other fields, and the importance of adequate support is recognised [39]. The findings of this study saw that AMHPs highly value opportunities to process these experiences, particularly through debriefing following complex or distressing cases. However, access to such support was inconsistent across teams. Furthermore, different types of support fulfil different functions. While line management was predominantly associated with operational and practical support, participants valued **having a more reflective space for processing the emotional impact of the role and developing coping strategies**. Peer support was also valued as a way of providing informal debriefing opportunities.

The findings of this study highlight the importance of being able to debrief and reflective supervision. Without such opportunities, staff may lack means to process the emotional demands of the role, which may have a detrimental impact on staff wellbeing, resilience and workforce sustainability. Therefore, it may be valuable to work towards **developing a more formalised supervision framework that prioritises reflective supervision and promotes peer support structures.**

Participants also acknowledged how the gravity of the decisions they make can affect them psychologically. This was seen to be particularly challenging for those with less experience, with many participants reflecting on how this has improved as they have gained confidence in the role. **It was suggested that improving confidence at an earlier stage would help support staff retention.** As this was seen to be developed over time in the role, it was then suggested that **increasing exposure to the role during training may be beneficial.** This has been explored in other fields, with findings suggesting that there is a strong positive relationship between increased exposure to the role during training and job retention [40]. Additionally, as seen discussed above, managerial and peer support can be seen to improve confidence with decision and are therefore valuable resources with regards to wellbeing, recruitment and retention.

Areas of support for the emotional and psychological wellbeing of AMHPs went beyond dealing with the demands of the role. For many, the demands of the role were easier to contend with if they were able to find overall value in their work. While many described finding value in fulfilling a moral obligation, participants also identified practical areas of value. As suggested in the interviews, **being able to draw more positive attention to the role within both the community of practise, but also among the general public may help to improve recruitment**. Doing so would help to enhance the reputation of the roll, which in turn may make it a more attractive career option.

Moreover, it was also seen that **changes to AMHP pay** may work towards improving retention. This was specifically reported regarding increasing financial renumeration. This has been seen to have a significant influence on employee performance and motivation [41] and as this study found instances where this lacked a standard approach across Wales, it is fair to assume that this is an area that may lead to dissatisfaction. It would therefore be suggested that a **standard pay scale** for the role would help the alleviate with inequality.

5.4 Strengths and Limitations

This study has explored the views of AMHPs with a diverse range of experience, both in time in role and local authority placement. The qualitative methods used have provided an in-depth understanding into the challenges experienced, what also helps them and areas for improvement. However, it should be acknowledged that there is always potential for bias in self-selected samples. Further, due to the nature of the workforce and the necessity of anonymity, we have not been able to explore specific examples and therefore are unable to provide further geographical context to some of our findings. Future work should explore the specific practices of different local authorities to provide this.

6. Recommended areas of improvement

Findings of this study indicate that factors influencing retention, recruitment and wellbeing of staff are often intertwined. Table 4 details both service and system level recommendations across shift design and staffing, supervision, support and management, interagency working service infrastructure and training and development.

	Service level recommendations	System level/policy recommendations
Shift Design and Staffing	- Increase AMHPs on rota (aim ≥2 per shift) - Explore cross-local authority collaboration to improve support for smaller teams - Implement overlapping shifts to reduce late-day burden and improve work–life balance	- Develop regional/shared AMHP service models to improve service sustainability and workforce capacity
Supervision, Support & Role Management	- Provide structured supervision (line management, reflective, and peer support) - Ensure reduced caseloads for dual-role AMHPs to prevent overload - Promote clear boundaries between AMHP and substantive roles - Standardise debriefing following high-risk cases - Protect time boundaries and reduce excessive overtime	- Develop national guidance on workload expectations for dual-role posts - Embed supervision standards within workforce policy - Recognise psychological wellbeing as a core workforce priority
Interagency Working	- Promote shared understanding of the AMHP role across disciplines - Escalate inappropriate police disengagement where RCRP is misapplied	- Improve communication pathways with police, NHS, and transport services - Develop national interagency guidance clarifying roles, responsibilities, and thresholds - Provide clear national guidance on RCRP implementation - Implement joint multi-agency training to strengthen collaboration and consistency
Service Infrastructure	- Support cross-local authority use of resources	- Ensure equitable access to designated places of safety for patients as a minimum service standard - Standardise pay and incentives across regions
Training & Professional Development	- Increase exposure to mental health assessments during training to build confidence - Support early-career development and decision-making capability	- Expand training provision across Wales - Review entry requirements to training programmes and enhance awareness to the role across professions

Table 4: Summary of recommendations

7. References

1. Department of Health and Social Care. *Modernising the Mental Health Act – final report of the Independent Review of the Mental Health Act 1983*. 2018 28/06/2025]; Available from: https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review.
2. Carter, C. *AMHP workforce faces squeeze with third over 55, warnings over lack of trainees and increased workload*. 2021; Available from: https://www.communitycare.co.uk/2021/03/05/amhp-workforce-faces-squeeze-third-55-warnings-lack-trainees-increased-workload/.
3. Community Care. *AMHP numbers shrink by 3% amid increase in detentions and plans to expand role*. 2022; Available from: https://www.communitycare.co.uk/2022/09/21/amhp-numbers-shrink-by-3-amid-increase-in-detentions-and-plans-to-expand-role/.
4. Stevens, M., J. Manthorpe, and S. Martineau, *Recruiting and retaining social worker AMHPs: evidence and a research agenda.* 2019.
5. Department of Health and Social Care. *Mental Health Bill 2025*. 2024; Available from: https://www.gov.uk/government/collections/mental-health-bill-2025.
6. Hemmington, J., *Approved Mental Health Professionals: Teamwork, 'Safety Nets' and 'Buckling Under'.* Journal of Social Work Practice, 2024. **38**(4): p. 423-436.
7. Department of Health and Social Care, *AMHPs: The invisible health professionals*, in *Social Work with Adults Blog*. 2017.
8. Carter, R. *'AMHPs are being left to improvise solutions to system failures'*. 2018; Available from: https://www.communitycare.co.uk/2018/03/27/amhps-left-improvise-solutions-system-failures/.
9. Scholfield, H. *NOT ENOUGH BEDS? An analysis of the provision of emergency psychiatric beds by Clinical Commissioning Groups in England and Health Boards in Wales under Section 140 of the Mental Health Act 1983*. 2024 29/06/2025]; Available from: https://www.hundredfamilies.org/not-enough-beds-an-analysis-of-the-provision-of-emergency-psychaitic-beds-by-clinical-commissioning-groups-in-england-and-health-boards-in-wales-under-section-140-of-the-mental-health-act-1983/.
10. Department of Health and Social Care. *The Approved Mental Health Professional Workforce in the social care sector*. 2024 29/06/2025]; Available from: https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/documents/The-Approved-Mental-Health-Professional-workforce-in-the-social-care-sector-2025.pdf.
11. Stevens, M.J., Martineau, S. J., Manthorpe, J., Steils, N., & Norrie, C. M. *Who wants to be an Approved Mental Health Professional?* 2018 29/06/2025]; Available from:

https://kclpure.kcl.ac.uk/ws/portalfiles/portal/101007101/Stevens_et_al_2018_AMHP_Report.pdf.

12. Department of Health & Social Care. *Right Care, Right Person*. 2024 29/06/2025]; Available from: https://www.gov.uk/government/publications/evaluating-the-implementation-of-right-care-right-person/right-care-right-person.
13. Spencer-Lane, T. *The mental health act 2025 summarised. Community Care.* 2026 June 2026]; Available from: https://www.communitycare.co.uk/content/news/the-mental-health-act-2025-summarised.
14. Bakker, A.B. and E. Demerouti, *Job demands-resources theory: Taking stock and looking forward.* J Occup Health Psychol, 2017. **22**(3): p. 273-285.
15. Skillsfocare, *The Approved Mental Health Professional (AMHP) workforce in the social care sector*. 2026.
16. (CQC), C.Q.C., *Briefing: Mental Health Act – approved mental health professional services.* 2018.
17. Lorlong, P. and J. Thaweepaiboonwong, *Burnout as an Early Signal of Unsustainable Work Design: Integrating Job Demands, Effort–Reward Imbalance, and Illegitimate Tasks in Thai Manufacturing.* Sustainability, 2026. **18**(4): p. 2058.
18. K, S., *Decisions on risk and mental health hospital admission by Approved Mental Health Professionals.* 2020.
19. Skillsforcare. *Approved Mental Health Professional (AMHP) workforce*. Workforce Intelligence 2025; Available from: https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/Topics/Social-work/Approved-Mental-Health-Professional-workforce.aspx.
20. Tempo. *Matrixed organization: Structure, pros, and cons.* 2026 [cited May 2026.
21. Klinga, C., et al., *Co-Leadership - A Management Solution for Integrated Health and Social Care.* Int J Integr Care, 2016. **16**(2): p. 7.
22. Kuusisto, A., *Case study: Navigating dual roles: Balancing supervisory and expert responsibilities in knowledge-based organizations.* 2025.
23. McFadden, P., A. Campbell, and B. Taylor, *Resilience and burnout in child protection social work: Individual and organisational themes from a systematic literature review.* The British Journal of Social Work, 2015. **45**(5): p. 1546-1563.
24. Ravalier, J.M., et al., *Social worker well-being: A large mixed-methods study.* The British Journal of Social Work, 2021. **51**(1): p. 297-317.
25. Griffiths, A., et al., *Physiological evidence of escalating stress during COVID-19: A longitudinal assessment of child welfare workers.* Journal of Public Child Welfare, 2024. **18**(1): p. 158-181.
26. Commission, C.Q., *Monitoring the Mental Health Act in 2023/24.* 2025.

27. Isreal, O., *Mental Health Benefits of Clearly Demarcated Safety Areas.* 2025.

28. Cadorna, G., et al., *Systematic review and metasynthesis of qualitative literature on young people's experiences of going to A&E/emergency departments for mental health support.* Child and adolescent mental health, 2024. **29**(3): p. 266-275.

29. Knapp, M., *National trends in spending on mental health services 2001–2012*. 2014, London School of Economics (LSE).

30. O'Reilly, C., *Editorial: Right care, right person? Changing police responses to mental health crises.* Journal of Mental Health, 2025. **34**(2): p. 125-127.

31. Services, H.I.o.C.a.F.R. *Threat, harm, risk, investigation.* June 2026]; Available from: https://hmicfrs.justiceinspectorates.gov.uk/glossary/threat-harm-risk-investigation/.

32. Police, W.M., *MHA assessments.* 2020.

33. *Rabone v Pennine Care NHS Trust [2012] UKSC 2; [2012] 2 AC 72*, in *Lawprof*. 2012.

34. Jefferson, L.A., et al., *Exploring Health and Social Care perspectives on the implementation of 'Right Care, Right Person', under the National Partnership Agreement.* 2024.

35. Gets, K., *The effects of relationships between colleagues and its influence on motivation and engagement at work.* 2023.

36. Waworuntu, E.C., S.J.R. Kainde, and D.W. Mandagi, *Work-Life Balance, Job Satisfaction and Performance Among Millennial and Gen Z Employees: A Systematic Review.* Society, 2022. **10**(2): p. 384-398.

37. Knapp, M., *National trends in spending on mental health services 2001–2012.* 2014, London School of Economics (LSE).

38. Sánchez-Hernández, M.I., et al., *Work-Life Balance in Great Companies and Pending Issues for Engaging New Generations at Work.* Int J Environ Res Public Health, 2019. **16**(24).

39. Isobel, S. and M. Thomas, *Vicarious trauma and nursing: An integrative review.* International Journal of Mental Health Nursing, 2022. **31**(2): p. 247-259.

40. Al Ghafri, K., A. Dad, and K. Al Abri, *IMPACT OF WORK EXPERIENCE ON JOB RETENTION: A CASE STUDY OF OMANI SCHOOL TEACHERS.* PONTE International Journal of Science and Research, 2022. **78**(1).

41. Paulus, P., *The effect of remuneration, work discipline and motivation on employee performance.* Golden Ratio of Human Resource Management, 2023. **3**(1): p. 23-32.

8. Additional Information

8.1 Information available on request

There is no additional information to be provided on request.

8.2 Conflicts of interest

The authors declare they have no conflicts of interest to report.

8.3 Acknowledgements

The authors would like to thank the Approved Mental Health Professionals (AMHPs), who participated in the interviews, and who generously shared their experiences and perspectives. Their contributions were essential to informing this research and enhancing understanding of the role of AMHPs in Wales.
The authors would also like to thank our stakeholders Judith Rheade, Dr Jeremy Dixon and Anthony Cope for their time, expertise, and contributions during stakeholder meetings, in guiding the focus of the research and interpretation of the findings.

Health and Care
Research Wales
Evidence Centre

Canolfan Dystiolaeth
Ymchwil Iechyd a
Gofal Cymru

The Health and Care Research Wales Evidence Centre

Our dedicated team works together with Welsh Government, the NHS, social care, research institutions and the public to deliver vital research to tackle health and social care challenges facing Wales.

Funded by Welsh Government, through Health and Care Research Wales, the Evidence Centre answers key questions to improve health and social care policy and provision across Wales.

Along with our collaborating partners, we conduct reviews of existing evidence and new research, to inform policy and practice needs, with a focus on ensuring real-world impact and public benefit that reaches everyone.

Director: Professor Adrian Edwards

Associate Directors: Dr Alison Cooper, Dr Natalie Joseph-Williams, Dr Ruth Lewis

@EvidenceWales @tystiolaethcym

healthandcareevidence@cardiff.ac.uk

www.researchwalesevidencecentre.co.uk