

Testing the water

One of the seven key areas up for reform under the government's amended Bill is the role that professionals play in implementing the 1983 Mental Health Act in England and Wales. Chris Merchant and colleagues report on a consultation exercise that gauges professionals' reactions to the proposed changes

The need to reform the 1983 Mental Health Act has been identified in a number of key governmental and legislative reviews (Scoping Study Committee 1999, Department of Health (DH) 1999a, 1999b). In July 2000, *The NHS Plan* set out the government's plans for mental health services, including its plans for reforming mental health legislation (DH 2000a). The government then published a White Paper, titled, *Reforming the Mental Health Act* (DH 2000b), which set out a proposed new legal framework for when and how care and treatment should be provided for a person with a mental disorder without his or her consent.

In June 2002, the government published a draft mental health

Bill for consultation. The response to these early proposals is beyond the scope of this paper and can be found elsewhere (Royal College of Psychiatrists 2001, Szmukler 2001, Zigmond 2001, Mind 2001).

In September 2004, the government published a revised draft Bill for pre-legislative scrutiny (DH 2004). Between November 2004 and March 2005, the 2004 draft Bill was scrutinised by a Joint Committee of Parliament, which, although accepting the need for reform, recommended a number of changes to the Bill. In March 2006, the government announced that, having further considered the views expressed about the 2004 draft Bill, it was proposing to amend the 1983 Act rather than

replace it. The proposed amended Bill was introduced in the House of Lords on November 16, 2006 (DH 2006).

The Bill proposed in 2006

The Bill proposes changes to seven key areas of policy: supervised community treatment; professional roles; nearest relative; definition of mental disorder; criteria for detention; the Mental Health Review Tribunal; and 'Bournewood' safeguards through amending the Mental Capacity Act 2005. This paper focuses on one of the proposed key policy changes: that of professional roles.

The Bill will broaden the group of professionals who can carry out those functions and responsibilities that were previously performed by

keywords

- > mental health: law
- > policy
- > professional development

These keywords are based on the subject headings from the British Nursing Index. This article has been subject to a double-blind review.

an approved social worker (ASW) and a responsible medical officer (RMO). In essence, the Bill will allow professionals from other disciplines, who have the right skills, experience and training, to carry out these key tasks rather than restricting them to ASWs and RMOs.

Obviously, the Bill has significant implications for the professional roles of mental health clinicians, their services and future workforce planning.

Changes to professional roles

The responsible clinician

The role that replaces the RMO will be known as the 'responsible clinician' (RC). The RC will have overall responsibility for a patient's

care but continue to be carried out in conjunction with the clinical team. In addition to doctors, it will be extended to mental health professionals with the appropriate training and competencies, including nurses, chartered psychologists, social workers and occupational therapists.

Mental health professionals who want to be responsible clinicians will need to be trained and approved to take on this role. Clinicians who are trained and approved to be responsible clinicians will be known as 'approved clinicians'. Minimum criteria for approval of a person as an approved clinician in England and in Wales will be set out in directions from the secretary of state and the Welsh Assembly Government.

The approved mental health professional

What is currently the role of the ASW will become a new role: that of 'approved mental health professional' (AMHP). The ASW role will be extended to other mental health professions including nurses, chartered psychologists and occupational therapists. The AMHP's function will be the same as the current role of the ASW under the 1983 Mental Health Act except they will be required to fulfil those additional functions relating to supervised community treatment (SCT).

Specifically: the AMHP must provide a second opinion for all cases where an RC wishes to implement SCT; the AMHP must agree with the RC the conditions of the

SCT; and the AMHP must provide a second opinion when patients are recalled to hospital from their SCT and where the RC wishes to re-detain the patient for inpatient treatment.

Local authorities will be responsible for approving AMHPs, as they are for ASWs, but the government is removing the requirement for ASWs to be employed by local authorities. This will give local authorities the freedom to approve appropriately trained and qualified members of staff whom they do not employ, and should make it easier to recruit AMHPs in areas which are experiencing a shortage of ASWs. Directions from the secretary of state and The Welsh Assembly Government will set out minimum criteria for approval of a person as an AMHP in England and Wales.

The consultation

Aims:

The consultation aimed to determine the possible impact on service structures and the workforce changes required within organisations in order to meet the proposed changes to professional roles.

Methods:

Mental health provider organisations across England were invited to express an interest in participating in 'scenario planning' for the introduction of proposed new professional roles, through their local regional development centres. An overwhelming response of 60 organisations to requests for participation in the consultation meant that two organisations from each Care Services Improvement Partnership/National Institute for Mental Health in England region in England were selected to participate. Organisations were selected in order to try and ensure a balance between organisations which served the needs of urban and rural populations and had established prison in-reach teams.

Additionally, the population ethnicity of areas was considered in order to ensure that those which serve black and ethnic minority populations were well represented.

The process on each consultancy day was divided into three: 1. An outline and update on the amending Bill; 2. Discussion and group work which focused on participants' perceptions surrounding the new professional roles and the potential

Table 1. Overview of the organisations and teams involved in the consultation

Organisation /Location	Teams included
East Sussex	Assertive Outreach/Older People/In Patient/Community mental Health
Morpeth	Forensic in patient
Cambridge and Peterborough	CMHT/In Patient/Assertive Outreach/BME
Leeds	CMHT/Forensic/Older People
Hertfordshire	CMHT/Older People/Assertive Outreach/Forensic
Doncaster	CMHT/Older People
Devon Partnership	Acute inpatient/Older People/CMHT/Assertive Outreach
Berkshire	Older People/CMHT/Assertive Outreach
Shropshire	CMHT/In Patient/Rural Issues
North Cumbria	CMHT/Older People/Assertive Outreach
Oxleas Trust	CMHT/Training Dept/Forensic/Assertive Outreach
Barnet & Enfield	CMHT/In Patient/Prison In-reach/Forensic
Coventry	CMHT/Assertive Outreach/Personality Disorder Specialist workers
Hull	Forensic/CMHT/Assertive Outreach

impact of the legislation on skill mix and workforce planning; 3. The opportunity to express individual comments on the Bill through a survey of each participant regarding the new professional roles, skill mix and workforce planning. Thematic analyses of the responses obtained through the consultation were undertaken. Written records were taken of each consultation event. This was supplemented by examination of the individual surveys received from participants.

Results

Consultation days occurred between April 13, 2006 and August 4, 2006. Fourteen organisations participated. Two withdrew due to local operational pressures prior to the consultation events. A good representation of mental health groups was achieved and about 300 participants attended.

The areas of work covered: acute working age mental health settings, community mental health teams, assertive outreach teams, forensic services, child and adolescent services, prison in-reach teams, older people's services, learning disability services and personality disorder services. Table 1 provides a summary of the services represented in the consultation.

Participants covered a wide range of professional groups in a variety of clinical and managerial roles (social work, psychology, psychiatry, nursing, and occupational therapy). Additionally, service users, trust non-executive directors, general

managers, MHA and clinical records manager, MHA administrators and trust chairpersons contributed.

The responsible clinician

The proposal to replace the RMO with a 'RC' was considered by all attendees to be a positive development. Clinicians expressed no concerns regarding this proposal. Four main themes arose: 1. The potential for improvements in patient care; 2. The potential for improved career/professional development; 3. The need for role clarification; 4. The need for clarification on the skills and capabilities that will be required for the role.

1. The potential for improvements in patient care

Improvement for service users were identified. Specifically, in having improved access to the lead clinician regarding personal care management, decision making, risk management and therapeutic risk taking, and a potential for reduction in delays in decision making (e.g. discharge and leave). One psychiatrist noted: 'The greater flexibility will be excellent.'

□ The potential to improve the continuity of patient care through reduced reliance on the use of locum medical staff.

□ The potential to facilitate a holistic approach to health care with less dominance of the medical model. One senior occupational therapist reported: 'I feel this is the direction mental health professionals should be moving in, ultimately taking a

more holistic approach away from the medical model.'

□ The opportunity for more widespread adoption of alternative models (e.g. the 'recovery model') within mental health services. One service user said they were: 'Broadly positive but would like stronger emphasis on working towards recovery approach and greater emphasis on user autonomy through advanced directives and Care Programme Approach.' An assistant director of social services reported that: 'It is vital to supporting new models of service provision.'

□ The proposed 'competency approach' was viewed as a 'significant improvement on the current RMO situation with the potential for improved governance in relation to quality assurance.' A clinical psychologist working in forensic learning disability service noted: 'a long-awaited opportunity for competency based and person centred policies in action.'

2. The potential for improved career/professional development

□ There was enthusiasm regarding the creation of career development for non-medical practitioners. One psychologist noted: 'it offers opportunities to share responsibilities across teams, but would have been useful to have in place prior to Agenda for Change.'

One consultant psychiatrist reported: '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.'

An occupational therapist (OT) reported: 'I think some OTs would welcome the opportunity to develop roles in this area. There also needs to be a balance of developing this generic role and maintaining an OT specific role.'

□ Many noted opportunities to maintain very experienced clinicians/practitioners in patient care, as opposed to the current system where they generally move into management. One psychiatrist stated: 'It is an excellent opportunity to develop much better "clinical careers for all disciplines".'

□ Many felt that it will improve recruitment and retention potentially. One nurse noted: '...good opportunity for staff to retain clinical function whilst progressing within their career, instead of moving into management.'

3. The need for role clarification

□ There were some concerns about how this new role would work in relation to medical team members, non-medical clinical supervisors, and care coordinators. One senior nurse wrote: 'Support opportunities to re-engineer structures within services, clarity need roles and responsibilities proposals and how this impacts on current roles, so the gaps don't appear somewhere else instead.'

□ It was noted that there was a need to consider how RCs will be appointed to patients across the spectrum of care (i.e. inpatient/community/readmission). One consultant psychiatrist working in an assertive outreach team felt it was 'very positive and encouraging, but some practical working issues must be clarified and further details on implementation need to be addressed'. There was a general consensus that it would be appropriate for non-medics to have a lead responsibility in selective cases.

□ It was felt that the roles created an opportunity for new perspectives in practice. One service user reported: 'The fact that the RMO role is being diluted and more team and partnership working could come about is good news.'

□ Some felt that the successful introduction of non-medical RCs might be hindered or prevented in some areas due to the 'attitudes of psychiatrists' and that there was a clear need for strong leadership in facilitating change.

4. The need for clarification on the skills and capabilities that will be required for the role

□ The need for nationally determined training programmes, approval and re-approval processes was consistently identified. One nurse stated: 'The system would not cope without multidisciplinary training in readiness for new arrangements.' A Mental Health Act administrator wrote: 'Care needs to be taken regarding skills and capabilities of non-medical staff in this role.'

The Approved Mental Health Professional

The proposal to replace the RMO with an 'AMHP' was considered a positive move but concerns were expressed about the role of the social worker. Three main themes arose:

1. The impact on the role of the social worker/ASW
2. Improved ability to address ASW shortfalls
3. The potential for improved career/professional development.

1. The impact on the role of the social worker

□ Concerns were expressed regarding the potential for the loss of the 'independence' of the ASW with no social work staff taking on this role. One social worker reported: 'Still gives cause for concern at the removal of the independent status of ASWs through offering short-term training to nurses on social perspectives. Increased isolation of the social work role.'

□ Some felt that the AMHP will create uncertainty about the role of social work in mental health. One social worker reported: 'I believe the amended Act is a good thing in general, as the 1983 Act is outdated. I am, however, very concerned about the social worker/ASW's role. I feel that as a professional group we are being pushed out of psychiatry. I would like to see the ASW or similar role strengthened and the specialism that social work requires in this Act. If nurses are able to become AMHPs, why is there a need to employ social workers?'

Another social worker reported: 'I see the demise of social workers over the next few years within mental health. I think it will be a great pity. Unless great care is taken the whole care of mental health service users will move towards

the medical model.'

Other social workers were more positive, with one saying: 'I accept and don't have an issue with the ASW role being offered to other professionals. They will need time and training to fulfil these roles.' Another reported: 'Much needed. Exciting. Would be good to have access to NHS training and better career pathway.'

2. Improved ability to address ASW shortfalls

One social worker reported: 'This will further help in multidisciplinary teams and address the issue of insufficient numbers of ASWs.' One senior ASW noted: 'I welcome this, I feel this is long overdue.' Many professions highlighted the importance of training. One social worker was generally supportive 'as long as the present intensive level of training is maintained this should be okay'.

3. The potential for improved career/professional development

Many commented on the expanding role of professional posts that the AMHP will offer. One occupational therapist pointed out that: 'For some it will give opportunity to extend their role.' Another occupational therapist commented: 'I think some OTs would welcome the opportunity to develop roles in this area. There also needs to be a balance of developing this generic role and maintaining an OT specific role.' A nurse noted: 'I look forward to having the potential to expand my role and feel it is a benefit to all with the proposed changes/liaisons of MH & SW services.'

Many identified the need for clarity regarding the role. A psychologist suggested that it, 'has to be ethically sound – evaluation of role of CS etc, particularly in relation to objectives of helping improve patients' health. Contracts have to be clear and attractive with parity'. While a CMHT manager reported: '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 about extending current (highly pressured) roles.'

Conclusions

This paper explores the perceived possible impact on service structures and workforce in order to meet the proposed changes to professional

roles. The results indicate that the provisions set out in the amended Bill could be managed with little change to existing workforce skill mix.

There was considerable support for the potential of expanding professional roles; however, it was noticeable that social workers had a number of concerns regarding the impact that such changes will have for their profession. The need for nationally agreed standards and the importance of training was apparent throughout the consultation.

The next stage of this work will be to engage with service providers in order to examine:

1. How these new roles can be implemented?
2. How meaningful workforce planning can be entered into to ensure appropriate skill mix in preparation for the introduction of the Amending Bill?

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Acknowledgements

The authors would like to thank all participant organisations professionals who took part in the consultation events.

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