1) Charlie. Depressed lady, services tried to engage G.P & SWDS. Visit made & when not answered letter put through door re concerns & saying when would visit again. Talked re meds, hospital etc. Said would get her some food. Went back again, took Dr Sarfo, door left on latch, Wrote to sister for her phone number, Sister able to say x, y + z might be worrying her. Reassured going to be helping her, She knew going to look for a hospital bed. Tried to do all could to help her, ended with MHA + detained but felt good had really tried. She would have preferred break door down.

2) a) People have over inflated concerns, establish what this are, establish urgency & if time to try other things. Try & involve the person & talk about the concerns.

b) As a service not reactive. Some are, South AMHPs take time to work it out, team good at delving in. Team consensus that these things take time to work out.

c) This is what we're here for. AMHP role bringing social perspective & not been completely medical, looking @ wider issues. Counterbalance to risk averse culture in CMHTS & CHTT's. Teams also under pressure.

3) Person centred, a more holistic view, central to what we do as AMHPS. Want understand & listen to people, promote dignity, be respectful.

4) Can be a lonely place as an AMHP - get others anxieties. Others expectations are that we will arrange a MHA Ax, not question. Better to have a discussion about the situation. AMHPs have contribution to make.

Feeling that health less risk aversive and y would work better with us.