

What do practitioners think about their new roles under the amended Mental Health Act?

Matching skills to needs

The current working practices of mental health professionals are still based on professional groupings that have their origins in a mental health system that no longer exists. The long-stay asylums dominated by 19th century psychiatric models and practice have mostly gone, and policy and provision are now firmly rooted in care in the community, and guided by the concept of recovery.

The amendments to the Mental Health Act 1983 are designed to bring the mental health legislation in England and Wales up to date with these radical changes in mental health practice that have taken place in recent decades. At the time of writing, the Bill is going through Parliament, and so its final form is still to be determined, and there is some time to go before the amended Act becomes law. However, those elements relating to changes in the roles and responsibilities of qualified mental health professionals – mental health nurses, psychiatrists, psychologists, approved social workers, and the other professionally qualified staff who specialise in mental health care such as occupational therapists – have been under discussion for several years.

This article looks specifically at the implications for the mental health workforce and mental health service users of the introduction of two new roles: those of responsible clinician (RC) and approved mental health professional (AMHP).

The government's proposed amendments to the Act progress an existing CSIP/NIMHE national workforce programme, *New Ways of Working*. This began with a major piece of work reviewing the role of psychiatrists (a final report on this work is due out shortly). The programme has since been extended to the other mental health professions.

The government's proposed amendments in the Act are aimed at creating a more flexible way of working that would allow other professionals to carry out

the statutory functions currently confined to the psychiatrist's remit:

'... allow staff who have the right skills and experience to carry out key roles instead of restricting roles automatically to particular professional groups.'¹

Responsible clinician

The role of responsible clinician would replace the current role of responsible medical officer (RMO), who is in charge of the patient's treatment and normally decides when they can be discharged and allowed leave of absence from hospital. This function would be opened up to other mental health professionals. This would be the most senior clinical role in mental health trusts. It is important to note that the responsible clinician remit would not constitute a job; it would be one part of a medical or non-medical practitioner's role. Instead of being allocated an RMO, patients subject to compulsion would be appointed an RC, who might be a nurse, occupational therapist, psychologist or social worker, not just a doctor. Practitioners taking on the RC role would need first to undergo training to ensure they have the necessary skills and experience, and they would have to be approved. Strategic health authorities will be responsible for approving practitioners to undertake this role in England; Welsh ministers will decide who should be the approving body in Wales.

Introduction of the RC role would allow services to appoint the most appropriate clinician to fit a patient's needs at any given point in their care pathway. Of course, in many instances, particularly at the inpatient end of the spectrum where there is an emphasis on pharmacological treatments, this may well need to be a doctor, but at the community end it might in some cases be better if the RC were a non-medical who has knowledge and skills in areas more relevant than medication to →

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Yes, and...

'That the RMO role is being diluted, and more team and partnership working could come about, is good news. Please include independent advocacy! Most important!' (Service user)

'Much needed, exciting. Would be good to have access to NHS training and better career pathway.' (Senior social worker)

'AMHP... will further help in multidisciplinary teams and address issue of insufficient numbers of ASWs – [responsible clinicians] – great potential to develop care/treatment plans – less led by medical model.' (Social worker)

'AMHP – as long as the present intensive level of training is maintained this should be OK. The responsible clinician could be very helpful in readdressing the present heavily medicalised bias within the trust – a good way of keeping skilled clinicians rather than becoming managers.' (Social worker)

'I feel this is the direction mental health professionals should be moving – ultimately taking a more holistic approach away from the medical model.' (Occupational therapist)

'A long awaited opportunity for competency-based and person-centered policies in action.' (Psychologist, forensic learning disabilities)

'New, broader group of professionals working as RCs seems a very practical and realistic way to deal with workload pressures. Good CMHTs should not have much problem in changing to new practice.' (Psychiatrist)

'Good opportunity for staff to retain clinical function whilst progressing within their career, instead of moving into management.' (Mental health nurse)

'The non-medicalisation of mental disorder will enable (hopefully) social issues around patient's mental distress [to be] taken into consideration.' (Community mental health team manager)

'It gives the opportunity for truly multidisciplinary working, which can ensure better care for the patient.' (Mental health nurse)

'Excellent opportunities for other professionals to extend their roles. Career opportunities opened up for other competent team members. Makes sense for service users to be clinically supervised by most appropriately skilled professional.' (General manager)

'It will be beneficial to remove the RMO and replace it with RC. It might make the consultants more part of the team and make the multidisciplinary team more valid.' (Mental health nurse)

→ some patients' treatment, care and support needs: notably, in risk management, positive risk taking, and skills in psychosocial interventions based on recovery.

Concerns have been expressed about a professional without medical training having the powers to renew a patient's section, and powers of granting leave and discharge (see, for example, the recent report of the Joint Parliamentary Committee on Human Rights²).

Note. As this issue of MHT goes to print, peers in the House of Lords have passed amendments to the Mental Health Bill that would require a doctor to agree key decisions made by a responsible clinician who is not a medically qualified practitioner. The government argues that the amendments would undermine the expertise of responsible clinicians from other professions. The Lords amendments will next be debated in the House of Commons.

The government's argument is that we currently employ highly skilled and highly trained non-medical clinicians on whom, in many instances, doctors rely, and whose knowledge of the patient is central to the decision-making processes. Indeed, in many instances now, doctors simply endorse the necessary documentation. Certainly in our recent scenario planning workshops with clinicians (see below and boxes) many psychiatrists had no reservations about senior non-medical clinicians taking on this role.

Considerable work has already been undertaken with regard to the possible implementation of the responsible clinician role. A competence framework outlining the role and duties of the RC has been agreed by a stakeholder group representing all the mental health professions and their professional bodies, and can be viewed on the Department of Health website. All clinicians acting in this role would have to demonstrate that they are competent in each of the areas listed. There would be an approval – and, indeed, re-approval – process in place, supported by a specific approved clinician training programme, representing a greater degree of governance than the existing situation.

There are a number of other workforce benefits in relation to the introduction of the RC. Some regions continue to experience difficulties in the recruitment and retention of psychiatrists. The RC role provides an opportunity to match the needs of the service user with available skills by drawing on the broader care team, instead of simply following professional designation.

Some argue that the change from RMO to RC represents a 'dumbing down' of services. Yet we currently have a range of senior non-medical roles held by staff who are highly competent and highly educated. This group of professionals would be more than capable of carrying out these responsibilities, subject to further training and support.

Last, but not least, the introduction of the RC role would finally remove the 'glass ceiling' that has held down the non-medical professions from practising to their full competence and ability. It would allow highly experienced non-medical practitioners to remain in face-to-face work with patients, rather than having to move to managerial positions – or, indeed, leave the service altogether – to attain more senior positions.

In the scenario planning workshops we were able to explore these possible new arrangements as they would affect the patient pathway in numerous scenarios: in urban settings, rural settings, inpatient and community settings, and across specialisms such as learning disability, older people and child and adolescent mental health services. Few concerns were expressed by participants about the introduction of this role, and by far the majority welcomed the opportunities these workforce reforms would bring.

Approved mental health professional

The introduction of the approved mental health professional (AMHP) again offers far greater flexibility and extensions to the working practices of mental health practitioners without an approved social work qualification. This could resolve workload pressures on the current ASW workforce, and potentially reduce delays in carrying out Mental Health Act assessments in

Yes, but...

rural areas. It should also bring closer together the working practices and approaches of mental health professionals.

The main concern expressed by existing ASWs relates to the potential loss to practitioner and service user of the benefits of the independence of the ASW in relation to psychiatrists (the other, NHS-employed, professional with an assessor role). To address this, non-social worker AMHPs will be trained and approved in accordance with the traditional ASW standards and ways of working. Their training will be approved by the General Social Care Council and the Care Council for Wales, and will be based on the current ASW training. This will prepare AMHPs to bring a social care perspective to their work, and to act independently. Local authorities will also continue to be responsible for approving AMHPs to carry out their functions under the Act, and all AMHPs (including those employed by the NHS) will, when acting in this role, be carrying out these duties on behalf of the local authority, rather than the NHS. Non-social worker entrants to AMHP training will also be expected to demonstrate a value base that reflects that currently held by ASWs.

Scenario planning workshops

Prior to the decision to introduce changes to the mental health legislation via an amending Bill, the CSIP/NIMHE New Ways of Working steering group had already begun work on a series of scenario planning workshops. These were originally intended to look at patient/service user pathways and how mental health practice might change to allow the use of more flexible roles after the enactment of the draft 2004 Bill.

The scenario planning days were changed to a series of briefings and consultations to explore issues arising from the amendments, particularly in relation to the new roles and inter-professional working. The workshops were held in a range of geographical locations representing urban and rural areas, areas with high density BME populations, and forensic mental health populations. Participants came from across the mental health workforce, and included mental health nurses (hospital and community), team leaders and nurse managers, occupational therapists, psychologists, psychiatrists, general managers and service commissioners. At the end of each workshop, participants were asked to complete an evaluation form, where they were invited to make their own comments on the new roles and perceived implications (personal and professional).

As can be seen from participants' comments (see boxes), many welcomed the potential benefits of the new roles for their own career paths and skills development, as well as the advantages for users from improved multi-disciplinary working and a lessening of the perceived dominance of medical treatment. Others also offered useful critical commentary on their implementation and the professional and practical issues this might raise. A common theme was the need for training, not just for those charged with the new statutory duties, but for the mental health workforce as a whole and, indeed, other agencies in contact with and providing services to mental health service users, such as the police, housing, and the voluntary and independent sectors.

'Broadly positive, but would like stronger emphasis on working towards recovery approach – emphasise user autonomy through advanced directives and CPA.' (Service user)

'I have concerns regarding the dilution of the ASW role and its effects on assessment and decision-making amongst patients. I feel that it may be a positive move to appoint non-medical staff into clinical supervisor roles.' (Social worker)

'Would be reluctant to see the roles attached to OTs. We would have trouble recruiting if they were attached to job descriptions. If pay increased then people may be more interested.' (Occupational therapist)

'Cynically, I expect this will be done as cheaply as possible when the real implementation process takes place. Unless remuneration is made attractive, then I doubt psychologists will volunteer.' (Psychologist)

'I think it's a good idea. As a medic I am happy for others to be clinical supervisors, provided it doesn't impact on my wages.' (Psychiatrist)

'Selection, standards and competencies for AMHP should be agreed nationally. RC to be open to all professionals – access to training and competencies should be standardised. Governance of RC to be clarified and standardised.' (Social worker)

'For the RC role, how can you determine if detention should continue yet not be deemed competent to say if it should commence – inherent contradiction? Can't see many psychologists taking it up – no financial gain, no real increase in power/role or psychiatrists letting go.' (Psychologist)

'A need to safeguard local authority spend on ASWs as they may try to reduce spend with introduction of AMHP if requirements no longer in statute.' (Psychiatrist)

'Not sure how RC role will pan out when you consider no power to compel services to engage with client, as opposed to compelling client to engage with services.' (Mental health nurse)

'Reduce possible tensions between existing practices and practitioners feeling threatened or challenged. Practitioners adopting new ways of working need to be clear about personal responsibilities with regard to limits of competence.' (Nurse manager)

'Potentially exciting – clinical roles often blurred, due to high level of social care issues. Will need incentive (grading/pay/resources) if clinicians to be enthusiastic re extending current (highly pressured) roles.' (Community mental health team manager)

The next stage of the CSIP/NIMHE New Ways of Working programme is to explore with NHS mental health service providers how these new roles can be implemented. Meaningful workforce planning will be essential to ensure an appropriate skill mix in preparation for the introduction of the new roles and responsibilities. ■

- 1 Department of Health. Improving mental health law: towards a new Mental Health Act. London: Department of Health, 2004.
- 2 Joint Parliamentary Committee on Human Rights. Legislative scrutiny: Mental Health Bill. Fourth report 2006–07. HL 40/HC. London: UK Parliament.