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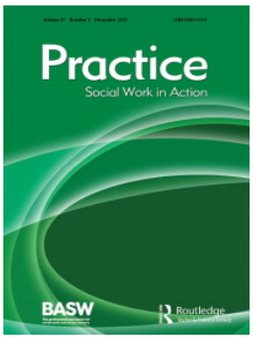

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How Do Factors External to Statutory Guidance Influence Approved Mental Health Professionals, When Making Decisions During Assessments with Service Users Presenting with Suicidal Ideation?

David Palfreyman

Approved Mental Health Professionals (AMHP) are often required to assess people experiencing suicidal thinking and they must make difficult decisions in challenging circumstances that require a range of factors to be considered, not least the safety of the person being assessed. This study explores some of the inherent challenges involved in this work and considers the preparedness of AMHPs, the complex dynamics that inform decision making and finally how AMHPs are supported by the organisations for whom they work. The research is an empirical study based on unstructured interviews with practitioners working in the field. It identifies that AMHPs can often believe the person being assessed is not mentally unwell, rather they are experiencing what the study describes as 'emotional distress' relating to stressful life events. The study also identifies evidence that AMHPs feel confident to fulfil their statutory role and reach independent decisions, however, despite some very good support structures, AMHPs would benefit from more enhanced support following cases where an undesired outcome occurs. The findings hope to assist social work training organisations and employers by highlighting the importance of training related to this area of practice and the necessity of robust support systems for practitioners.

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Introduction and Background

Suicide is a crucial public health issue with 727,000 lives lost globally each year and in England alone there are approximately 5,000 deaths annually, leading to profound loss for all those affected and rightly raising a focus on opportunities for prevention and exploring how those involved in responding to crisis can work more effectively (WHO, 2025; Department of Health and Social Care 2022). This study aims to develop a greater understanding of how AMHPs experience this area of their work, considering what some of the challenges might be and how they can be supported to fulfil their role effectively. It seeks to go beyond what AMHPs do when assessing a person experiencing suicidal ideation, to consider how prepared they are, what dynamics exist at ground level, and finally, how any pressures are experienced by AMHPs.

It is important to recognise the inherent complexity of suicidal acts, which can be seen as gambles made with life and death (Taylor and Gilmour 1996). AMHP decision making is critical in terms of both a human concern for people and a need to protect the welfare of those being assessed. AMHPs find themselves at an intersection with people at a critical moment and hence their decision-making carries enormous gravity. Instructive studies have considered the AMHP role as a counterweight to medical perspectives, in terms of how practitioners operate within a context of risk that can be viewed as a contested notion (Karban et al. 2021).

A dichotomy at the centre of social work practice is the inherent challenge of promoting autonomy *via* empowerment, alongside the need to protect people from harm (BASW 2021). This dilemma is also reflected in the competing duties held by AMHPs in relation to human rights, namely, to protect life and to promote liberty and privacy (Human Rights Act 1998). Careful consideration is needed regarding the risk of harm, alongside legal responsibilities to consider all circumstances in the case, including less restrictive alternatives to hospital admission (Stone, Vicary, and Spencer-Lane 2020). There are challenging dilemmas present in relation to assessing people experiencing suicidal ideation. AMHPs can be aware of significant distress experienced by the person, but also there might be evidence to suggest it is unlikely the person wants to end their life (Brammer 2023). Here, ethical responsibilities need to be balanced alongside conflicting opinions within multi agency discussion and resource availability, creating a complex range of pressures for the AMHP.

An AMHP is required to consider the safety of the individual being assessed and the protection of others (S2/3, MHA 83). For those involved in making decisions about whether to use compulsory mental health powers, there are a complex range of considerations, of which risk is often at the forefront in the minds of professionals. One common theme is that professionals must adopt a framework to support with considering what the least restrictive option might be. This illustrates the important role practitioners can play in evaluating risk in a way that considers the social context in which it occurs (O'Hare et al. 2013).

The ability to consider less restrictive alternatives to hospital admission is essential to upholding both statutory guidance for AMHPs and adopting a values-based approach to practice. It does, however, highlight that professionals are making challenging judgements, which can facilitate the risk of undesired outcomes for those being assessed. This involves such factors as organisational pressures, resource demands and wider social disadvantage (Campbell 2010). Although some practitioners are attracted to the complex dynamics of AMHP work, there are difficulties in terms of coping with emotionally laden work and the pressure of having to make life changing decisions. This can be a barrier to continuing in the role, or it can discourage social workers (or other eligible professionals) from wanting to become an AMHP (Stevens, Manthorpe, and Martineau 2021).

Given 95% of AMHPs are from a social work background (Skills for Care 2024), it is important to consider how this might influence their experience of assessment in relation to suicide. Sanders, Jacobson, and Ting (2008) carried out what they believed was the first study that specifically explored the needs of social workers regarding training and education in relation to suicide, noting concern that so little specific research has been carried out given that the study identifies 31% of US social workers will experience a client suicide. Social work is not alone in experiencing challenges in relation to this area of practice, with 'over 90% of patients who die by suicide having visited their GP within weeks or months of their death' (Saini, Chantler, and Kapur 2016.260).

The risk factors associated with suicide can have a limited impact in terms of identifying appropriate predictions about risk or formulating prevention plans (Sommers-Flanagn and Shaw 2017). Furthermore, they argue the extremely low base rate of death by suicide means that warning signs are not effective in distinguishing factors between people expressing suicidal behaviour and non-suicidal behaviour. Indeed, the ability of assessors to predict the future in this area is poor (Zortea et al. 2020). Newton-Howes (2018) supports this view, drawing on reflections from psychiatrists involved in assessing suicidal risk, contending that there is a focus on risk of death, which is hard for clinical assessment to predict. One of the unintended consequences of this, is that more mundane risks can be overlooked, such as the impact of self-neglect.

A mixed method study considered social workers carrying out a simulated client interview with a suicidal person and making a judgement about whether hospitalisation was required. The simulated interviews led to a variation in decision making, in one case 63% believed admission was required as opposed to 37% that did not believe it was indicated. They argue this supports earlier studies which indicate scales cannot identify a clear point where hospital admission is required (Regehr et al. 2016).

Further research considered levels of perceived stress in relation to social workers working with clients experiencing suicidal ideation, labelling this as CSB (client suicidal behaviour) (Ting, Jacobson, and Sanders 2011). They reported workers can go through similar emotional reactions to families

following a completed suicide, including grief, but also self-doubt and anger associated with either their competency or anger at the client or their agency.

Qualitative interviews with mental health workers, service users and their families were used to explore the experiences of those involved in assessment (Coffey et al. 2017). 'Accepted fictions' relates to the processes workers go through, which are constructed to help define a situation which is ambiguous. They highlight that workers often feel compelled to show that risk has been considered and that any interventions relate to either monitoring or maintaining the safety of the service user. This can lead to paternalistic responses, which fail to consider the iatrogenic risks, that is, the impact of interventions by the professional. The study alludes to limitations of actuarial methods of assessment and how risk assessment is often seen as judgements for professionals with a tendency to be cautious. Coffey et al. (2017) argues this impairs meaningful engagement with service users and leaves them less involved in decisions about managing risk.

In contrast to the fields of psychiatry and psychology, Ting, Jacobson, and Sanders (2008) note that there has not been a study of the support available and coping behaviours of social workers following a fatal or non-fatal suicide event in the US, even though the likelihood of experiencing this is comparable with other mental health professionals. Interestingly, peer support was perceived as being more helpful than supervision, with 39% of respondents finding supervision helpful, compared to 80% approval for peer support. The authors suggest formal supervision was associated with agency priorities around legal exposure and record keeping, which ignored the loss of life and the personal reactions of the social worker. Peer support instead was able to offer a genuinely empathic response.

Methodology

This small-scale study used unstructured interviews with five AMHPs to explore a range of issues related to assessing people experiencing suicidal thoughts and feelings. An unstructured approach was used to provide participants the space needed to raise issues they felt relevant from their own practice experience. As an aide-memoire, a limited number of key areas were identified to support the process in terms of providing prompts and a very open-ended direction to the interview. These included training, agency support and other factors influencing decision making.

Sample and Population

A non-random method of purposive sampling was adopted with participants recruited *via* their employer on a voluntary basis. The sample size was limited

to five participants of mixed gender. The decision for this focused on a desire to capture a wide range of qualitative data *via* an in-depth interview. The intention was to ensure participants have direct experience in this field by identifying appropriately qualified social workers. To be included in the study, participants needed to be approved by a local authority to practice as an AMHP and to be currently carrying out Mental Health Act (1983) assessments as a routine part of their job. The focus was on capturing the voice of AMHPs with participants having varying degrees of experience, which is reflected on during the discussion. One limitation to note, is the sample did not include any AMHPs from other disciplines. To support participants to speak openly, AMHPs were recruited from across two separate local authority areas with a formal agreement of each service. This allowed the analytical process to identify general conclusions from the whole data set and hence not attributable to one geographical area.

Analysis of Data

Data from the in-depth interviews were recorded and then transcribed. This was subsequently coded to highlight any arising themes by adopting a process of thematic analysis, drawing on Braun and Clarke's model and developing semantic codes in the data to help represent the experiences of practitioners, leading to the identification of three key themes (Braun and Clarke 2006; Byne 2021). To assist in validating the findings, corroboration was sought from the data in terms of themes arising from more than one participant. Of those themes arising, reliability was aided by cross comparison with themes arising from similar topical studies considered in the literature review. It is acknowledged that participants will have drawn on their own personal experience of practice. This was reflected in the study design, however, the corroborative process of analysis attempted to eliminate bias and ungeneralisable data within the study's findings.

As per the University of Birmingham policy, data is to be held for up to 10 years then disposed of. Data is stored on an electronic flash device kept in a locked environment.

Ethical Considerations

Permission was granted by the relevant ethics committee at the University of Birmingham for the study to proceed. Due consideration was given both in terms of confidentiality and participant support because of the sensitive nature of the subject. Interviewees were not paid for their participation and were recruited on a voluntary basis. Participants were given the right to withdraw from the study at any point. They were also able to withdraw permission for use of their data for up to six months post the interview taking place.

The positionality of the author is as a former AMHP and AMHP Lead, now working in academia. Hence, the research aims are motivated by a desire to determine how practitioners can be supported to provide high quality assessment for those in need.

Findings

Training and Worker Experience

The interview process explored the experience that practitioners had in terms of their core social work training and their training as an AMHP. Interestingly, there was strong evidence from all participants to suggest that learning about mental health on their social work qualifying programmes was limited. Furthermore, none of the interviewees recalled exploring the issue of suicide at any point in their qualifying training. This changed when participants trained to be an AMHP, whereby they received specific input on risk assessment during their taught programme and three out of the five participants recalled spending, at least some time discussing suicide.

It was generally noted that prior to working as an AMHP, participants including those working in mental health settings, did not frequently come across people experiencing suicidal ideation. One interviewee described a lack of confidence dealing with cases when people were experiencing suicidality. In contrast, another interviewee said of their AMHP training course, *'before if someone said they were suicidal, I would automatically think they needed to be in hospital in a safe environment Now I would consider Home Treatment or other community services'* (participant 1). There was evidence to suggest that post qualifying as an AMHP, training was available, including content around the assessment of risk and understanding suicidality.

Assessment Dynamics and External Influences

During the interview process, time was spent exploring the influence of the relationships AMHPs had with fellow assessors and other involved parties, including colleagues from the wider MDT (multi-disciplinary team), other partner agencies and the family and carers of service users. It was noted that both AMHPs and doctors often approached an assessment from a different perspective, with some participants highlighting that AMHPs more commonly took the lead on seeking alternative options to hospital admission and tending to be more proactive in terms of considering positive risk taking. Several participants noted that doctors will vary in terms of their approach to risk, and one interviewee highlighted, there are doctors who are very much socially minded in their approach to assessments. There was a sense that selecting a doctor

whom you trust was important. Furthermore, the data suggests there was value in working with a doctor experienced in a specialist area related to the service user's needs.

There was no evidence to suggest conflict with fellow assessors in terms of decision making in assessments. Several participants highlighted they often reached a consensual view with doctors about the outcome of an assessment. Across all participants, there was a strong sense around the need for independent decision making and an understanding that parties will sometimes hold differing views. When assessors reached opposing conclusions, this generally led to a constructive discussion. There was no evidence to suggest AMHPs were swayed in terms of their decision making, with participants saying they felt able to challenge doctors and hold a discussion around considering an alternative plan to hospital admission.

AMHPs are aware of external influences when assessing suicidal people, such as the prospect of needing to justify their decision making in a coronial process. One participant commented that such court processes can 'drag you through the mud' and there was evidence to suggest that AMHPs were very conscious of the need for good recording, in which the rationale associated with decision making is clear and documented. Two interviewees noted the prospect of scrutiny is not a bad thing and that it really encourages a focus around risk. It was very clear from all participants, that although they were aware of the prospect of coronial inquiry, this did not influence their decision making, with one participant saying *'I try to practice [to] the best of my ability without thinking what the coroner would think. What is the best outcome for the individual at the time'* (participant 2). This attitude was consistent across the range of AMHPs interviewed, even by those with less experience of AMHP practice.

Context and AMHP Impressions of Service User Background

All participants described carrying out assessments in several settings, including; psychiatric hospitals, emergency departments, Section 136 Suites (Health based places of safety where assessments can take place under the remit of Mental Health Act police powers), police custody settings, prisons and in people's homes. The evidence indicated a very clear split in terms of the reason for presentations, with participants believing that in general terms, those experiencing major mental illness, such as psychosis, were less likely to present with suicidal ideation. Presentations in relation to suicidality tended to be crisis type Mental Health Act assessments and as such, there was a consensus from interviewees that these assessments generally occurred in crisis settings, such as emergency departments, or more commonly, Section 136 Suites.

For people experiencing suicidal thoughts or behaviours, participants indicated they were less likely to be known to mental health services and where

they were known, they were more likely to have been diagnosed with a personality disorder, such as 'Emotionally Unstable Personality Disorder'. Participants also believed it was common for mental health services not to be recommended as part of the post assessment care plan. The explanation for this generally lay in the reason or trigger proceeding the presentation. There was clear evidence from participants that presentations relating to suicidality, commonly had a social trigger. A range of complex social problems were identified, including; the loss of employment, relationship breakdown, family pressures, domestic abuse, bereavement, experience of racism or prejudice, reduced income, problems with drugs or alcohol, debt, social isolation and restricted access to their own children. A picture was created of very distressing life circumstances for this cohort of people. The data pointed to difficulties that were not necessarily related to mental disorder, with those being assessed often describing feelings of not being listened to and believing others did not understand what they were going through. One participant described this as emotional distress and not always a mental disorder, with another saying that such difficulties are more social and psychological than they are medical.

Professional Confidence, Decision Making and Risk

Across the range of participants, there was a consistent indication that, as practitioners, they had very limited or no experience of assessing people presenting with active suicidality prior to their AMHP training. This was something they were increasingly exposed to once beginning to practice as an AMHP. There was a consensus that participants did not feel confident with carrying out such assessments at the point they commenced practice as an AMHP, with one person saying they dreaded going out to complete assessments. Although interviewees acknowledged this was a challenge during their transition into AMHP practice, there was very clearly a sense that confidence grew with experience.

Several participants said they were not afraid of having conversations about suicide with people they were assessing and there was no evidence to suggest assessment of risk in relation to suicidal people was something to be feared. In fact, it was recognised that some of the core skills social workers have, can be particularly useful. When discussing the expertise AMHPs bring to assessments, one participant said although her knowledge of the Mental Health Act and mental disorders was poor when she started as an AMHP, '*risk assessing, strengths-based practice and relationship-based practice – I think those things are skills that social workers have wherever they work'* (participant 3). There was an interesting dichotomy running through the responses from interviewees, whereby the AMHPs felt somewhat ill-prepared for this element of AMHP practice, however, they very much felt the skills they had as a social worker,

particularly in terms of positive risk taking, were crucial and they were not perturbed by the idea of having challenging conversations in this area. One person alluded to a conversation with a colleague who said that a discussion about suicide is not going to put the idea into someone's mind if it is not already there. The notion of discussions about suicide not being linked with an increased risk has a clear evidence base, unknown to this particular AMHP, but nonetheless part of their thinking (Dazzi et al. 2014).

Participants did not have a specific risk model which they were required to apply by their agencies. Instead, they had either a specific risk section of the AMHP assessment form or separate risk document. One of the less experienced participants said they found this helpful. Although the form is filled in retrospectively, the experience of filling it in reminded them of the key areas to consider. One interviewee thought the more experienced you are, the less reliant you are on prompts, whilst another questioned the value of such prompts to recording risk, highlighting any such tool for recording is only as good as the person completing it. Another participant recognised the limitations of prescribed systems for considering risk, instead saying they relied on a range of factors and strategies to inform their thinking, including knowledge of risk models. All AMHPs were satisfied with a narrative approach to recording risk.

AMHPs from both participating authorities highlighted the value of collateral information from the person's history, particularly in relation to suicidality. Of concern, was evidence from some participants that there were difficulties accessing historical information. This happened despite there being a local information sharing agreement in place. Such difficulties could occur with partners in health settings, including Crisis Resolution Teams and with partners in different geographical areas. One AMHP described at times '*there being a barrier to gathering information because of GDPR … … Even yesterday I tried to call the ward to get some information about* [someone] *that had recently been discharged, and one of the nurses couldn't share the information*' (participant 1). Such difficulties appeared to relate to a nervousness about sharing information with AMHPs, even though in many cases, participants confirmed formal structures were in place to support this.

The Emotional Burden of AMHP Practice

The data provided a clear indication that being involved in the assessment of people experiencing suicidal ideation carried an emotional burden. There were examples of the impact this had on the participants' lives, but also there were positive examples of how they coped with this and how they had been supported by others. One participant talked about experiencing huge anxieties following assessments with the overriding concern about the prospect of having made the wrong decision. In circumstances when a person had not been admitted to hospital, the AMHP would find themselves checking the records,

in some cases for weeks after the decision. They developed some strategies to help manage this, one of which was informally debriefing with a colleague. For this AMHP, it was about telling themselves, they had made the best decision they could.

One participant described taking the fear home with them and hoping nothing happens. They too alluded to the need to try and rationalise the process of their decision-making and they generally felt able to do this. It was acknowledged by another AMHP that this work does generate difficult feelings, and they tried to be clear in their mind about the plan made during the assessment. They said that about 8 times out of 10 this reassures them, but they would often think about cases on their way home or sometimes during the night. Another interviewee described being told by a very experienced colleague that they still reflected on a case involving a completed suicide many years later. It helped to hear how their colleague had tried to cope and move on from this very sad case. For this participant, they had experienced a suicide following a Mental Health Act assessment in the recent past and described the experience as a personal trauma. The impact of being involved in this case had implications for their personal life and they required counselling support to help deal with the consequences of this.

A very experienced AMHP explained that they often feel sympathy or empathy when assessing people experiencing suicidal ideation, but they can rationalise this and recognise that it is not their emotional burden to carry. They did experience one occasion when a person took their own life while they were trying to rearrange a previously aborted assessment. The information shared with them by the health team about the suicide was highly distressing and they described having to put this all to one side and complete their shift. This experience was a big emotional shock for them.

The interviews identified a range of ways in which AMHPs received support. Across all the data, the idea of peer support was evident with several participants really valuing comradeship from colleagues. Often this was the first line of support for AMHPs in the study and occurred outside of formal organisational structures. There was reference to a 'WhatsApp' group for AMHPs in their organisation and they never felt on their own with access to both colleagues and managers.

The data confirmed that all participants had access to supervision where they could talk to an AMHP supervisor specifically about AMHP issues and this supervision was available every four to six weeks. The value of this supervision was recognised and appreciated, but three participants alluded to the fact that AMHPs needed more immediate support from someone senior after dealing with emotionally laden cases. There were no formal arrangements to support this in terms of policy, but it was recognised that senior practitioners and AMHP managers would make themselves available to provide informal debriefing and discuss cases at short notice. One participant said that accessing this support in a timely manner, particularly if they were distressed was valuable.

Interviewees working in both authorities were aware that specialist support was available formally to AMHPs, such as counselling for those that had been involved in an untoward incident. It was recognised that support might be delivered more appropriately by someone outside the service and this was confirmed by a participant that had received counselling, who said it was helpful to talk to a non-AMHP.

There was a consensus that participants felt well supported by their immediate supervisors and the AMHP Lead. One interviewee described being visited at home by an AMHP Lead after having been involved in a case where a service user had died by suicide. They found this very supportive and alluded to being lucky in terms of the support they received. This comment was interesting, with another interviewee saying that managers would go to staff in such circumstances, but this was outside of a formal policy. The process of a manager providing an informal debrief was described by a participant that supervised AMHPs as allowing an opportunity to prepare staff for the formal post incident process following the death of a service user. One participant referred to their organisation's post incident process as being constructive and not seeking to find fault, but for others this was more difficult. One AMHP was aware of corporate defensiveness in the post incident process and said this was compounded by media interest in the case. They still felt supported by immediate managers, and it was acknowledged they would work alongside staff through this process, for example helping them through any further formal steps, such as an inquest. Managers recognised the need to provide support for staff subject to such processes, but what was not clear, was the extent to which this was formally recognised as part of their role and supported by the agency.

Discussion

AMHPs – Preparedness, Skills and Confidence

This study raised interesting questions about what we understand as the practice context and how the values and skills of AMHPs are applied to practice. Participants made a distinction between those presenting with traditional mental health problems, such as a psychotic illness with coexisting suicidal thoughts and those that were suicidal but seemingly were not experiencing an acute mental disorder. The former presented fewer in number than the latter. The latter group were described as experiencing emotional distress rather than mental disorder, which was commonly preceded by an event that triggered the presentation. Interviewees said commonly, traditional mental health services were not the type of support required for this cohort. There is a need to recognise distress and the importance of relational work, which is increasingly important in wider crisis mental health care (Haslam et al. 2024). Interestingly, the difficulties experienced by this group raised distinct

questions about the role of AMHPs and the benefits that their skills and training have to offer the assessment process. Participants recognised this and some commented on the value their social work training provided in terms of being able to find links with community resources, in thinking about risk in a positive sense and seeking intervention outside of the psychiatric domain. This evidence emphasised the importance of the AMHP role in terms of providing a statutory counterbalance to medical approaches. This approach is key in terms of broadening the scope of suicide risk assessment to consider psychosocial factors (Stevens, Manthorpe, and Martineau 2021; Zortea et al. 2020).

Although participants valued the skills they brought to AMHP practice, in their training as social workers, the evidence suggested a gap in knowledge and experience of mental health work and specifically the assessment of risk related to suicide. This raised a concern and indicated a consistency with research by Sanders, Jacobson, and Ting (2008), that suggested social workers have a high probability of exposure to a suicide event in their career and that greater training is needed. Furthermore, for those commencing mental health practice, the evidence suggested limited exposure to those experiencing suicidal ideation, leading to a sense, for some, of dread around becoming involved in this work. Although the evidence suggests that mental health social workers are not routinely required to assess suicide risk, similar to findings from Saini (2016) exploring the experience of general practitioners, this study suggests there would be clear benefits for social workers having access to greater awareness around suicide.

The Mental Health Act Assessment - A Complex Arena

Risk dominates the literature in relation to suicide, and this often fails to recognise more nuanced risks in relation to loss of independence and damage to interpersonal relationships (Newtown-Howes 2018; Simpson 2020). AMHPs must consider the wider social context of a person's life and the fact that, even if the criterion for detention appears to have been met, there is no obligation for AMHPs to make an application under the Act (Barcham 2016). AMHP decision making is independent, and the principles contained within the Mental Health Act Code of Practice (Department of Health 2015) require AMHPs to seek the least restrictive option available and to maximise independence wherever possible. The AMHPs participating in the study clearly recognised this and often identified themselves as taking the lead on seeking alternatives to hospital admission and promoting positive risk taking. There was no evidence to suggest AMHPs were afraid to reach different conclusions to their medical colleagues, and where this happened, the evidence demonstrated constructive approaches were adopted.

Several participants highlighted the value of collateral information about a person's history. There was evidence to suggest that accessing this information

was challenging at times, partly due to practical reasons, or of more concern, due to erroneous fears that other professionals had of sharing information. This implies those leading AMHP services need to be made aware of such concerns and act accordingly.

Other external factors were explored in the evidence, namely the influence of potential coronial processes and whether this had any impact on AMHP practice. All participants were aware of the gravity of their decision-making. Despite this, the study found no evidence to suggest having to account for your actions at an inquest encouraged defensive practice. In fact, the consensus indicated AMHPs maintained a primary focus on fulfilling their statutory role and working in the overall interests of the person being assessed. Where AMHPs were more conscious of the coroner was in terms of justifying their decision. Earlier research considering risk in MHA assessments, notes the influence of a culture of blame leading to hospital admissions being seen as a lower risk option, although assessors are more confident in adopting less restrictive options when supported by a team that know the persons case (Quirk et al. 2003).

Interviewees were very aware of the requirement to provide clear recording that demonstrated why they had reached the conclusions they had. Practitioners appeared to favour the narrative approach to doing this and they were satisfied with agency systems. This is consistent with the notion that formalised risk assessments may hold limited value in terms of predictive assessment (Zortea et al. 2020). There was a consensus among participants that recording decisions based on the evidence was an accountable approach to practice. This created a reassuring picture of the professionalism adopted by the participating AMHPs.

The AMHP – Impact and Supporting Practitioners

AMHPs involved in the study demonstrated a high level of professionalism, however, it was acknowledged that dealing with such emotionally laden work had implications for them. It is crucial for those involved in leadership to understand this in more detail, particularly when considering work by Ting, Jacobson, and Sanders (2011), that identifies the potential implications for social workers being involved in suicide events. Contained within the evidence, there was reference to words such as trauma and emotional shock. The evidence also indicated that involvement in a negative outcome, can have significant implications for an AMHP. This highlighted the need for employing organisations to be aware of this and reflect the needs of staff within their support systems.

There were very positive examples of both how AMHPs sought to manage the emotional strain of this area of practice and the extent to which they felt supported by their managers. Consistent with earlier related studies (Stevens,

Manthorpe, and Martineau 2021; Ting, Jacobson, and Sanders 2008), peer support was recognised as being important, but such networks appear to have developed organically, and the evidence suggested they might have been utilised outside of work time in an informal manner. The evidence was very clear and highlighted a need to have timely access to debriefing. One participant that had experienced a client suicide said they had valued peer support, but they also highlighted the limitations of this. External support was helpful and should be recognised as a good practice standard in responding to such events.

Participants involved in the study reported the more formal processes following an incident, such as a client suicide, were generally viewed as constructive and AMHPs felt consistently supported by their managers. A distinction was made between the supportive role played by managers and the corporate defensiveness involved in the post incident process. It is positive that the overall approach was seen as constructive, and one would expect consideration of corporate liability to be a feature of such important post incident reviews. A key finding is that in addition to emotionally supporting staff, managers need to recognise the importance of preparation in terms of any formal processes that might follow.

Conclusion

This study sought not to understand the role of the AMHP in assessing people experiencing suicidal ideation, this is understood within the statutory context of the role. The evidence above was concerned with understanding more about the 'AMHP eye view' of this area of practice. AMHPs placed a high value on their skills and experience of working in the social domain and they recognised a distinct group of people experiencing, what this study terms, emotional distress relating to social and psychological difficulties.

AMHPs recognised the gravity of the decisions they made, and they were conscious of the associated scrutiny. This had generated a culture of them being committed to record keeping. Involvement in a case concerning a completed suicide or cases with a heavy emotional burden for AMHPs can have a significant impact on wellbeing. There was strong evidence to say AMHPs valued support from their peers and there was a culture of support from supervisors and managers, however, services do need to be satisfied that systems for accessing this are robust, both immediately after an incident, and beyond.

This study was somewhat limited by the small sample size and broad range of territory it tried to cover. Further in-depth work is recommended in relation to three areas: the value of social perspectives, preparatory training needs and AMHP support systems. This study suggests that we cannot be confident in the robustness of training and support systems for AMHPs working in this field. Raising the profile of these challenges and further scholarly exploration could drive change and aid monitoring.

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