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International Journal of Law and Psychiatry 106 (2026) 102206

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

journal homepage: www.elsevier.com/locate/ijlawpsy

Wrong touch regulation: The limits to effective regulation of approved mental health professionals☆

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ARTICLE INFO

Keywords:
Approved mental health professionals
AMHP
The mental health Act 1983 (as amended 2007
Right-touch regulation
Professional standards authority
Regulatory fragmentation

ABSTRACT

Approved Mental Health Professionals (AMHPs) hold essential decision-making authority on whether individuals will be subject to compulsory detention under the Mental Health Act 1983 (as amended 2007) in England and Wales. Despite exercising profound coercive powers affecting individual liberty, the regulatory architecture surrounding AMHP practice is fragmented and diffuse, with oversight distributed across the Care Quality Commission, Social Work England, and multiple professional body regulators, and with no single body holding end-to-end accountability for decision quality. The dominant regulatory approach in contemporary UK health and social care is Right-touch Regulation (RTR), developed by the Professional Standards Authority and articulated through successive iterations since 2009. RTR presents itself as a model of proportionate, targeted, and risk-based intervention: a 'third way' between heavy-handed oversight and regulatory absence. The central claim of this article is that Right-touch Regulation, as currently utilised by the PSA, is structurally unsuited to AMHP oversight. The model presupposes conditions that are not present in AMHP governance. Situating RTR within broader regulatory theories (responsive regulation, smart regulation, and harm-based regulation), the article reviews what RTR claims as lineage but omits in practice. The conclusion argues that, until the preconditions for proportionate regulation are established (visibility, ownership, feedback), the language of Right-touch continues to legitimate a system that does not effectively regulate at all.

1. Introduction

Approved Mental Health Professionals (AMHPs) play a crucial role in the facilitation of the Mental Health Act 1983 (amended 2007) and hold the final decision-making power on whether service users will be subject to compulsory powers under the Mental Health Act 1983 (amended 2007) of England and Wales. The nature of their professional role is well recorded, and the academic literature reflects on the specifics of their duties and obligations, and the factors that impact the AMHP professional identity. *Less known, however, is the precise nature of AMHP regulation and whether AMHPs are effectively regulated.* There is no independent AMHP regulator or 'standard setter'. Instead, AMHP regulation is based in secondary to statutory guidelines, the service regulator of the Mental Health Act (the Care Quality Commission, CQC), and the professional bodies regulator of social workers (Social Work England, SWE), nurses (Nursing and Midwifery Council, NMC), and allied health professionals (Health and Care Professions Council, HCPC). In the vast matrix of professional body regulators, meta-regulators and service regulators, there is an open question of how to ensure accountability for potential poor practice and unsupported decision-making, and to provide redress for service users, and to determine the development of effective regulation.

Formally, AMHPs are statutory decision-makers authorised by local authorities in England and Wales to perform key functions under the Mental Health Act 1983 (s 114(1)). Most AMHPs are social workers (Skills for Care, 2025), though the role may also be undertaken by nurses, occupational therapists, or psychologists following specialist postgraduate training (Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008, SI 2008/1206, Sch 2; Skills for Care, 2025). The defining statutory function of the AMHP is to determine whether the legal threshold for compulsory admission or guardianship is met, taking into account not only medical evidence but also the individual's personal, social, and economic circumstances (s. 13; DoH, 2015,para 8.32).

The core duties of the AMHP are set out in s. 13 of the Act, which requires an AMHP to make an application for compulsory admission or

☆ This article is part of a Special issue entitled: 'Mental Health Law' published in International Journal of Law and Psychiatry.

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https://doi.org/10.1016/j.ijlp.2026.102206
Received 15 August 2024; Received in revised form 21 January 2026; Accepted 4 February 2026
Available online 15 February 2026

guardianship only if satisfied that such an application 'ought to be made' in respect of the patient and that it is necessary, having regard to the wishes of relatives and all other relevant circumstances, for the application to be made by them (s. 13(1 A)(a)–(b)). In addition, the AMHP must be satisfied that detention is, in all the circumstances of the case, the most appropriate means of providing the care and medical treatment the patient requires (s 13(2)). In exercising this judgment, AMHPs coordinate the statutory assessment process, including obtaining the requisite medical recommendations for detention or guardianship consulting the service user and, where practicable, the nearest relative, and considering whether compulsory intervention represents the least restrictive option available (s.2, s.3. s.7. s.11 s.12, 13; Code of Practice, 2015, paras 14.49, 14.52).

Although compulsory admission ultimately depends on acceptance of an application by hospital managers, managers do not exercise a merits-based discretion in relation to properly made applications. Where an application is made by an AMHP and satisfies the statutory requirements, hospital managers cannot refuse it on the basis that they disagree with the AMHP's judgment or would have preferred an alternative course of action. While the Act also permits applications to be made by the nearest relative, the AMHP route is the primary mechanism through which compulsory detention is initiated in practice. AMHPs are therefore required to act independently and cannot be directed by their employer or by medical professionals in the exercise of their statutory judgment (Code of Practice, 2015, para 14.35; St George's Healthcare NHS Trust v S, 1999). This combination of independence, discretion, and responsibility for initiating coercive state intervention renders the AMHP role a particularly significant focus of regulatory concern.

The significance of effective AMHP regulation becomes clear when the differing concepts of risk engaged by AMHP practice are considered. The recent Independent Review of the Mental Health Act, for example, called for greater clarity in the determination and articulation of risk, with proposals requiring AMHPs to substantiate their assessment of risk more actively, framed as a safeguard against erroneous detention (DoHSC, 2018). In the course of their statutory functions, AMHPs' interpretation of the level of 'risk' broadly includes risk to self (more commonly understood as suicide or self-injury), risk to others, and risk arising from the consequences of 'immediate and catastrophic' self-neglect (*GJ v Foundation Trust* [2009]). The outcome of this decision-making may result in the deprivation of an individual's liberty. The act of deciding whether or not to compel a person under statutory powers creates both legal vulnerability and the potential for stress and burnout on the practising AMHP (Leah, 2020).

Whilst some risks associated with the AMHP role are explicit, others are less readily identifiable. AMHPs, following the 2007 amendments and their predecessors (Approved Social Workers under the Mental Health Act 1983), are professional roles created to perform a defined statutory purpose. The competency and quality of the AMHP workforce therefore correlates directly with how effectively this statutory safeguard is realised in practice. AMHPs are responsible for bringing the 'social perspective to bear' (Code of Practice, 2015, para. 14.52), for considering the least restrictive option (Code of Practice, 2015, para. 14.13; para 14.52), for applying an understanding of the legal framework intended to protect service users from erroneous deprivations of liberty, and to mitigate risks to the individual and the public. However, competency exercised in conditions of uncertainty, scarcity, and constraint is difficult to measure, support, and sustain, giving rise to more implicit and less tangible forms of risk.

These implicit risks are structural in nature and operate primarily on a regulatory, rather than a strictly legal, terrain. AMHPs are accountable to a substantial number of regulatory and institutional stakeholders, yet the hierarchies of accountability governing these arrangements remain unclear. As a result, scrutiny of 'less than perfect' practice is difficult to achieve, not because such concerns are necessarily rare or egregious, but because the mechanisms required to identify, escalate, and address them at a system level remain underdeveloped within existing regulatory arrangements.

The dominant regulatory approach in contemporary UK health and social care is Right-touch Regulation (RTR), developed by the then Council for Healthcare Regulatory Excellence (CHRE), now the Professional Standards Authority (PSA) and articulated through successive iterations in 2009, 2015, and most recently in 2025. Right-touch regulation presents itself as a model of simplicity and minimalism: it advocates for regulatory intervention only when necessary, and aims for responses that are proportionate, targeted, consistent, transparent, accountable, and agile (CHRE, 2009; PSA, 2015). Right-touch regulation principles guide all regulation aspects in health and social care, including the design of regulatory organisations, their governance, functions and decision-making. The framework has become influential across health professional regulation in the UK and internationally, offering what appears to be an appealing middle path between heavy-handed intervention and regulatory absence.

This article examines whether RTR, as applied by the PSA, provided an adequate framework for the oversight of AMHP practice. RTR presupposes conditions that are not present: that risk is rendered visible by reliable decision-quality signals; that a regulatory object can own and target the risk(s) within its remit; and that feedback loops recalibrate practice over time (e.g., that interventions for specific risks will influence practice). This paper argues that the lack of national and targeted procedures overviewing AMHP practice causes the regulation of this work to be completed in the margins of existing regulations, leading to potential blind spots and regulatory failure. Furthermore, that the current methodology and regulatory approach, 'right-touch regulation', is inherently insufficient to regulate contemporary AMHP practice due to the barriers to risks associated with the practice being effectively identified. Where these preconditions (visibility, ownership, and feedback for example) do not obtain, as they do not for AMHPs, proportionality cannot be calibrated, targeting has no determinate locus, and regulatory oversight defaults to weak proxies that say little about adherence to the statutory safeguards that define decision quality.

The article proceeds in six parts. Section 2 maps the AMHP regulatory architecture as it is now—the formal bodies responsible for AMHP professional regulation and how responsibility of AMHP practice is fragmented and diffuse between multiple bodies (including the CQC, Social Work England, the NMC, the HCPC, and Local Social Service Authorities), with no single body holding end-to-end accountability. Section 3 introduces the core regulatory ideas that shape RTR and professional regulation in Health and Social Care, tracing the rise of RTR from the Better Regulation movement through its institutionalisation via the PSA. Section 4 situates RTR within broader regulatory theories—responsive regulation, smart regulation, and harm-based regulation; reviewing the PSA's Right-Touch assurance method to evidence why calibration to risk is not possible without role level visibility and an identifiable owner for pattern-level risk. Section 5 demonstrates why the methods misfit this context: AMHP practice is invisible at a system level, responsibility is dispersed without orchestration, and assurance defaults to proxies weakly coupled to statutory safeguards. Section 6 evaluates the 2025 RTR revision ('RTR3'), showing that the proposed addition of 'fairness' and 'collaboration' as principles does not address the operational gaps that render the framework inapplicable to fragmented regimes. Section 7 outlines a harm-based alternative that specifies the required data, ownership, and reporting arrangements for proportionate AMHP oversight. The conclusion argues that, without the preconditions for proportionate regulation being established—visibility, ownership, feedback—the language of Right-touch continues to legitimate a system that does not effectively regulate at all.

2. Who regulates AMHPS

2.1. The care quality commission: the service regulator

The Mental Health Act implicates multiple regulatory actors,

including professional regulators, service regulators, professional bodies, task forces, and interest groups. To understand the fragmented oversight of AMHP work, it is necessary to distinguish these bodies and their respective remits. Statutory instruments such as The Mental Health (Approved Mental Health Professionals)(approval)(England) Regulations 2008 (SI 2008/1206) and the Code of Practice (DoH, 2015) guide Local Social Service Authorities and educational programmes, which in turn should inform how professionals carry out their responsibilities. Beyond statutory instruments, the Care Quality Commission (CQC) is instructed by parliament to monitor the Mental Health Act and the environments in which the Act's functions take place. The CQC replaced the Mental Health Act Commission following the Health and Social Care Act 2008, which was provided with a broader range of enforcement strategies including the ability to issue warnings, impose financial penalties, and close facilities that do not meet safety standards (Laing, 2023, p. 44).

For Approved Mental Health Professionals, however, the CQC's role is tangential. The CQC reviews how services exercise their powers, provides a second opinion appointed doctor (SOAD) service, and produces an annual report to parliament (s.120D(3) of the Act). Nonetheless, the CQC does not comment on AMHPs specifically. Despite AMHP work being fully implicated in the final statistics: routes diverted from the Act, difficulties finding suitable therapies or treatments, and the over-representation of black people and ethnic minorities subject to compulsory powers—the CQC's monitoring focuses on provider compliance rather than practitioner-level decision-making (DoH, 2018).

Whilst the CQC does not explicitly monitor the AMHP service annually, the Commission was recommended by the Crisis Care Concordat in 2017 to review how the AMHP service was delivered in England (CQC, 2018). The review was broadly uncritical of AMHP practice, citing positive reports of crisis prevention and leadership, whilst noting concerns about recruitment, retention, and resource pressures. Importantly, there are variations in health and social care integration between NHS trusts and local authorities. Section 75 of the NHS Act 2006 allows NHS bodies and local authorities to pool funds and share functions to facilitate greater integration. Where s.75 agreements have disaggregated, AMHPs are caught between the priorities of the local authority and the trust, resulting in greater difficulty locating s.12 doctors, more limited multidisciplinary work, and difficulty running 24-h services (CQC, 2018, p. 11).

The CQC reports wide inconsistencies in recorded data regarding AMHP provision nationally—there is no specific register of AMHPs—and difficulties with data sharing between local authorities (CQC, 2018, pp. 5–7; Laing, 2015). AMHPs report significant difficulty with necessary data gathering on their patients, whilst little is recorded on AMHP activity that does not result in compulsory detention. Here lies the bind of AMHP regulation: whilst the CQC has some oversight function, the range of impactful regulatory mechanisms is constrained. The CQC can raise awareness of good practice but cannot compel trusts and local authorities to engage in s.75 agreements, cannot compel a shared data collection system, and cannot enforce greater record keeping of AMHP work. The lack of collaboration between trusts and local authorities is consistently linked to poorer effectiveness of service, and the lack of data recording results in a lack of clarity on the impact of poor service (APPG and BASW, 2019).

2.2. Social work England: the professional regulator

Social Work England is a specialist regulator for the social work profession, established in 2019 following the Children and Social Work Act 2017. SWE operates as a Non-Departmental Public Body at 'arm's length' from government. The formational drive toward SWE's creation was concern about inconsistent and not 'sufficiently clear or robust' knowledge of social workers and social work trainees (DoE, 2016, p.5). The ambition was to radically reform social work via improved educational and training standards, moving from 'the initial and generic qualification of social workers [that] is not sufficient to bring social work to its full potential' (DoE, 2016, p.5).

The Government consultation emphasised two objectives: to 'operate streamlined, proportionate and efficient systems' and to 'build public trust' (DoE and DoHSC, 2018, p.3) in pursuit of public protection. The consultation highlighted the potential benefits of a 'specialist' social work regulator with 'in-depth understanding' (DoE and DoHSC, 2018, p.5) in contrast to the multi-professional Health and Care Professions Council (HCPC). However, SWE's formation through secondary rather than primary legislation drew criticism as 'a power grab' (HC Deb 2 July 2015, vol 597, col 4). Moreover, the ambition for SWE to operate at arm's length of government has yet to be fully realised, with large sections of its expenditure still supplemented by the Department of Education through 'grant-in-aid' (SWE, 2023a, p.99) rather than being self-revenue generated through registration fees. Social Work England was both created by the Secretary of State and funded by it—calling into question the validity of the initial claim of 'independence'.

The SWE regulates all social worker AMHPs, following the long tradition that AMHPs are regulated alongside general social workers. Whilst the SWE does not have direct oversight over AMHP powers or practice, they are responsible for approving and monitoring AMHP education and training courses. SWE also operates a Fitness to Practise (FtP) regime applicable to social worker AMHPs. This provides an important mechanism for individual professional accountability, but is primarily concerned with misconduct, impairment, or fitness, rather than with the quality or proportionality of routine AMHP decision-making. The implications and limits of FtP as a mechanism for overseeing AMHP practice are examined further in section 6.a. The SWE has criteria matched to Schedule 2 regulations (The Mental Health (Approved Mental Health Professionals)(approval)(England Regulations 2008, 1206, Schedule 2) but does not 'dictate how education providers should meet the criteria' (SWE, 2024).

In 2022, the SWE consulted on proposed 'new education and training approval standards for approved mental health professionals' (SWE, 2022) which are due to take effect. The SWE commissioned a report on the 'AMHP, BIA and people with lived experience' in advance of drafting the renewed standards, with the objective of ensuring consistent standards between qualifying students and appropriate levels of training (Hemmington et al., 2021, p.116). The proposals tighten entrance criteria, requiring sufficient literacy and English language skills, placing entrance criteria closer to medical professionals (nurses, for example, are required to meet more stringent literacy standards than social workers, see Allan and Westwood, 2016; NMC, 2015). There is greater emphasis on the appropriateness of practice placements, strategic planning between educational and placement providers, and a shared commitment to anti-discriminatory practice. Most respondents were supportive of the proposed new standards. However, it remains to be seen whether these changes prove meaningful in practice, particularly given that the SWE does not 'dictate how education providers should meet the criteria' (SWE, 2024). There is no mechanism to compel consistent implementation across the multiple local authorities and educational providers responsible for AMHP training.

2.3. The nursing and midwifery council and health and care professions council

Of the approximately 3800 AMHPs, 93% are social workers (DoHSC, 2023, p.15). Consequently, 93% of the AMHP workforce adhere to SWE professional standards and are potentially subject to SWE FtP proceedings. For the remaining 7% (6% nurses, 1% occupational therapists or psychologists) (DoHSC, 2024, p.19), Social Work England has confirmed that it does not regulate non-social worker AMHPs; instead, fitness to practise proceedings for nurse AMHPs fall under the remit of the NWC, whilst occupational therapists and psychologists are regulated by the HCPC (FOI response, SWE, IRR-1828, on file with author). This jurisdictional split means that AMHP-specific conduct may be reviewed

under different professional standards and frameworks depending on the practitioner's base profession, with no single regulator holding oversight across all AMHPs.

Schedule 1 of the Mental Health Act AMHP approval regulations requires that all those approved to train and work as an AMHP must be either: a) a social worker registered with Social Work England/Wales, b) a mental health nurse registered with the Nursing and Midwifery Council, c) an occupational therapist registered with the Health and Care Professions Council, or d) a psychologist registered with the HCPC (The Mental Health (Approved Mental Health Professionals)(approval) (England Regulations 2008, 1206, Sch.1). To maintain eligibility to perform AMHP functions, practitioners must maintain their professional standing under their profession-specific registers. If removed or suspended from the register following FtP proceedings, or if they fail to maintain requirements such as CPD, they are under a duty to inform the LSSA, who may suspend their ability to perform as an AMHP.

The HCPC, as the previous regulator of social work and AMHPs, produced research attempting to understand the unique challenges of the role. The transference of regulation and monitoring of AMHP training programmes was a targeted focus of the HCPC's announcement for transferring social work regulation to Social Work England (HCPC, 2019a, 2019b). The HCPC conducts FtP proceedings for the professionals it regulates and consequently can review AMHP work in the context of AMHP occupational therapists or chartered psychologists. The Nursing and Midwifery Council has not produced independent guidance for nurse AMHPs, though it regularly responds to consultations and provides data on workforce eligibility.

2.4. Workforce planning and standard setting

Beyond the formal regulators, governmental departments and public interest groups influence AMHP practice and help determine standards for the service and workforce, though without day-to-day regulatory authority. Shortly after the Independent Review of the Mental Health Act 2018, the Department of Health and Social Care published the 'National Workforce Plan for Approved Mental Health Professionals' (DoHSC and SWE, 2019a, 2019b), followed by NHS Health Education England's 'Approved Mental Health Professionals (AMHP) National Service Standards: Evaluation, Mapping and Planning Toolkit' (HEE, 2020). Each document was addressed to Social Work England, local authorities, directors of adult and children's social care, and NHS trusts, with the ambition of developing consistent national standards and harmonising service between local authorities (DoHSC and SWE, 2019a, 2019b, p.20; HEE, 2020).

Whilst not critical of AMHP practice per se, the reports highlight the lack of consistency and organisation in AMHP service provision. The NHS acknowledged 'there is a lack of any workforce plan' and that 'there is no system of consistency from one local authority to the next' (HEE, 2020). The risks raised by this lack of consistency are not explicitly mentioned, but there is a sense of a 'post-code lottery' concerning effectiveness between local authorities, unclear levels of support available to AMHPs, and the need to update service provision in greater adherence with the Mental Health Act Review.

The 'National AMHP Service Standards' propose objectives for local authorities and NHS trusts to map AMHP provision effectiveness, emphasising increasing the visibility and accountability of AMHPs to other service providers and communities. Importantly, however, whilst the 'toolkit' can be strongly recommended, there is no authority to compel adherence in a 'prescriptive' manner (HEE, 2020). The workforce plan calls for closer CQC regulation to inspect AMHP service within Mental Health Act monitoring—again highlighting the lack of specific AMHP monitoring by the CQC (DoHSC and SWE, 2021, p. 21). Similarly, it calls for a 'nationally agreed data collection process for the AMHP role and mental health detentions' (DoHSC and SWE, 2019a, 2019b, p.21), a recommendation that has not been implemented.

Both the AMHP workforce plan and toolkit will potentially impact regulatory stakeholders: the SWE, HCPC, NMC, and the CQC. This renewed impetus toward workforce and education standard setting leaves two impressions: a professional ambition to achieve greater visibility and support within the system, and a profession that has received remarkably little technical and coherent oversight.

3. The rise and reach of right-touch regulation

Concepts bound up with 'Better Regulation' have become popular buzzwords of regulators, parliamentarians, and industry alike, insinuating a middle road between decentred and monopolistic governance. The roots of the Better Regulation movement stem from deregulation efforts of the 1985 Conservative Government—the White Paper 'Lifting the Burden' (DTI, 1985) stressed the negative impact of compliance cost and legislative burden (Baldwin, 2005, p.485). Yet it was under the Blair government that the terminological and philosophical shift from 'deregulation' to 'Better Regulation' occurred, with the establishment of the 'Better Regulation Task Force' in 1997 arguing 'Deregulation implies regulation is not needed. In fact good regulation can benefit us all—it is only bad regulation that is a burden' (Cabinet Office, 1997). The core aims were to 'advise the Government on action to reduce unnecessary regulatory and administrative burdens, and to ensure that regulation and its enforcement are proportionate, accountable, consistent, transparent and targeted' (BRTF, 1997 cited in BRTF, 2005, p.48).

The theory was that government, rather than being a monopolistic regulator, would be a 'meta-regulator' and would endorse minimalistic or self-regulatory mechanisms in the first instance. As regulatory authority is shared between public, private and hybrid organisations, this opened up the requirement of a supra-regulator to identify specific regulatory issues, offer an operational definition of 'good regulation', and identify regulatory principles (Baldwin, 2010). The aim was to 'steer' rather than 'row', structuring the marketplace so that naturally occurring private activity may assist in furthering public policy objectives (Osborne and Gaebler, 1992: 25).

This meta-regulatory philosophy found concrete institutional expression in the healthcare sector through the National Health Service Reform and Health Care Professions Act, 2002, which fundamentally restructured the oversight of healthcare professional regulation. Prior to this Act, healthcare professions operated under a fragmented system of self-regulation with no centralised oversight mechanism. The 2002 Act established the Council for the Regulation of Healthcare Professions (later renamed the Council for Healthcare Regulatory Excellence, and subsequently the Professional Standards Authority in 2012) as an independent, arm's-length body accountable to Parliament (Health and Social Care Act 2012 Sch 7, para 1), embodying the meta-regulatory approach within the specific context of healthcare governance.

This legislative reform was precipitated by mounting concerns about patient safety and public confidence in healthcare regulation, most notably highlighted by the Kennedy Report into failings in children's heart surgery at Bristol Royal Infirmary. The existing regulatory framework was deemed inadequate, with legislation that was 'often outdated, overly prescriptive, and lacked flexibility,' hampering regulators' ability to respond effectively to emerging risks (DoHSC, 2019, p.5). The CHRE was deliberately positioned as a 'meta-regulator' with significant powers, including the authority to advise ministers, develop principles of good regulation, and direct professional regulatory bodies to make or change rules (National Health Service Reform and Health Care Professions Act, 2002, s.25). This statutory mandate, combined with its oversight role across nine statutory health professional councils, placed the CHRE in a unique institutional position to operationalise the broader meta-regulatory theory within healthcare governance, creating the conditions from which RTR would emerge.

RTR represents a direct evolution of the Better Regulation Task Force's foundational work. The approach explicitly builds upon the five core principles of good regulation originally identified by the Better Regulation Executive in 2000: proportionality, consistency, targeting,

transparency, and accountability (Cabinet Office, 2000). However, it took nearly a decade for these abstract principles to be translated into a more practical regulatory methodology in the healthcare context.

The genesis of RTR appears somewhat ad hoc. Harry Cayton, the chief executive of the Council for Healthcare Regulatory Excellence (CHRE), described drafting the principles in September 2009, noting that after a Board discussion about what good regulation should look like, he 'scribbled down the principles on a single piece of paper' (PSA, 2018a, 2018b, p.4). Over the following months, Cayton's team at the CHRE debated, expanded, and refined these hastily sketched ideas, emphasising clarity and simplicity as key strengths (PSA, 2018a, 2018b), though critics might argue this simplicity masked the complex challenges of determining what constitutes 'proportionate' intervention in practice (Yeung, 2004, pp.168–70). This rather informal origin story raises questions about the theoretical rigour underlying what would become a significant regulatory approach. Principles-based systems such as RTR rely heavily on discretionary power, which can be enhanced rather than limited by the flexibility of rules (Westerman, 2012, p.90). This discretionary power, if not consistently applied, can lead to regulatory uncertainty and moving targets for compliance, further challenging the theoretical clarity and practical application that Cayton's team claimed as virtues.

By 2010, the Professional Standards Authority was actively promoting Right-touch regulation within health and social care, with 'agility' added as a sixth principle by 2015. The framework gained influence across health professional regulation in the UK and internationally, including regulators involved in mental health: Social Work England, the Nursing and Midwifery Council, the Health and Care Professions Council, and the PSA itself. Yet RTR's institutional success masks operational failure. In fragmented regimes, such as AMHPs the preconditions for proportionate regulation do not exist.

4. Location right-touch AMOUNG regulatory theories

Whilst RTR emerged from the specific institutional context of healthcare professional oversight, a cited influence on its philosophical underpinnings is 'responsive regulation'. Responsive regulation is described as a 'regulatory philosophy' rather than a uniform set of prescriptive strategies, which advocates that regulation should respond to industry structure and that government action should be attuned to the varying motivations of regulated actors (Ayres and Braithwaite, 1992, p.4). Developed by Ayres and Braithwaite as a critique of the binary proposition between command-and-control regulation and laissez-faire regulation, responsive regulation proposed a middle way, which promised to be more nuanced and context-sensitive.

Two principles remain archetypal of the philosophy. First, responsiveness to the unique regulatory contexts, histories, motivations and interests of each industry. Regulated industries may comply out of profit-seeking logic, reputational concerns, professional ethics, or respect for legality, while individuals within industries may embody 'multiple selves' that prevail in different circumstances (Ayres and Braithwaite, 1992, p.19). Regulation is most effective for those already motivated by ethics or responsibility, while the credibility of escalating sanctions remains essential for those guided primarily by economic calculation. In this sense, responsiveness to context and motivation rejects 'one-size-fits-all' regulation in favour of dynamic engagement that adapts to structure, culture, and incentive, whilst keeping the credible threat of escalation—the 'big gun'—in reserve (Ayres and Braithwaite, 1992, p.48).

Second, responsive regulation is notorious for the concept of the 'enforcement pyramid'. The enforcement pyramid encourages regulators to commence with supportive measures such as education and persuasion before progressing through warnings and penalties to ultimate sanctions including licence revocation if compliance cannot be achieved (Ayres and Braithwaite, 1992, p.36). This adaptive enforcement strategy encourages regulators to assume initial willingness to comply and escalate responses only as resistance increases, thereby promoting normative desire for compliance rather than mere punishment avoidance (Ayres and Braithwaite, 1992, pp.38–9).

Right-touch shares family resemblances with responsive regulation, even though the PSA's own accounts trace its lineage to Better Regulation and smart regulation (Better Regulation Task Force, 2003; CHRE, 2010; Gunningham and Grabosky, 1998), with the 2015 revision expressly influenced by Malcolm Sparrow (PSA, 2015; Sparrow, 2008). In particular, the idea that regulatory intervention should be attuned to the motivations and behaviours of those regulated, and the notion of graduated enforcement through escalation, resonate strongly with Right-touch's emphasis on proportionality and minimal necessary intervention. However, where responsive regulation foregrounded relational responsiveness and adaptive escalation, Right-touch regulation translated these insights into a more bureaucratically calibrated framework, centred on systematic analysis of risk, harm and context to determine the appropriate regulatory response (CHRE, 2010; PSA, 2015).

The refinement of responsive regulation into 'really responsive regulation' by Baldwin and Black provides an important intellectual bridge between Ayres and Braithwaite's framework and the PSA's articulation of RTR (2008). Baldwin and Black argued that regulators must be 'responsive' not only to the behaviour and motivations of regulated parties, but also to their own institutional environments, regulatory performance, and the broader regime context (Baldwin and Black, 2008). This broadened the model beyond the linearity of the enforcement pyramid, emphasising that responsiveness must also incorporate considerations of consistency, transparency, accountability, and the legitimacy of regulatory institutions themselves. In doing so, 'really responsive regulation' highlighted precisely those tensions—between flexibility and consistency, persuasion and proportionality—that RTR later sought to reconcile within professional oversight.

Criticisms of responsive regulation illuminate why RTR sought more formalised structures. The enforcement pyramid is rarely implemented in practice, and regulators often apply its principles inconsistently (Mascini, 2013, p.52). Its emphasis on cooperation risks disproportionate outcomes: cooperative regulated parties may escape sanction even for serious violations, whilst resistant actors can be punished harshly for relatively minor breaches (Parker, 2006, p.595). RTR sought to mitigate these weaknesses by embedding responsiveness within risk-based assessment and the principles of good regulation (PSA, 2015).

Unlike responsive regulation, smart regulation proposes a form of regulatory pluralism as an alternative to either command-and-control state regulation or laissez-faire approaches (Gunningham and Grabosky, 1998, p.10), by harnessing the capacities of business, third parties and commercial interests to act as surrogates for direct government regulation (Gunningham and Grabosky, 1998, pp.35–36). This 'third phase' seeks to combine government intervention with market and non-market solutions, where the government is the 'catalyst, activator or facilitator' (Gunningham and Sinclair, 2017, p.140) that steers rather than rows the marketplace (Grabosky, 2017, p.154).

Smart regulation builds on the enforcement pyramid of responsive regulation to expand it to a three-sided model, with each side representing a different category of regulatory actors: first parties (government), second parties (business or industry as self-regulator), and third parties (commercial or non-commercial actors as surrogate regulators) (Gunningham and Grabosky, 1998, p.398; Baldwin et al., 2011a, 2011b, p.136). It is between this combination of instruments across different sectors that, Gunningham and Grabosky argue, creates complementary strategy mixes that foreground the need for coordination, redundancy, and shared responsibility, particularly in complex policy environments. Whilst smart regulation initially developed in the context of environmental regulation, its method is transferable to other domains where regulatory challenges are characterised by uncertainty, dispersed responsibility, and the limits of state capacity.

Where responsive regulation is characterised by the stratification of

enforcement strategies, smart regulation is distinguished by its emphasis on plurality and complementarity. Rather than visualising regulatory tools as a vertical escalation from persuasion to sanction, smart regulation foregrounds the simultaneous deployment of diverse instruments across different actors and institutional sites. Its logic is therefore less about sequencing and more about layering, overlap, and redundancy, with the expectation that the inevitable weaknesses of one instrument or actor will be counterbalanced by the strengths of another.

Nonetheless, the language and strategies of smart regulation are often appropriated to justify regulatory reforms that bear loose resemblance to the original academic concept. Policymakers may embrace 'pluralism' on the surface but fail to engage third-party actors or remain unwilling to escalate up the enforcement pyramid. As Gunningham and Sinclair observe, 'policymakers have selected particularly juicy morsels that appeal to the political rhetoric of their masters, largely irrespective of their likely effectiveness or efficiency' (Gunningham and Sinclair, 2012, p.145). Similarly, the theory is criticised for institutional blindness, failing to address limitations constrained by the variations in formal authority that different regulators have in choosing regulatory options, and deep-rooted institutional values on how policies are made and implemented (Baldwin and Black, 2008; Richardson et al., 1982, p.2). Perhaps most damning, the level of competence and sophistication needed to uniformly select regulatory strategies requires a level of orchestration that the theory tries to prevent; the performance sensitivity of different strategies is strained when centralised communication and feedback between different regulatory actors is constrained.

A structural constraint reinforces this dilution of smart regulation's principles. The evaluation of regulatory effectiveness is largely determined by Regulatory Impact Assessments (RIAs), which aim to clarify regulatory objectives, identify alternatives, and enhance accountability (Cabinet Office, 2003). Yet RIAs are best suited for assessing a single regulatory proposal, not the pluralistic or diverse regulatory systems encouraged by smart regulation, which leads to what Baldwin calls 'heroic guesswork' (Baldwin, 2005, p.86). Rather than embracing the underlying principles of smart or responsive regulation, policymakers are inclined toward simpler regimes that pass more easily through RIA processes (Baldwin, 2005, p.92). This prevents what smart, Right-touch and responsive regulation take as a first-order principle: accurately defining the problem rather than allowing the assessment strategy to define the problem (Baldwin, 2005, p.92). For AMHP governance, this creates a perverse incentive: the complexity of multi-actor oversight that would be required for effective regulation is precisely what makes such oversight difficult to justify through standard RIA frameworks.

These regulatory theories establish the criteria by which AMHP governance should be judged. RTR claims their lineage but omits their operational features: credible escalation (responsive), designed layering with redundancy and backstops (smart), and the active detection and shrinkage of cumulative harms (harm-based, discussed below). The following analysis demonstrates that, in AMHP governance, the absence of these mechanisms routinely collapses the purported 'third way' into delegation without design.

5. Regulatory silence and invisible harms

The 2015 revision of RTR explicitly acknowledges that it was 'influenced by Malcolm Sparrow's work on the prevention of harms' (Cayton, n.d; PSA, 2018b, p.38). In practice, however, that influence is rhetorical. RTR adopts Sparrow's language of prevention but not his operational methods—particularly his tools for detecting invisible, cumulative harms (Sparrow, 2008, p.182) and building proactive harm portfolios (Sparrow, 2008, pp.154–55). Sparrow conceives regulatory craft as an active discipline of detecting, analysing, and managing harm, especially where harm does not appear as a discrete incident (Sparrow, 2000). At its core is the idea of knots—specific, tightly bounded clusters of harm that regulators can name, size, analyse, and then shrink through targeted action (Sparrow, 2008, pp.256–60). In practice, a knot is a defined problem-unit: a repeat-detention hotspot, a biased pathway, a recurring failure mode— that is mapped and assigned to a team who owns it end-to-end until measurable reduction is achieved.

Harm-based regulation begins by diagnosing incident blindness: systems that rely on complaints and case-by-case inspection systematically miss cumulative harms—the very spaces where RTR assumes proportionate, incident-led responses will suffice (Sparrow, 2008, pp.145–56, 182–90). Sparrow positions regulatory work in the textured middle layer between policy abstraction and individual cases. This marks a step beyond Right-touch's rhetorical principles and beyond responsive regulation's escalation logic, which presumes a visible failure to trigger upward movement within the enforcement pyramid (Ayres and Braithwaite, 1992).

Sparrow's approach claims to create stronger accountability than smart regulation's generic pluralism by assigning clear problem ownership and requiring cross-agency orchestration rather than mere decentralisation (Gunningham and Grabosky, 1998; Sparrow, 2000). Regulators manage harm portfolios, continuously adding, refining, and retiring knots based on evidence of reduction—an operational discipline absent in Right-touch and not guaranteed by responsive or smart regulatory models. Because catastrophic events are rare, Sparrow prioritises precursor indicators and near-misses to enable intervention before visible damage occurs (Sparrow, 2000, 2008). He embeds iterative experimentation: establish a baseline, implement an intervention, re-measure, and retain what demonstrably reduces harm.

Yet harm-based regulation is not ethically neutral. The same data-driven precision that promises focus can invite gaming, target chasing, and political distortion. Priorities shift toward harms that are measurable or newsworthy, whilst less visible injustices fall away. Technocratic habits crowd out debate about values and rights when regulation is framed as a problem of optimisation. As Right-touch drifts toward measurable proxies (e.g., Fitness-to-Practise timeliness, CPD compliance), harm-based regulation risks similar closure around the choice and calibration of 'knots'. Success becomes a function of how baselines are set and what counts as reduction. Unless questions of equity and accountability are built into portfolio selection, the politics of choice simply migrate to another level.

6. Why right-touch regulation fails for AMHP oversight

This review of regulatory theories places Right-touch alongside responsive, smart, and harm-based regulation to do more than catalogue influences. These models share a regulatory philosophy: each promises a 'third way' between laissez-faire and command-and-control. However, Right-touch, as articulated and operationalised by the PSA, omits core features that give those approaches force: credible escalation (responsive), designed layering, redundancy, and backstops (smart), and the active detection and shrinkage of cumulative harms (harm-based). *The result is a gap between avowed philosophy and institutional design. That gap matters for AMHPs. To evaluate AMHP governance, we must distinguish a Right-touch vocabulary of proportionality and risk from the mechanisms that would make a middle path effective in practice.* The analysis that follows demonstrates that, in AMHP governance, the absence of escalation, layering, and harm-ownership routinely collapses the purported 'third way' into delegation without design.

6.1. The invisibility problem

Risk-based proportionality exposed by regulatory tools such as Right-touch presumes and relies on visibility (PSA, 2016). Yet, the professional identity and the outcomes of AMHP work is often not sufficiently visible or scrutinised. AMHPs do not exist as a national, cross professional object; they are composed of multiple occupational groups, and their focused professional regulation is diffused between multiple regulators (The SWE, NMC and the HCPC). Beyond the individual data held by LSSAs on approval and re-approval of AMHPs and the choice to

annotate the SWE register, there is no nationally maintained register of active AMHPs. There is also no consistent data for how many AMHPs are practising at any time nor how their work is distributed. An FOI study found that Local Authorities collect different fields for approval and re-approval (Fish, 2026). There is no systematic data or regulatory analysis that captures a substantial proportion of AMHP activity that does not culminate in detention (e.g., diversions from the MHA through community pathways, voluntary admission) (NHS England, 2024), nor does data or regulatory analysis capture practitioner's work to prevent hospitalisation and cases where people would have been detained but for lack of beds (Samuel, 2024).

Local Social Service Authorities are responsible for the 're-approval' of AMHPs every 5 years (e.g., s.114 obliges the Local Social Service Authority to provide a sufficient number of AMHPs). The LSSAs have a duty to re-approve AMHPs and ensure that a person 'has appropriate competence in dealing with persons who are suffering from mental disorder' (The Mental Health (Approved Mental Health Professionals) (approval)(England Regulations 2008, 1206, Sch 2, s.4.). This provides a method to appraise AMHP practice, and to potentially 'de-approve' those that are not performing to the appropriate competency. AMHPs may be de-approved for failing to complete the statutory 18 h of continued professional development (CPD) and for not maintaining registration with their specific professional body. Yet, little is known about what the LSSAs criteria for re-approval are, as there is no consolidating guidance. Individual LSSAs enjoy the devolved ability to develop their own guidance. Derbyshire County Council, for example, provides guidance on AMHP approval and re-approval, which contains the conditions set above, with an additional stipulation that the AMHP ought to be directed by a line manager and participate in 'buddy systems' and a team rota, and complete a minimum of 12 MHA assessments per year (Derbyshire County Council, 2024). However, nothing is written about the implications for 'poor conduct'. Indeed, Mearns conducted a study into the approval process and LSSAs criteria for re-approval. The study reviewed the lack of a standardised process or policy guidance and suggested that there was room for significant reform (2022).In particular, the study called for consistent comprehensive service standards across all organisations responsible for overseeing the AMHP role, and for these service standards to be regularly reviewed and updated to ensure that the guidelines align with best practices (Mearns, 2022).

Mearns' hypothesis is confirmed from the results of Freedom of Information requests submitted to every Local Authority in England and Wales (Fish, 2026). Many Local Authorities reported either re-approving no AMHPs, or stated that NHS Trust holds the responsibility to re-approve AMHPs. The findings from this study, based on FOI requests to all 173 authorities with AMHP functions in England and Wales, confirm those concerns. Of the 145 valid responses (83.8% response rate), 3654 AMHPs were reported as applying for re-approval over a five-year period. Of these, 3410 (93%) were successfully re-approved, while only 56 (2%) were refused. A further 188 (5%) fell into 'movement' categories such as retirement, relocation, or role change. At council level, 133 authorities (78%) reported approving all AMHPs during the period, while 32 (22%) reported refusing at least one. Where refusals occurred, the vast majority were attributed to 'failure to demonstrate required competence' (60.7%), with far fewer linked to training hours (16.1%) or personal conduct (1.8%). No authority reported non-approval primarily on the basis of poor conduct (Fish, 2026). These findings highlight, not only the rarity of refusals, but also significant inconsistency in local authority approaches. Some councils reported never refusing re-approval, while others treated competence issues as grounds for refusal. Many appeared uncertain about their statutory responsibilities, with several indicating that NHS Trusts held the function.

Another source of potential risk visibility of AMHPs is Fitness to Practice proceedings. As of November 2019, AMHPs and BIAs have been provided the ability to request an annotation denoting their specialism be added to the register (SWE, 2019). The visibility of specialism seeks to add public transparency, as the public can search the register to view the standing of the professionals which they may encounter. However, it is optional and requires individual AMHPs apply (SWE, 2025). It is not currently possible to search the SWE register for annotations, and nor is it possible to apply specialised searches to the register of fitness to practise case decisions. In other words, understanding whether AMHPs are subject to proceedings and access to case decisions is not easily viewable. Data gathered from an information request revealed that currently 920 AMHPs have the annotation (approximately 24.21% of the total AMHP workforce), and the SWE confirmed that it is in their remit to review social worker AMHP conduct, 'conduct will be reviewed if the person is a registered social worker and if it is relevant to the Fitness to Practise proceeding' (FOI response, SWE, IRR-1828, on file with author). Since the ability for AMHPs to annotate their registration, however, there have been only three instances where an annotated AMHP was subject to FtP proceedings (0.326% of total annotated AMHPs). In contrast to 1.6% of SWE registered social workers passing through at least some part of the fitness to practice process each year (BASW, 2024).

In Case A, a registered AMHP who was employed within an Emergency duty service, was removed from the register after failing to disclose that she was disqualified from driving, along with a number of documented instances of unprofessional behaviour (Case decision SW17635). In Case B, an AMHP working on a mental health team was removed from the register after findings of inappropriate sexual behaviour toward clients and colleagues. It is unclear from the case hearing whether the inappropriate behaviour was expressed during AMHP duties, but revealed a pattern of unprofessional conduct toward vulnerable clients (Case decision SW38936). In Case C, an AMHP was issued a warning after being found to have committed council tax fraud and failing to notify their employer and regulator (Case decision SW101686). Of the 3 cases, only one involves misconduct toward clients/service users, and even here, it is not clear whether the assault occurred while performing the role as an AMHP, or while performing their duties within a mental health team. It remains unclear which aspects of AMHP-specific conduct are deemed relevant to fitness to practise proceedings by Social Work England, as there are no published decisions concerning the conduct of social workers acting in their capacity as AMHPs. Likewise, no such cases have been brought before the HCPC or the Nursing and Midwifery Council in relation to non-social worker AMHPs.

The number of AMHPs subject to FtP proceedings is noticeably fewer compared to the general pool of social workers. One possible interpretation of this disparity is that AMHP practice is characterised by a higher level of professional caution, and that the nature of AMHP work renders it less likely to receive complaints from the public or their employer (the Local authority). However, the available data do not permit this interpretation to be distinguished from alternative explanations linked to the structure and visibility of the role itself, including the difficulty of translating AMHP decision-making, exercised within statutory discretion, into issues that are legible to professional fitness to practise processes.

A number of factors contribute to a statistically higher likelihood of receiving fitness to practise concerns, many of which may disproportionately impact the AMHP workforce. Men are significantly more likely to progress through the fitness to practise process than women (SWE, 2023b; Worsley et al., 2020); while men represent only 17% of the social work register (SWE, 2023b, p.4) they make up 22% of the AMHP workforce (SoC, 2025, p.28) and 31% of those in fitness to practise hearings (SWE, 2023b, p.20). Older social workers are more likely to receive 'concerns' compared to the average. Social workers aged 40 and over have higher triage progression rates (43%) than those under 40 (34%) (SWE, 2023b, p.33), and approximately 31% of the AMHP workforce is aged 55 or over (SoC, 2025, p.27). Organisational issues, such as high caseloads, inadequate supervision and inadequate

resources (Leigh et al., 2017) have been raised by the national AMHP workforce plan as factors impacting the profession (DoHSC and SWE, 2019). Issues of poor public understanding of the role and its general lack of professional visibility also contribute to the over-representation of social workers in public complaints, another issue that is well researched as impacting AMHPs (Morriss, 2017; AsifAMHP Blog, 2017).

AMHPs, in contrast to other social workers, are less likely to have a sustained relationship with a case load. Unlike social workers who work in child protection, care leavers and related profession may develop a relationship with service users over years, the AMHPs relationship is often temporal, and many have an interaction with a service user only for a short period of time. The consequence is that service users may often not quite understand their rights vis-a-vis an AMHP (Marriott et al., 2001) or have certain misaligned treatment expectations. We have some insight into the potentially coercive nature of mental health act assessments (Glover-Thomas, 2011) and ways the assessment may be a 'threatening' or 'frightening' experience (Hemmington, 2024) – but what the threshold and weight of these factors in meeting a definition of misconduct is ambiguous. Furthermore, the nature of AMHP work is highly individualistic (necessarily, as it is the individual decision, which is the cornerstone of AMHP work and the principle that confers an essential safeguard to service users); but this also translates into light community oversight into their decision-making and the nature of their relationship with service users.

NHS Digital maintains records on assessments that result in detention and the basic demographics of the person subject to mental health assessments. For example, in 2022–23 there were a total of 20,016 people subject to the Mental Health Act (NHS Digital, 2024). Not covered in this statistic are how many persons entered into hospital voluntarily, how many total assessments were completed, and how many mental health act referrals where made. Consequentially, there is no clear picture of what AMHPs do, as their conduct is not recorded, or if recorded locally, the data is not subject to public oversight. Currently, reform to data collection is included in the consultation 'Health and social care statistical outputs', published by the Department of Health and Social care, The Office of National Statistics, NHS Business Services Authority, UK Health Security agency, and NHS England (DoHSC, 2024). The proposal is to discontinue the annual report on the Mental Health Act due to the development of monthly mental health services statistics, yet there is no proposal to collate all information relevant to the implementation to the MHA and MHA assessments.

The consideration of the 'least restrictive' option is a guiding principle of the Mental Health Act Code of Practice. AMHPs need to be assured before applying for compulsory detention that a lesser restrictive option is not available. The value of this principle is commonly queried as being valuable unless there are options between which to choose (APPG and BASW, 2019). AMHPs are under no statutory obligation to record what options were considered before agreeing to detain a service user; therefore, it is impossible to verify whether some AMHPs are adhering to this guiding principle in practice. Rooke has called for greater emphasis on protective practice, specifically using Section 115 to document the 'less controlling' aspects of AMHP practice (Rooke, 2020; Stone, 2019). She highlights that both good and potentially poor practices are often not recorded, underscoring the need for better documentation.

Equally, referrals for compulsory psychiatric detention are not recorded or thoroughly researched. Little is documented about what occurs between the point of referral and the AMHPs fulfilment of s.13 MHA - 'an AMHP may decide not to arrange an assessment interview with doctors following a referral, yet decision making at this point is hidden' (Simpson, 2024, p. 799). While the process of referral is mostly considered as procedural in the literature (Grace, 2015), the available literature insinuates a high level of discretion available to AMHPs to divert service users away from formal applications for detention (Simpson, 2024), citing that the involvement of doctors usually results in detention (Wickersham et al., 2020). In pursuit of s.13, AMHPs have the most access to a service user and carry out the majority of background investigations before formally requesting a s.12 doctor and a psychiatrist. But what factors contribute to their decision making receives no statutory guidance, and the effectiveness and influence of these decisions remains unexamined.

There is a correlation between the number of people detained under the Mental Health Act 1983 and the volume of Mental Health Tribunal (MHT) cases: more detentions create more eligibility to apply and more automatic referrals. MHTs function as a key safeguard by providing independent review of the lawfulness and continued necessity of detention. The Draft Mental Health Bill 2022 would, if enacted, alter tribunal access in ways likely to increase applications and referrals (DoHSC, 2022). In particular, it proposes to amend MHA 1983, s.66(2) so that the window to apply after admission under s 2 extends from 14 to 21 days, and the initial eligibility period for s.3 changes from six months to three months; it also proposes more frequent automatic referrals. The quarterly figures for the number of MH tribunals are currently 7700 for the period January to March 2023 (MoJ, 2023). For applicants detained under s.2, approximately 10% (561) are discharged via tribunal and a further 3481 are discharged by clinicians prior to a hearing (CQC, 2024).

On one hand, MHTs are (in part) evidence that an AMHP decision to detain was made at one point, but on the other, the purpose of the tribunal is not to query the legality of that initial decision; rather, the question is whether the continued deprivation of liberty is lawful. While AMHPs are often involved in the route by which many patients or service users come before a tribunal, their main contribution lies in providing and reviewing the social evidence that underpins the detention. This responsibility is reflected in their duty to prepare a Social Circumstances Report and to contribute to the s.117 aftercare plan. The 'Social Circumstances Report' is extensive and requires responses to 24 headings, which include the service users' strengths and progress, the service users' and their nearest relatives' wishes and beliefs, a summary of the service users' interactions with mental health services, and importantly, 'legal and safety considerations' (which includes 'justification for hospital detention or medical treatment in hospital' and 'likelihood of dangerous behaviour if discharged'). The statistics reveal the majority of s.2 detention decisions do not result in a discharge, adding substance to the criticisms that tribunals are a 'rubber stamp' of clinical decisions and that they disproportionally listen to the cultures of clinicism rather than patient views or the 'social perspective'. Despite the limitations of the Mental Health tribunals, there is no reporting on to what extent the social circumstances reports influence final decisions. Furthermore, the likelihood of an AMHP (and specifically the decision-making AMHP) writing the Social Circumstances report is increasingly limited, deferring the task to case managers. The dichotomy remains, that MHTs are a good resource to review the quality of AMHP decision making, but this is not the explicit purpose of the MHT, nor is it guaranteed that an AMHP will produce the report/evidence to review.

6.2. *The fragmentation problem*

The promise of targeted intervention presumes a coherent locus for action. The AMHP regime is intentionally disaggregated: local authorities approve and re-approve (MHA 1983, s 114), Social Work England regulates registration and conduct for social workers, NHS trusts operate pathways, the CQC inspects providers, and tribunals adjudicate the lawfulness of continued detention. Each institution may be compliant within its remit while the patterned harm persists between remits. The CQC's thematic review of AMHP services illustrates this diffusion: it reports on service delivery conditions and system pressures, not AMHP decision quality, because no single actor 'owns' those cross-boundary patterns (CQC, 2018). In such circumstances RTR's 'targeting' has nowhere to land, and synonymous adoption of 'innovations' is slow or impossible to implement uniformly – in part evidenced by the variation in LSSA local approval rates (Fish, 2026).

The purposeful layering of regulatory function and responsibilities

endorsed by Smart regulatory theorists (or what has come to be know as 'the Swiss Cheese model' (Reason, 2000; Wiegmann et al., 2022)); seeks to leverage multiple different institutions as regulatory actors and to provide a 'back stop' for regulatory failures or gaps in one of the actors. Rather than assigning a singular task to a singular body, smart regulation recognises that regulatory effectiveness can be enhanced when multiple actors perform similar functions from different vantage points. In theory, the oversight of AMHPs might appear to reflect a smart regulatory framework. The role sits at the intersection of multiple legal, professional, and institutional domains. AMHPs are trained and approved by local authorities, regulated by professional bodies, bound by statutory duties under the Mental Health Act, and subject to judicial oversight in the event of unlawful detention. However, what appears on paper as multi-actor regulation lacks the essential features of smart governance in practice. There is no structured layering of responsibility or secondary safeguards. Failures at the local authority level, such as inadequate approval, training, or supervision, are not systematically detected or remedied by professional regulators or central government. AMHPs, under s.139, receive immunity from criminal and civil liability without leave, limiting potential case law, and courts intervene only ex post (and only where serious harm or procedural impropriety occurred). There is little evidence of escalation pathways, shared intelligence, or coordinated oversight mechanisms that are consistent across the Local Authorities (DoHSC and SWE, 2019; HEE, 2020). Instead, the system relies on ambiguous and dispersed responsibility, underpinned by informal norms and professional discretion.

The language of right-touch regulation has often been used to justify this minimalist and fragmented model. Proportionality is interpreted not as a call for strategic deployment of layered instruments, but as an argument against comprehensive or centralised oversight. The appeal to risk-based intervention serves to obscure the absence of a coherent regulatory strategy. This distortion becomes clearer when viewed through the lens of smart regulation. Gunningham and Sinclair emphasise that smart regulation is not simply decentralisation, but decentralisation with design. It requires explicit planning around who regulates, how, and with what mechanisms for coordination and correction. In the AMHP context, decentralisation has functioned instead as delegation without oversight, and local autonomy has come to mask systemic gaps in responsibility.

It is not suggested that AMHP practice is wholly unmonitored. AMHPs are subject to local forms of oversight, including supervision, re-approval, in some settings, peer review (forthcoming). These mechanisms may address individual concerns and support practitioners within organisations. However, they do not operate as regulatory mechanisms in the sense assumed by Right-touch regulation: they do not routinely generate structured, role-specific information capable of identifying patterned risks, enabling comparison across localities, or supporting escalation and system-level learning. Right-touch regulation presupposes that risks are visible, attributable, and owned by a regulator capable of targeting and recalibrating intervention. Where governance is fragmented in the manner described above, without role-level visibility, a determinate locus of responsibility, or shared feedback mechanisms, those preconditions do not obtain, and proportionality cannot be meaningfully assessed.

6.3. *From preconditions to proxies*

The foregoing analysis showed that AMHP activity is only partially visible at system level, that assurance mechanisms are locally heterogeneous, and that responsibility for decision quality is dispersed across institutions. Taken together, these conditions unsettle the premises on which Right-touch regulation is said to operate. RTR presupposes that risks are rendered visible through reliable signals, that a determinate body can target and be answerable for those risks within its remit, and that feedback loops recalibrate practice over time (CHRE, 2010; PSA, 2015; PSA, 2025a). None of these assumptions holds for AMHP governance as it is presently constituted.

RTR's proportionality depends on intelligible risk signals; it does not itself generate them. AMHP practice is not constituted as a national regulatory object: there is no national AMHP register, local approval and re-approval records are variable, and dispositions that do not culminate in detention (diversions, voluntary admissions) are not collated nationally. The Care Quality Commission's monitoring of the Mental Health Act is provider-facing and does not require reporting of AMHP decision activity as such; annual reports to Parliament do not analyse AMHP practice. In consequence, patterned risks (for example, repeat detentions in specific localities, clusters of tribunal outcomes, or disparities across protected characteristics) do not appear as regulatory signals. RTR's proportionality 'trigger' cannot engage where the underlying phenomena are not rendered visible.

Yet for the purposes of regulation that relies on accurate data gathering for the identification and 'targeting' of risks, AMHPs exist in a vacuum, where proxies crowd out decision-quality signals. Professional regulators report on FtP throughput (timeliness, case volumes) and compliance proxies (CPD completion), but these do not index the quality of AMHP decision-making or adherence to core statutory safeguards (least-restrictive option, nearest relative or nominated person consultation, consideration of practicable alternatives) in individual assessments. SWE does not systematically role-tag AMHP incidents, and non-social-worker AMHPs (NMC/HCPC registrants) fall entirely outside SWE's FtP data. The optional AMHP annotation on the Social Work England register is not searchable at scale (SWE, 2023a; FOI response, SWE, IRR-1828, on file with author). Low AMHP representation in fitness-to-practise outcomes may indicate few problems, but it is equally consistent with blind spots created by missing role-level fields and the internalisation of error within employers. The RTR texts reiterate proportionality, targeting, and outcomes-focus (PSA, 2025a), but they do not specify the operational spine required where risks are patterned and ownership is dispersed: define a bounded problem set at role level, establish a baseline, assign an owner with convening powers, intervene across organisations, re-measure, and retire the problem only upon sustained reduction (contrast Sparrow, 2000, 2008). In the absence of such a method, assurance defaults to administratively tractable proxies that say little about adherence to statutory safeguards in practice (DoH, 2015). Proportionality, in practice, becomes assertion rather than evidence.

RTR assumes visibility, single-actor accountability, and effective feedback. AMHP risk is patterned, sits between actors, and returns little role-specific feedback. Without role-level visibility, assigned ownership of defined problems, and an operational method for working them, RTR certifies compliant processes whilst leaving the relevant harm architecture intact.

7. RTR3: Principles without preconditions

In March 2025, the Professional Standards Authority (PSA) announced a further revision of its RTR framework, a decade after its previous review, with implementation due October 2025, dubbed 'RTR3' (PSA, 2025a). The 2025 revisions proposed to add 'fair' and 'collaborative' as principles to adapt and reflect the 'current and future expectations of regulators in today's world' (PSA, 2025a, p.5). RTR principles guide all regulation aspects in health and social care, including the design of regulatory organisation, and their governance, functions and decision making (PSA, 2025a, p.7; PSA, 2025b). The proposed addition of 'fairness' and 'collaboration' to RTR responds to legitimate concerns about regulatory burden and the need for coordination across complex systems. Yet for AMHP governance, these amendments address symptoms whilst leaving the underlying structural deficits intact. Fairness presupposes that patterns of disproportionate impact, procedural delay, or inconsistent outcomes are visible at system level and attributable to identifiable decisions. Collaboration presupposes that relevant parties can be convened around shared objectives

and that coordination mechanisms exist to translate agreement into action. As demonstrated in Section 6.c, neither condition holds: AMHP practice is invisible at system level, responsibility is dispersed without orchestration, and assurance defaults to proxies weakly coupled to statutory safeguards.

Similarly, 'collaboration' assumes that relevant parties can be convened around shared objectives and that coordination mechanisms exist to translate agreement into action. Local authorities approve and monitor, professional regulators (SWE, NMC, HCPC) investigate conduct, NHS Trusts operate pathways, and the CQC inspects provider compliance with the Mental Health Act. Each operates within its own statutory remit, reporting to different lines of accountability, with no single body holding convening authority across the regime (DoHSC and SWE, 2019; HEE, 2020). Exhortations to collaborate do not create the institutional architecture required to make collaboration effective (assignment of a problem owner, establishment of shared data standards, specification of escalation pathways, or publication of joint reduction targets).

Most fundamentally, RTR3 retains the same operational assumptions that render Right-touch inapplicable to AMHP governance: that risk is rendered visible through reliable signals, that a regulatory body can target and own the relevant risks within its remit, and that feedback loops recalibrate practice over time. The discussion paper emphasises that RTR 'involves assessing the level of risk of harm to the public and deciding on the most proportionate and effective response' (PSA, 2025a, p.1). Yet where risk is patterned, dispersed, and invisible (as it is for AMHPs) assessment cannot occur, proportionality cannot be calibrated, and effectiveness cannot be verified. Adding fairness and collaboration as principles does not generate the data infrastructure, institutional ownership, or feedback mechanisms their realisation would require. The revisions acknowledge fragmentation ('regulators must increasingly work together', PSA, 2025a, p.5) without specifying the operational architecture that would make collaboration effective: assignment of a problem owner, establishment of shared data standards, specification of escalation pathways, or publication of joint reduction targets (contrast Sparrow, 2000, 2008). RTR3 represents a rhetorical evolution rather than an operational redesign. It acknowledges contemporary regulatory challenges without specifying the changes in method, data collection, or institutional responsibility that would address them in fragmented regimes. For AMHP oversight, the principles remain sound, but the preconditions for their application remain absent.

8. Harm-based AMHP oversight

RTR supplies principles—proportionate, targeted, outcomes-focused, agile—but it does not specify the operational method required when risk is patterned and responsibility is dispersed. As demonstrated above, in AMHP governance, that vacuum is filled by technocratic proxies. These metrics are administratively tractable yet only weakly coupled to the legal safeguards that define decision quality—consideration of least-restrictive alternatives, consultation with nearest relatives or nominated persons, and the availability of practicable options (DoH, 2015). In such conditions, proportionality becomes assertion rather than evidence.

A workable method is needed to convert principles into action on defined patterns of harm. Sparrow's harm-based craft sets out a clear sequence: identify a bounded problem, establish a baseline, assign ownership, act, re-measure, and retire only when reduction is sustained (Sparrow, 2000, 2008). Transposed to AMHP oversight, this requires three operational elements: a minimal data infrastructure, a designated owner with convening authority, and an iterative method for shrinking defined harms.

8.1. Data infrastructure: Making AMHP practice visible

The first requirement is a minimal, standard dataset at assessment level, role-tagged across providers and regulators. The necessary fields are few but decisive: the disposition (detention, non-detention, voluntary admission, diversion); whether the least-restrictive alternative was considered; whether nearest-relative consultation occurred; the availability and timeliness of section 12 practitioners; the minutes of any bed delay; an out-of-hours flag; and protected characteristics sufficient to permit equity analysis. These fields do not score performance. They render visible the statutory safeguards and pathway properties that matter for public protection, and they permit routine pattern-finding views.

This dataset need not be burdensome. Much of it can be generated through minor amendments to existing forms. The statutory application for detention already captures clinician availability and nearest-relative consultation. Adding additional fields for non-detentions and a bed-delay timestamp could be done. Equally, data recording for decisions made when a service user is first referred to be 'triaged' could feel existing data gaps (Simpson, 2024). Crucial shift is that data becomes nationally aggregated and role-tagged, rather than remaining locked in local authority silos or buried within trust-level mental health statistics that do not disaggregate AMHP-specific activity.

8.2. Ownership: assigning accountability for patterns

The second requirement is institutional ownership of defined patterns. Harm-based regulation does not ask, 'Who made this error?' It asks, 'Who owns this pattern and is responsible for shrinking it?' For AMHP governance, this means designating a single body – perhaps most plausibly the PSA, given its meta-regulatory remit (Health and Social Care Act 2012, Sch 7, para 1) - or a new AMHP oversight function within the CQC, which would have authority to convene local authorities, NHS Trusts, professional regulators, and data support around specific, bounded problems.

If the data reveals, for example, that repeat detentions within 90 days cluster in three specific local authority areas, or that tribunal discharge rates for section 2 applications are twice as high on one trust's pathway compared to regional averages, or that Black service users experience disproportionate out-of-hours detentions in particular localities, then the designated owner convenes the relevant actors, establishes why the pattern exists, and coordinates a response. This is not micromanagement of clinical judgment. It is the identification and active reduction of systemic harms that no single institution currently has remit or capacity to address.

8.3. Method: defining and shrinking 'knots'

The third requirement is an operational method for working patterns. In Sparrow's terminology, these are 'knots' - specific, tightly bounded clusters of harm that regulators can name, size, analyse, and then shrink through targeted action (Sparrow, 2008, pp.256–60). In practice, a knot is a clearly defined problem-unit and mapped, assigned to a team responsible for reducing it, and tracked over time. The owner establishes a baseline, specifies an intervention in mechanism terms, and re-measures after a defined period. Success is judged by observed reduction in the pattern, not by completion of process tasks. Where reduction does not occur, the owner revises the intervention and tries again. Learning is built into the structure, rather than relying on voluntary adoption of 'lessons learned' reports that circulate without enforceable follow-up.

This approach does not presume that all harms are preventable. Some baseline level of repeat detention may be clinically appropriate, reflecting the nature of relapsing conditions. The method instead asks whether the current rate is higher than it should be, whether it varies inexplicably across localities with similar populations, and whether interventions can move it in a beneficial direction. Transparency is achieved through publication of quarterly pattern-reduction reports showing what was tried, what worked, and what did not. These three

elements do not supplant Right-touch principles but specify what those principles require to operate where responsibility is dispersed and risk is patterned.

9. Conclusion

This article has argued that RTR, as articulated and operationalised by the Professional Standards Authority, is structurally unsuited to the oversight of Approved Mental Health Professionals. The failure is not one of implementation or commitment, but of fit. RTR presupposes conditions are absent in AMHP governance: that risk is rendered visible through reliable signals, that a determinate regulatory body can own and target those risks within its remit, and that feedback loops exist to recalibrate practice over time. None of these preconditions holds for AMHPs.

AMHP practice is invisible at the system level. There is no national register of active practitioners, no consistent data on assessments that do not result in detention, and no role-tagged reporting across the fragmented regulatory architecture. Local authorities apply divergent re-approval criteria with minimal transparency (Fish, 2026), professional regulators cannot systematically identify AMHP-specific conduct in fitness-to-practise proceedings, and the CQC's monitoring of the Mental Health Act focuses on provider compliance rather than decision quality in individual assessments. In the absence of visibility, proportionality cannot be calibrated. RTR's risk-based methodology requires intelligible signals; it does not generate them.

Responsibility for AMHP oversight is dispersed. Local authorities approve and re-approve, Social Work England regulates social worker AMHPs' conduct, the NMC and HCPC regulate nurses and allied health professionals, NHS Trusts operate pathways, and the CQC inspects provider settings. Each institution may be compliant within its own remit whilst patterned harms, e.g., repeat detentions, tribunal overturns, racial disparities, persist between remits. RTR's promise of targeted intervention presumes a coherent locus for action. Where no single body owns the problem end-to-end, targeting has nowhere to land. Regulatory pluralism becomes regulatory silence.

The proposed RTR3 revisions acknowledge contemporary challenges—burden, fairness, collaboration—but do not address the operational gaps that render the framework inapplicable to fragmented regimes (PSA, 2025a). Adding 'fairness' and 'collaboration' as principles does not create the data infrastructure, institutional ownership, or feedback mechanisms their realisation would require. The revision is rhetorical rather than structural.

A workable alternative exists. Harm-based regulation, as developed by Sparrow, offers an operational method for contexts where risk is patterned and responsibility is dispersed: define bounded problems ('knots'), establish baselines, assign owners with convening authority, intervene, re-measure, and retire problems only upon sustained reduction (Sparrow, 2000, 2008). Applied to AMHP governance, this requires a minimal standard dataset at assessment level, a designated body with authority to convene across local authorities and trusts, and a discipline of iterative experimentation on defined patterns. These are not abstract principles but concrete institutional changes: role-tagged data fields, published reduction targets, and accountable ownership of cross-boundary harms.

The stakes are considerable. AMHPs exercise profound coercive powers, depriving individuals of liberty on the basis of mental disorder. The safeguards written into the Mental Health Act such as the consideration of least-restrictive alternatives, and consultation with nearest relatives, matter only if they are realised in practice (DoH, 2015). A regulatory framework that cannot see whether these safeguards are being applied, cannot identify where they fail, and cannot assign responsibility for patterns of failure is not proportionate. It is absent.

Right-touch Regulation has become influential precisely because it articulates appealing principles: proportionality, targeting, agility. But principles without operational method are aspiration. For AMHP oversight, the choice is not between heavy-handed intervention and light-touch regulation. It is between designed accountability and regulatory invisibility. Until the preconditions for proportionate regulation are established; visibility, ownership, feedback—the language of Right-touch will continue to legitimate a system that does not regulate at all.

CRediT authorship contribution statement

Jessica L.H. Fish: Writing – original draft.

Declaration of competing interest

None.

References

Allan, H. T., & Westwood, S. (2016). English language skills requirements for internationally educated nurses working in the care industry: Barriers to UK registration or institutionalised discrimination? *Int. J. Nurs. Stud., 54*, 1–10. https://www.sciencedirect.com/science/article/pii/S0020748914003368.

All-Party Parliamentary Group on Social Work and the British Association for Social Work. (2019). Social workers and a new Mental Health Act: Final report. https://production.basw.co.uk/sites/default/files/resources/Inquiry%20Report%20-%20APPG%20on%20Social%20Work%20-%20Social%20Workers%20and%20A%20New%20Mental%20Health%20Act..pdf.

Asif AMHP. (2017, June 26). Guest blog: Are we the invisible health professionals? Social Work with Adults Blog. https://socialworkwithadults.blog.gov.uk/2017/06/26/amhps-the-invisible-health-professionals.

Ayres, I., & Braithwaite, J. (1992). *Responsive regulation: Transcending the deregulation debate*. Oxford University Press.

Baldwin, R. (2005). Is better regulation smarter regulation? *Public Law*, 485–511.

Baldwin, R. (2010). Better regulation: The search and the struggle. In R. Baldwin, M. Cave, & M. Lodge (Eds.), *The Oxford handbook of regulation*. Oxford University Press. https://doi.org/10.1093/oxfordhb/9780199560219.003.0012.

Baldwin, R., & Black, J. (2008). Really responsive regulation. *The Modern Law Review, 71* (1), 59–94. https://doi.org/10.1111/j.1468-2230.2008.00681.x

Baldwin, R., Cave, M., & Lodge, M. (2011a). Introduction. In R. Baldwin, M. Cave, & M. Lodge (Eds.), *Understanding regulation: Theory, strategy, and practice* (2nd ed., pp. 1–17). Oxford University Press.

Baldwin, R., Cave, M., & Lodge, M. (2011b). Regulatory strategies. In *Understanding regulation: Theory, strategy, and practice* (2nd ed.). Oxford University Press. https://doi.org/10.1093/acprof:osobl/9780199576081.003.0007.

Better Regulation Task Force. (2003). In Regulatory and Quality Improvement Authority (Ed.), *Principles of good regulation*. https://www.rqia.org.uk/RQIA/media/RQIA/Resources/Better-Regulation-Task-Force-Principles-of-Good-Regulation.pdf.

Better Regulation Task Force. (2005). In Cabinet Office (Ed.), *Regulation—Less is more: Reducing burdens, improving outcomes (annex a, p. 47)*.

British Association of Social Workers. (2024, July 29). What to expect from the fitness to practise process. In *Professional Social Work Magazine*. https://basw.co.uk/about-social-work/psw-magazine/articles/what-expect-fitness-practise-process.

Cabinet Office. (1997, July 3). *Better regulation – Not deregulation (news release CBA 46/97) [press release]*.

Cabinet Office. (2000). In Better Regulation Unit (Ed.), *Principles of good regulation*.

Cabinet Office. (2003). In Cabinet Office (Ed.), *Better policymaking: A guide to regulatory impact assessment*.

Care Quality Commission. (2018). Mental health Act: Approved mental health professional services. https://www.cqc.org.uk/sites/default/files/20180326_mha_amhpbriefing.pdf.

Care Quality Commission. (2024). Monitoring the mental health Act in 2022/23. https://www.cqc.org.uk/publications/monitoring-mental-health-act/2022-2023.

Cayton, H. (n.d.). Right-touch regulation. Retrieved October 20, 2024, from https://www.harrycayton.net/righttouch-20.

Council for Healthcare Regulatory Excellence. (2010). *Right-touch regulation*. Council for Healthcare Regulatory Excellence. https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2010.pdf.

Department for Education. (2016). Children's social care reform: A vision for change. https://assets.publishing.service.gov.uk/media/5a81a89040f0b623026987ef/Childrens_social_care_reform_a_vision_for_change.pdf.

Department for Education & Department of Health and Social Care. (2018). Social Work England: Consultation on secondary legislative framework. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/713240/SWE_Secondary_Legislative_Framework_Consultation_Response.pdf.

Department of Health. (2015). *Code of practice: Mental health Act 1983*. The Stationery Office. https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983.

Department of Health and Social Care. (2018). Modernising the mental health Act: Increasing choice, reducing compulsion: Final report of the independent review of the mental health Act 1983. https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review.

Department of Health and Social Care. (2019a). National workforce plan for approved mental health professionals (AMHPs). https://assets.publishing.service.gov.uk/media/5dbaaf13e5274a4aa55a0a1c/AMHP_Workforce_Plan_Oct19_3_.pdf.
Department of Health and Social Care. (2019b). Promoting professionalism, reforming regulation: Government response to the consultation. https://assets.publishing.service.gov.uk/media/5d386abfed915d0d0446885f/Promoting_professionalism_reforming_regulation_consultation_reponse.pdf.
Department of Health and Social Care. (2021, August). Guidance: Liberty Protection Safeguards — The approved mental capacity professional role. https://www.gov.uk/government/publications/liberty-protection-safeguards-factsheets/liberty-protection-safeguards-the-approved-mental-capacity-professional-role#:~:text=The%20approved%20mental%20capacity%20professional%20(%20AMCP%20)%20is%20a%20new%2C,independent%2C%20trained%2C%20registered%20professionals.
Department of Health and Social Care. (2022). Draft Mental Health Bill 2022. https://www.gov.uk/government/publications/draft-mental-health-bill-2022.
Department of Health and Social Care. (2023). The approved mental health professional workforce in the social care sector. In *Skills for Care*. https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/documents/AMHPs-Briefing.pdf.
Department of Health and Social Care. (2024). Health and social care statistical outputs: Published by DHSC including OHID, NHSBSA, UKHSA, ONS and NHS England. https://www.gov.uk/government/consultations/health-and-social-care-statistical-outputs/health-and-social-care-statistical-outputs-published-by-dhsc-including-ohid-nhsbsa-ukhsa-ons-and-nhs-england#mental-health.
Department of Trade and Industry. (1985). *Lifting the burden (Cmnd. 9571)*. Her Majesty's Stationery Office.
Derbyshire County Council. (2024). Approval and re-approval of approved mental health practitioners. https://staff.derbyshire.gov.uk/site-elements/documents/working-here/adult-care/approval-and-re-approval-of-approved-mental-health-practitioners.pdf.
Fish, J. (2026). The re-approval of approved mental health professionals in England and Wales: A study of local authority practice. *J. Soc. Welf. Fam. Law. forthcoming*.
GJ v Foundation Trust. (2009). *EWCA 2972*.
Glover-Thomas, N. (2011). The age of risk: Risk perception and determination following the mental health Act 2007. *Medical Law Review, 19*(4), 581–611. https://doi.org/10.1093/medlaw/fwr023
Grabosky, P. (2017). Meta-regulation. In P. Drahos (Ed.), *Regulatory theory: Foundations and applications* (pp. 149–162). ANU Press. http://www.jstor.org/stable/j.ctt1q1crtm.17.
Grace, J. D. (2015). *The experience of being assessed and detained under the mental health Act (1983): An interpretative phenomenological analysis [doctoral thesis, University of Staffordshire and University of Keele]*. CORE. https://core.ac.uk/download/pdf/43608959.pdf.
Gunningham, N., & Grabosky, P. (1998). *Smart regulation: Designing environmental policy*. Oxford University Press.
Gunningham, N., & Sinclair, D. (2012). *Regulatory pluralism: Designing policy mixes for environmental protection*. Edward Elgar.
Gunningham, N., & Sinclair, D. (2017). Smart regulation. In P. Drahos (Ed.), *Regulatory theory: Foundations and applications* (pp. 133–148). ANU Press. http://www.jstor.org/stable/j.ctt1q1crtm.16.
Health and Care Professions Council. (2019a). Fitness to practise annual report 2019. https://www.hcpc-uk.org/globalassets/resources/reports/fitness-to-practise/fitness-to-practise-annual-report-2019.pdf.
Health and Care Professions Council. (2019b). Transferring the regulation of social workers to social work England. https://www.hcpc-uk.org/education-providers/updates/2019/transferringregulation-of-social-workers-to-swe.
Health and Social Care Act 2012.
Health Education England. (2020). Approved mental health professional (AMHP) national service standards: Evaluation, mapping and planning toolkit. https://www.hee.nhs.uk/sites/default/files/documents/National%20AMHP%20Service%20Standards.pdf.
Hemmington, J. (2024). Approved mental health professionals' experiences of moral distress: "Who are we for"? *Br. J. Soc. Work., 54*, 762–779. https://doi.org/10.1093/bjsw/bcad258
Hemmington, J., Graham, M., Marshall, A., et al. (2021). In Social Work England (Ed.), *Approved mental health professionals, best interests assessors and people with lived experience: An exploration of professional identities and practice*. https://www.sociallworkengland.org.uk/media/4046/amhp-bia-research-report.pdf.
Laing, J. M. (2015). Perspectives on monitoring mental health legislation in England: A view from the front line. *Medical Law Review, 23*(3), 400–429. https://doi.org/10.1093/medlaw/fwu029
Laing, J. (2023). Independent mental health monitoring: Evaluating the care quality Commission in England's approach to regulation, rights and risks. In B. D. Kelly, & M. Donnelly (Eds.), *Routledge handbook of mental health law* (pp. 44–59). Taylor & Francis.
Leah, C. (2020). Approved mental health professionals: A Jack of all trades? Hybrid professional roles within a mental health occupation. *Qual. Soc. Work., 19*(5), 987. https://doi.org/10.1177/1473325019873385
Leigh, J. T., Worsley, A., & McLaughlin, K. (2017). An analysis of HCPC fitness to practise hearings: Fit to practise or fit for purpose? *Ethics & Social Welfare, 11*(4), 382–396. https://doi.org/10.1080/17496535.2017.1293119
Marriott, S., Audini, B., Lelliott, P., Webb, Y., & Duffett, R. (2001). Research into the mental health Act: A qualitative study of the views of those using or affected by it. *J. Ment. Health, 10*(1), 33–39. https://doi.org/10.1080/09638230124934
Mascini, P. (2013). Why was the enforcement pyramid so influential? And what price was paid? *Regulation & Governance, 7*(1), 48–60. https://doi.org/10.1111/rego.12003
Mearns, G. (2022). What does the "a" stand for? Exploring the process of AMHP "re-approval" and opportunities for improvement: Themes from a narrative literature review. *Practice, 35*(5), 389–403. https://doi.org/10.1080/09503153.2022.2129047
Ministry of Justice. (2023). Tribunal statistics quarterly: January to March 2023. https://www.gov.uk/government/statistics/tribunal-statistics-quarterly-january-to-march-2023.
Morriss, L. (2017). Being seconded to a mental health trust: The (in)visibility of mental health social work. *Br. J. Soc. Work., 47*(5), 1344–1360. https://www.jstor.org/stable/26612513.
National Health Service Reform and Health Care Professions Act. (2002). *The NHS Act 2006*.
NHS Digital. (2024, June 21). Mental Health Act statistics: Annual figures 2022–23. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2022-23-annual-figures.
NHS England. (2024, September 12). Mental health Act statistics: Annual figures 2023–24. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2023-24-annual-figures.
Nursing and Midwifery Council. (2015). The code: Professional standards of practice and behaviour for nurses, midwives and nursing associates. https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf.
Osborne, D., & Gaebler, T. (1992). *Reinventing government: How the entrepreneurial spirit is transforming the public sector*. Addison-Wesley.
Parker, C. (2006). The "compliance" trap: The moral message in responsive regulatory enforcement. *Law Soc. Rev., 40*(3), 591–622. https://doi.org/10.1111/j.1540-5893.2006.00274.x
Professional Standards Authority. (2015). Right-touch regulation revised. https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015.pdf.
Professional Standards Authority. (2016). Right-touch assurance: A methodology for assessing and assuring occupational risk of harm. https://www.professionalstandards.org.uk/publications/right-touch-assurance-methodology-assessing-and-assuring-occupational-risk-harm.
Professional Standards Authority. (2018a). Right-touch regulation in practice: International perspectives. https://cy.professionalstandards.org.uk/sites/default/files/attachments/right-touch-regulation-in-practice—international-perspectives_0.pdf.
Professional Standards Authority. (2018b). Health professional regulation: A long view, with annual report and accounts 2017–18. https://assets.publishing.service.gov.uk/media/5b46095eed915d39e1b703b5/professional-standards-authority-annual-report-and-accounts-2017-2018-web-accessible.pdf.
Professional Standards Authority. (2025a). Reviewing right-touch regulation: A PSA discussion paper. https://www.professionalstandards.org.uk/sites/default/files/attachments/Reviewing%20Right-touch%20regulation%20-%20a%20PSA%20discussion%20paper%20%28March%202025%29.pdf.
Professional Standards Authority. (2025b). Right-touch regulation 2025 (interactive PDF). https://www.professionalstandards.org.uk/sites/default/files/attachments/Right-touch%20regulation%202025%20%28interactive%20pdf%29_0.pdf.
Reason, J. (2000). Human error: Models and management. *BMJ, 320*(7237), 768–770. https://doi.org/10.1136/bmj.320.7237.768
Richardson, J. J., Gustafsson, G., & Jordan, A. (1982). *Government and the economy: A strategy for regulation*. Oxford University Press.
Rooke, R. (2020). Facilitating the "least restrictive option and maximising independence" under section 115 mental health Act 1983. *Practice, 32*(4), 269–283. https://doi.org/10.1080/09503153.2020.1782871
Samuel, M. (2024, February 23). Mounting demand for AMHPs and unmet need masked by fall in number of detentions, say service heads. Community Care. https://www.communitycare.co.uk/2024/02/23/mounting-demand-for-amhps-and-unmet-need-masked-by-fall-in-number-of-detentions-say-service-heads.
Simpson, M. (2024). Changing gears and buying time: A study exploring AMHP practice following referral for a mental health Act assessment in England and Wales. *Br. J. Soc. Work., 54*(2), 797–814. https://doi.org/10.1093/bjsw/bcad18
Skills for Care. (2025). The approved mental health professional workforce in the social care sector. https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/workforceintelligence/resources/Reports/Regulated-professions/The-Approved-Mental-Health-Professional-workforce-in-the-social-care-sector-2025.pdf.
Social Work England. (2022). Consultation on new education and training approval standards for approved mental health professionals. https://www.socialworkengland.org.uk/about/consultations/consultation-on-new-education-and-training-approval-standards-for-approved-mental-health-professionals/#consultationquestions.
Social Work England. (2023a). Annual report and accounts 2022 to 2023. https://assets.publishing.service.gov.uk/media/64b91ba806f78d00147425d9/Social_Work_England_annual_report_and_accounts_2022_to_23.pdf.
Social Work England. (2023b). Social work England's fitness to practise process: An initial analysis of diversity data. https://www.socialworkengland.org.uk/media/lqlhvazf/an-initial-analysis-of-our-diversity-data-september-2023.pdf.
Social Work England. (2024, July 10). Approved Mental Health Professionals (AMHP) course guidance. https://www.socialworkengland.org.uk/education-training/amhp-course-guidance/#mapping%20AMHP%20criteria%20to%20the%20education%20and%20training%20standards.
Social Work England. (2025, January 6). Registration annotations: Guidance for Approved Mental Health Professionals (AMHPs) and Best Interests Assessors.

https://www.socialworkengland.org.uk/registration/registration-annotations/#annotations.
Sparrow, M. K. (2000). *The regulatory craft: Controlling risks, solving problems, and managing compliance*. Brookings Institution Press.
Sparrow, M. K. (2008). *The character of harms: Operational challenges in control*. Cambridge University Press.
St George's Healthcare NHS Trust v S. (1999). *Fam 26*.
Stone, K. (2019). Approved mental health professionals and detention: An exploration of professional differences and similarities. *Practice, 31*(2), 83–98. https://doi.org/10.1080/09503153.2018.1541783
The Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations. (2008). SI 2008/1206 Sch. 2 (UK). https://www.legislation.gov.uk/uksi/2008/1206/schedule/2/made.
the Mental Health Act 1983 as amended 2007.
UK Parliament. (2015, July 2). *HC Deb. 597*. col 4 https://hansard.parliament.uk.
Westerman, P. (2012). Pyramids and the value of generality. *Regulation & Governance, 6*(1), 90–106. https://doi.org/10.1111/j.1748-5991.2012.01155.x
Wickersham, A., Hami, R., Marwaha, S., & Morriss, R. (2020). The mental health Act assessment process and risk factors for compulsory admission to psychiatric hospital: A mixed-methods study. *Br. J. Soc. Work., 50*(3), 642–662. https://doi.org/10.1093/bjsw/bcz143
Wiegmann, D. A., Wood, L. J., Cohen, T. N., & Shappell, S. A. (2022). Understanding the "Swiss cheese model" and its application to patient safety. *J. Patient Safety, 18*(2), 119–123. https://doi.org/10.1097/PTS.0000000000000810
Worsley, A., Shorrock, S., & McLaughlin, K. (2020). Protecting the public? An analysis of professional regulation—Comparing outcomes in fitness to practice proceedings for social workers, nurses and doctors. *Br. J. Soc. Work, 50*(6), 1871–1889. https://doi.org/10.1093/bjsw/bcaa079
Yeung, K. (2004). *Securing compliance: A principled approach*. Hart Publishing.