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Non-medical approved clinicians: Results of a first national survey in England and Wales

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ABSTRACT

The 2007 amendments to the Mental Health Act, 1983 in England and Wales enabled non-medics to take on the role of legally 'responsible clinician' for the overall care and treatment of service users detained under the Act, where previously this was the sole domain of the psychiatrist as Responsible Medical Officer. Following state sanction as an 'Approved Clinician', certain psychologists, nurses, social workers or occupational therapists may be allocated as a Responsible Clinician for specific service users. Between 2007 and 2017 only 56 non-medics had become Approved Clinicians. This study reports on a first national survey of 39 non-medical Approved Clinicians. Descriptive statistics and thematic analysis of free text answers are presented here. The survey results show the limited uptake of the role, save for in the North Eastern region of England. Non-medical Approved Clinicians were motivated by a combination of altruistic intents (namely a belief that they could offer more psychologically-informed, recovery-oriented care) and desire for professional development in a role fitting their expertise and experience. Barriers and facilitators to wider uptake of the role appear to be: organisational support, attitudes of psychiatrist colleagues and a potentially lengthy and laborious approvals application process. The survey is a starting point to further research on the interpretation and implementation of the range of statutory roles and responsibilities under English and Welsh mental health law.

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1. Introduction

The Mental Health Act, 1983 in England and Wales is the primary legislation regulating the compulsory care and treatment of those people who have a diagnosed mental disorder of a 'nature or degree' which warrants their detention in hospital for treatment that is 'necessary for the health or safety of the person or for the protection of other persons' (Department of Health, 2015a, para 14.4). The amended Mental Health Act (MHA) 2007 expanded the roles that non-medical[1] mental health professionals could undertake in its implementation. After 2007, nurses, psychologists, social workers and occupational therapists could become Approved Mental Health Professionals (AMHPs) or Approved Clinicians (ACs). These roles had previously been the domain of social workers (Approved Social Worker) and psychiatrists (Responsible Medical Officer) respectively. This was a statutory manifestation of the Department of Health's *New Ways of Working* programme which aimed to distribute clinical responsibility within competency based teams for mental health service users' care and treatment (Department of Health, 2007), in the context of workforce pressures and moves towards more multidisciplinary approaches to mental health practice (Coffey & Hannigan, 2013; Rappaport & Manthorpe, 2008). The changes were met with trepidation from professional groups, concerned that their professional domain was being encroached upon and that their therapeutic relationship with service users may be adversely affected (Rappaport & Manthorpe, 2008). Of the professions involved, only the British Psychological Society has provided guidance to members on the role (Gillmer & Taylor, 2016; Ledwith, Todd, Gillmer, & Taylor, 2017). As of August 2017 there were 49 non-medical ACs in England and 7 in Wales, compared to over 6000 medical ACs (personal communication from Department of Health, 2017a).

Whilst there has been some primary research and discussion of the AMHP role (Coffey & Hannigan, 2013; Morriss, 2016; Watson, 2016) so far there has been just one research paper on 'non-medical' ACs (Ebrahim, 2018). Lack of information on the motivation and experiences of ACs has previously been noted (Veitch & Oates, 2017). In this paper we present findings from the first national survey of non-medical ACs, offering insight into the characteristics of this (thus far)

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[1] The term 'non-medical' is used in this paper to describe the professional groups that the MHA 2007 introduced; that is, nursing, occupational therapy, psychology and social work. There is, however, no distinction in the primary or secondary legislation regarding the legal powers of medical and non-medical ACs.

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small group. This is a timely study, given the recent UK government launch of an Independent Review of the MHA in England and Wales (Department of Health, 2007) and the increased numbers of detentions under the MHA, estimated at an increase of 2% between 2015/16 and 2016/17 (NHS Providers, 2017). A further impetus to explore the extent to which professional roles are being developed is the current UK recruitment crisis in the mental health professions (British Medical Association, 2017; Buchan, Seccombe, & Charlesworth, 2016; Royal College of Nursing, 2014). With National Health Service mental health service providers raising concerns about how to recruit, retain and motivate their staff to meet increasing demands (NHS Providers, 2017), the scope given by the MHA 2007 for professions other than medicine to lead clinical care could be one way of reshaping the workforce to meet clinical need.

An AC is a registered mental health professional who has been deemed competent by an 'approving body' with delegated authority from the Secretary of State for Health to become the responsible clinician - the Responsible Clinician (RC) - for the overall care and treatment of certain service users detained under the MHA or subject to compulsion in the community. Approval is based on a portfolio of evidence submitted to the panel as affirmation of their competence to take on the role (Department of Health, 2017b). The competencies required by ACs are set out in secondary legislation (the 'Instructions', Department of Health, 2015b). It is the duty of Hospital Managers to allocate service users to an AC with 'appropriate expertise to meet the service user's main assessment and treatment needs' (Department of Health, 2015a, para 36.3). An AC, acting as the service user's RC, can grant and revoke section 17 leave; renew detention; initiate holding powers; discharge from detention; discharge onto community treatment orders (CTOs); extend, revoke and discharge CTOs; and oversee Guardianship Orders (National Institute for Mental Health in England, 2008).

Mental health legislation in the UK, as in other European and common law countries has its roots in the rise in status of the medical profession in nineteenth century and subsequent iterative negotiations of the role of the state versus the role of the medical profession in the detention and treatment of those deemed 'mentally ill' (Rogers & Pilgrim, 2014). As well as substantial revisions of professional roles and responsibilities, the MHA 2007 introduced Community Treatment Orders (CTOs) and revised definitions of both mental disorder, medical treatment and criteria for detention. Alongside the primary legislation the MHA Code of Practice (Department of Health, 2015a) provides statutory guidance on the interpretation of the MHA. This includes reference to the Equality Act 2010, the Care Act 2014, revised interpretation of the Mental Capacity Act 2005, and an increased focus on promoting the 'least restrictive option' (Department of Health, 2015a, 2015b, para 1.1).

The move towards least restrictive practice is characteristic of recovery-oriented working (Anthony, 2000), whereby shared decision-making between service users and professionals is a routine approach (Le Boutillier et al., 2015; Miller, Whitlatch, & Lyons, 2016). Calls for collaborative mental health practice have, however, been countered by empirical evidence that there is a lack of consensus regarding what true 'shared decision' making means and how it is best enacted (Farrelly et al., 2016; Miller et al., 2016). It has been described as a 'spectrum' of approaches (Miller et al., 2016). This notion is complicated where the MHA is concerned because there is always the 'shadow' of coercion (Sjöström, 2006; Szmukler, Daw, & Callard, 2014). A further complication to notions of 'shared decision making' regarding the MHA is the 'discretionary' nature of detention and treatment decisions, made often by professionals with limited training in the law and human rights (Peay, 2003). Having said this, non-medical ACs' portfolios must evidence significant awareness of the law (Department of Health, 2017b) compared to as little as two days' medico-legal training for medical colleagues to be approved under Section 12 (Peay, 2003).

The MHA 2007 extension of professional roles has been viewed by some as characteristic of neoliberal government policy, whereby cost saving (through getting less well paid professionals and individual service users to take on more responsibility and risk) is positively framed as distributed power and increased professional and personal agency (Ramon, 2008; Veitch & Oates, 2017). What is different between now and 2007 is the economic and political context of mental health care in the United Kingdom. The 2007 amendments were implemented at a time when distributed leadership was being proffered as a solution to overburden and misdirected focus in the work of consultant psychiatrists (Department of Health, 2007; Procter, Harrison, Pearson, Dickinson, & Lombardo, 2016), and recovery-oriented practice (Department of Health, 2009) was still in its infancy.

Current workforce pressures in mental health services, namely high vacancy rates in consultant psychiatrist posts and increased workloads on other professions, mean that innovative workforce solutions are required. In the spirit of the UK government's 'do more with less' approach to NHS funding (Harlock et al., 2017; Hurst & Williams, 2012), this might include less well paid professionals taking on more professional responsibility. The promotion of recovery-oriented mental health practice has arguably been an opportunity for non-medical professionals to deliver services with a stronger psychosocial rather than medical focus. In light of the lack of published research on extended roles under the MHA 2007, the aim of this study is to describe the characteristics and concerns of non-medical ACs ten years after the AC role was introduced. These findings have been taken from a wider mixed methods study that explores the professional perspectives of non-medical ACs, from which further results will be published.

2. Method

Ethical approval for the study was gained from the lead author's university ethics committee.

The survey comprised 66 questions, requiring a combination of free text and multiple choice responses. The questions whose responses are presented here are given in Appendix 1. The questions included in this initial survey were developed collaboratively by the authors, a group of academics and clinicians with an interest in MHA 2007 extended roles, including 3 non-medical ACs. The survey was completed online between June and September 2017 by non-medical ACs on the regional approvals panel registers who were sent a link to the survey in an e-mail by the Department of Health lead for AC approvals in England and Wales. The three ACs who helped to design the survey also took part in the survey. Sample survey responses were analysed by three members of the study group, undertaking a collaborative coding exercise for a sample of the open questions, reaching a consensus on the themes. Following this exercise, complete coding was undertaken by one team member, sense-checking with two team members (both non-medical ACs). It should be noted that whilst there were 36 completed surveys from which textual information was extracted and coded. Some participants' responses were coded against multiple themes due to several points being made in responses to open questions.

3. Results

There were 39 survey returns, giving a response rate of 70% (39/56). Three participants only completed the initial demographic and workplace questions in the survey, giving 36 full survey responses. All responses to each question were included in the analysis. The findings presented here focus on the demographic characteristics of respondents, their professional qualifications and experience, areas of clinical practice, their views on their own effectiveness as ACs, their experiences of becoming ACs and their reported motivations to take on the role**. I**n our discussion we draw out broader themes and consider the insights offered by the quantitative and qualitative data we have gathered.

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