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Title: Non-Medical Approved Clinicians: Results of the First National Survey in England and Wales

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Abstract

The 2007 amendments to the Mental Health Act in England and Wales enabled non-medics to take on the role of 'legally responsible clinician' for the overall care and treatment of patients 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 patients. 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 corner of England. Non-medical Approved Clinicians were motivated by a combination of altruistic motives (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, 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 UK mental health law.

Keywords

mental health law; responsible clinicians; professional roles; motivation

Main text

1. Introduction

The Mental Health Act (MHA) 1983 in England and Wales is the primary legislation regulating the compulsory care and treatment of those people who have an identified 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 (DoH), 2015a, para 14.4). The amended MHA 2007 expanded the roles that 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's *New Ways of Working* programme which aimed to distributed clinical responsibility within competency based teams for mental health patients' care and treatment (DoH, 2007).

Whilst there has been some primary research and discussion of the AMHP role (Coffey & Hannigan, 2013; Morriss, 2015; Watson, 2015) so far there has been just one research paper on 'non-medical' ACs (Ebrahim et al., in press). 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) small group. This is a timely study, given the recent UK government launch of an Independent Review the MHA in England and Wales (Department of Health, 2017) and the increased numbers of detentions under the MHA, estimated at an increase of 2% between 2015/16 and 2016/17 (NHS Digital, 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 et al, 2015; Royal College of Nursing, 2014). With United Kingdom 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 in 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 legally responsible clinician - the Responsible Clinician (RC) - for the overall care and treatment of certain patients 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. The competencies required by ACs are set out in secondary legislation (the 'Instructions', DoH, 2015b). It is the duty of Hospital Managers to allocate patients to an AC with 'appropriate expertise to meet the patient's main assessment and treatment needs (DoH, 2015a, p. 373). An AC, acting as the patient's RC, can grant and revoke section 17 leave; renew detention; 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). As of August 2017 there were 49 non-medical ACs in England and 7 in Wales, compared to over 6,000 medical ACs (personal communication from Department of Health, 2017).

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 19th century and subsequent iterative negotiations of the role of the state versus the role of the medicine 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 and revised definitions of mental disorder, medical treatment and the criteria for detention. Alongside the primary legislation the MHA Code of Practice (Department of Health, 2015) provides statutory guidance on the interpretation of the MHA. This includes reference to the 2010 Equality Act, the Care Act 2014, revised interpretation of the Mental Capacity Act 2005, and an increased focus on promoting the 'least restrictive option' (p. 23). The move towards least restrictive practice is characteristic of recovery-oriented working (Anthony, 2000), where shared decision-making between service users and professionals is a routine part of business of mental health care (LeBoutillier et al, 2016; Miller et al, 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 (Miller et al, 2016; Farrelly et al, 2016).

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 patients as 'service users' to take on more responsibility and risk) is positively spun 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 et al, 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 focus of this study is to describe the characteristics and concerns of non-medical ACs ten years after the AC role was introduced. The wider study also further explores some of the themes described in a recent case study of non-medical ACs, of distributed leadership and shared decision making (Ebrahim, 2018).

2. Method

The questions included in this initial survey were developed collaboratively by the authors, by a group of academics and clinicians with an interest in MHA 2007 extended roles, including four 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. Sample survey responses were analysed by three members of the study group, which undertook a collaborative coding exercise for a sample of the open questions, reaching a consensus on the themes identified. Following this exercise, complete coding was undertaken by one panel 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

The email link to the survey was sent to the 56 ACs via Department of Health contacts. 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. In our discussion we draw out broader themes and consider the insights offered by the quantitative and qualitative data we have gathered.

3.1 Participant Demographics

Participant characteristics are summarised in Table 1. Twenty participants were men (51.3%), 19 were women (48.7%). Thirty-five participants (89.74%) were White British; one participant was of mixed ethnicity; and three described their ethnicity as 'other'. Twenty-five participants (64.1%) had doctorate qualifications; 12 (5.1%) had a postgraduate degree; and only two participants' (5.1%) highest level of educational qualification was a first degree. Twenty-six participants (64.9%) were psychologists; nine (24.3%) were nurses; three (8.1%) were social workers; and one (2.7%) was an occupational therapist.

Over half of the participants were based in the North East of England (n = 19, 51.4%) and were employed by two neighbouring large specialist mental health NHS Foundation Trusts (n = 18, 48.7%). As might be expected given the preponderance of non-medical ACs in the North East of England, 21 of 36 participants (58.3%) were approved by the North of England Approvals Panel. However, Approvals Panels throughout England and Wales were represented (see Table 2).

3.2 Clinical Experience

The majority of participants specialised in either forensic mental health (n = 15, 42.9%), adult acute care (n = 11, 31.4%) or learning disability (n = 9, 25.6%), but child and adolescent mental health, older adult, general adult and forensic rehabilitation, personality disorder, psychotherapy, community care, and eating disorder services were also represented. Eight participants said they worked in more than one specialty. Participants described their service users as having a wide range of diagnoses, and many were working with people with a high degree of complexity and, multiple morbidities.

Participants had substantial clinical experience, (mean number of years' professionally qualified was 21.5, range 5 to 35 years. Most participants had Consultant in their job title, either consultant clinical psychologist (n = 20) or consultant nurse (n = 6). Four also held directorial roles within the organisations they worked for. Most participants were relatively recent ACs, with 19 being approved for less than 2 years and 11 being approved for between 3 and 5 years. Only six had been approved for over 6 years. The process of becoming an AC took between 8 months and 4 years (mean 19 months), with the majority of ACs reporting that it took between 18 and 24 months.

3.3 Current RC role

Eight out of 36 (22.2%) participants were not currently acting as named RC for detained patients. A number of reasons were given for this. Three participants said that it was because their trust had not supported the development of the role. (This issue is explored further below.) The number of people that participants were acting as RC for was between one and 25 (mean 5.4). Eight (22.9%) ACs were working with people subject to CTOs. Sixteen ACs (47.1%) were working with service users subject to section 41 Restriction Orders which requires regular reporting to the Ministry of Justice on patient's progress.

3.4 Motivation to become an AC

Participants were asked about their motivation to take on the AC role. From the 35 responses received, three major themes emerged: to benefit service users; to benefit themselves as professional/individuals; to meet organisational demands/expectations. Motivation to improve service user experience had a number of elements. Participants said that they wanted to improve patient care by: offering a more recovery-focused approach; increasing service user involvement; and offering more choice, for example choice of RC based on expertise to meet their particular treatment needs, which could be more psychologically than medically oriented. Participants viewed their role as part of a movement towards more holistic, person-centred, psychologically-informed care:

‘To improve patient choice based on most relevant profession for need, influence culture care and treatment, hope to improve patient experience and have more influence by leading on whole inpatient care and transitions/interface’

(female CAMHS clinical psychologist, 2 years as an AC)

As illustrated by the quote above, the drive to improve patient choice and experience was linked in some cases with a personal interest in having more influence on services and

systems (the second thee). The AC role enhanced the individual's professional standing and the status of their profession. The role was also described as a logical step in their continuing professional development:

'I have worked on rehab wards for a number of years and have learned a lot about the Mental Health Act during this time, so it felt like the natural next step in my career.'

(male Consultant Clinical Psychologist in rehabilitation, one year as AC)

It was seen as being particularly suited as a developmental path for clinical psychologists:

'It felt like this would be expected of psychologists and, being a Consultant in the Forensic Team, I was a natural candidate to be asked! For me, it adds to my CV, and I firmly believe that psychologists have the skills and competencies to undertake the role, and are more appropriate for some cases.'

(female Consultant Clinical Forensic Psychologist, 5 years as AC)

A less prominent theme was organisational expectation, where participants described the role as an established one in their organisation, with expectations that they would provide 'cover' for RCs, or where their employer had been part of the pilot scheme for the role.

We asked participants whether they enjoyed being an AC, and if so why or why not? Thirty four (97.1%) said they did enjoy the role. One person said they did not. There were 29 comments provided in response to this question. The themes of benefits to service users and benefits to the individual clinician were prominent here also. Most commonly ACs' responses centred on 'making a difference', with the AC role being seen as one in which participants could advocate for their service users and facilitate their progress. Participants said the AC role enabled them to work collaboratively with families and carers, and had facilitated closer relationships. As with the question on motivation, the second most common theme was the personal impact of being an AC. The role was seen as conferring authority and autonomy, which could be used to lead and transform services. Words like 'challenge', 'intellectual stimulation' and (in two cases) 'scary' were used. The role was seen as befitting the seniority and expertise of clinicians, for example;

'As a nurse consultant I feel the role of the AC/RC is a natural progression in providing clinical leadership.'

(male Nurse Consultant in intellectual disability services, less than one year as AC).

A third theme was described enjoyment in terms of multidisciplinary working, whereby the non-medical AC role:

‘enables me to facilitate truly multidisciplinary team working using a team formulation driven approach.’

(female Consultant Clinical Psychologist in older adult services, 4 years as AC).

However, two responses mentioned unenjoyable aspects of the role, namely stress associated with the high level of responsibility and a lack of administrative support, remuneration or access to cover, for example when joining what have been traditionally medical on-call rotas.

3.5 Support to be an Approved Clinician

We asked participants what helped and what hindered them in preparing for and implementing their AC role. Responses on what helped were clustered into four themes, the most frequent being ‘mentorship and support’, whereby ACs had had access to mentorship and shadowing opportunities from psychiatrist colleagues and existing non-medical ACs, and when their taking on the role had been championed by psychiatrist colleagues and their managers. Similarly peer learning and support had been important (the second theme), as had their training course and the ‘action learning set’ which had been facilitated by the course (the third theme). A fourth theme was the AC’s own personal motivation and determination, whether for professional enhancement or to be in the best position to influence care and treatment:

‘A passionate belief that clinical outcomes could be at least as good and - in many cases much better - for the clients/patients we work with.’

(male Social Worker in adult acute care, 4 years as AC)

There were 35 responses to the question ‘What or who hindered you most in your journey to becoming an AC? Why? How?’ Several common themes emerged, although it should be noted that four participants reported ‘no hindrances.’ The most prevalent theme was ‘time’ whereby the time taken to complete the portfolio was ‘tedious and burdensome’, as well as there being a lack of guidance and some confusion about the process of becoming an AC. Several participants said that they had not been given time from ongoing responsibilities to complete the AC process and were balancing it on top of their other work:

‘Lack of organisational support in providing time to build the skills, implement the role, it was undertaken ‘on top of everything else’.

(female Consultant Clinical Psychologist, speciality not given, 4 years as AC)

As well as having difficulty making time to complete the process required for approval as an AC, several participants described a lack of organisational or management buy-in, meaning that their AC skills were not being used effectively. A main hindrance was the atti-

tude of psychiatrist colleagues, interpreted as either the psychiatrists not understanding the role or process, or being protective of their domain of knowledge and power.

‘Difficulties with getting cross cover due to politics here I have been unable to take annual leave for several months at a time (some medical doctors believe they shouldn’t provide cover for non medical AC/RCs) and the dismissive attitude from the same group of people who voice concerns that we may undermine the position of their profession.’

(female Consultant Clinical Psychologist in older adults, 4 years as AC)

A sole participant described quite a different hindrance, namely their own ‘personal uncertainty’ about their ability to take on such a formidable, potentially challenging extension of their existing clinical role.

3.6 Effectiveness

Participants were asked ‘Do you consider yourself to be effective in your AC/RC role?’

Thirty three (94.29%) said they did and two (5.71%) said they did not. Common themes in the free text responses were objective evidence of effectiveness; my role in the multidisciplinary team and my impact on service culture; contrasting my work with medical approaches. Some ACs said they had become more effective over time. They saw the AC role as an effective use of their considerable years of clinical experience. They also perceived their effectiveness in terms of being able to support their organisation and colleagues by providing RC duty cover. Some participants said they felt they were not effective, due to having to balance the role with other duties, being too busy with other duties and because of ‘organisational politics.’

Participants’ viewed ‘good feedback’ from service users, colleagues and commissioners as evidence of their effectiveness, although three participants described having collected data on the impact of their role on discharge and readmission rates. Effectiveness in relation to the multidisciplinary role and service change was due to their having introduced or championed either a more ‘psychology informed’, more ‘social’ model of care or having fostered a more flexible and responsive approach to service users. One AC said:

‘I have found that the AC/RC role has been pivotal in having a truly multidisciplinary psychological approach, particularly in implementing positive behaviour support’

(female, Consultant Clinical Psychologist, older adults, four years as AC)

There was a perceived contrast between the non-medically led and medically led approach, for example:

'Being a non-medical RC has its advantages. I approach people from a nursing position first, a medical view second. I have managed many difficult cases and been able to form and maintain good therapeutic relationships with people who traditionally struggle talking to a consultant.'

(male, Nurse, acute adults and forensic, four years as AC)

4. Discussion

Currently, most non-medical ACs are psychologists or nurses. They all have several years of professional experience and are in senior, usually Consultant-level roles. A wide range of mental health specialties were represented in the survey, albeit with a preponderance in acute and forensic mental health services, suggesting that the role may be undertaken in any setting.

At the time of the survey (summer-autumn 2017) the role has only been embraced in a concerted manner by a couple of trusts in the North East of England. The site with the most ACs was a field-test site for the role, which has subsequently consolidated it into workforce planning and development. Outside of the North East of England there are a small groups of non-medical ACs or lone practitioner ACs. This suggests that there remains either some resistance or impediment to uptake to the non-medical AC role. Some insight into this resistance may be illustrated by the hindrances described by some of the ACs in this survey; namely lack of organisational support and lack of support from managers and psychiatrist colleagues. The substantial amount of time and effort required for non-medics to create the portfolios of evidence required to meet Approvals Panel criteria is a further potential impediment. It must be noted though, that some ACs reported having effective organisational, managerial, medical and peer support. On an individual basis, the relative increase in personal responsibility for risk, a lack of increased remuneration or limited remuneration are also a likely limiting factor.

Participants described a combination of altruistic and personal motivations and rewards for taking on the AC role. A commitment to personal development and enhancement of profession standing was combined with commitment to a 'recovery-oriented approach' that was psychologically rather than medically orientated. Organisational (that is, employer) expectations were influencing factors for some ACs, but this was less prominent than has been reported in a recent study of the motivations of recently trained AMHPs (Watson, 2015). A major difference between the AMHPs in Watson's study and the ACs in the current study was their different articulation of the authority conferred by the role. AMHPs val-

ued being able to work with a service user in crisis and to exercise their expertise in a time limited situation. For ACs there was an ongoing, long-term relationship, which both parties could shape. Participants said they offered patients a better experience as well as shifting the focus of the multidisciplinary team. Ebrahim's (2018) case study of non-medical ACs in one organisation also found that ACs considered that their role gave them increased power and authority, which could be used to offer patients more choice and could influence the therapeutic focus and nature of relationships in their team. Being approved in the statutory role of AC formalised participants' status as clinical leaders.

These findings suggest that the rhetoric of New Ways of Working holds true in that distributed leadership offers professions other than psychiatry the chance to direct care, however thus far it has only been seized as an opportunity by this small group of determined individuals. Only longitudinal, comparative research will reveal whether the experience of this vanguard group of non-medical ACs is typical. As 'early adopters' in influential roles, their aptitude for and commitment to distributed leadership may have been a key factor in those individuals putting themselves forward and being approved as ACs. Ebrahim (2018) noted that non-medical ACs described their clinical leadership as driving change and service transformation. Where participants in this study described becoming an AC as a 'natural progression', it may be that they, as early adopters in a vanguard organisation were always going to be at the forefront of new approaches to care and would make the most of any role that enabled them to lead innovation.

Professional rivalries and lack of collegiality were reported as obstacles by some participants, suggesting that the culture of distributed responsibility (and thus power) between mental health professionals has not been fully embraced by all professional groups. A study such as this, where the focus is on those professionals who have been approved as ACs, cannot provide insight into whether effective 'distributed leadership' is occurring in multidisciplinary mental health services where there are no non-medical ACs, but the limited numbers of non-medical ACs nationally suggests that this culture change has not yet been widely welcomed. Distributed leadership has a number of effects, and is not just about clinical responsibility for detained patients moving from psychiatrists to a non-medical colleagues. The non-medical AC may proffer distributed leadership through a consensual multidisciplinary approach and meaningful collaboration with service users, characterised as being 'different' to a more directive traditional medical approach (Ebrahim, 2018; Barrow et al 2015). Shared decision-making is undoubtedly highly valued by service users

(Gunasekera et al, 2017), although perceptions of shared decision making in practice may be different between professionals and service users. Where professionals may believe that 'we are already doing it', service users' may be less convinced (Farrelly et al, 2016).

This study has a number of limitations. First we only received responses from 39 of the possible 54 respondents. A survey methodology was justified as an initial attempt to map the impact of this statutory innovation, but the initial findings would be strengthened by the inclusion of more qualitative data gleaned by interviewing a sample of respondents and by a repetition of the survey at a future date when the numbers will have increased significantly due to more trusts preparing people for these extended roles. There would also be some benefit in comparing findings here with views from medically trained ACs. This would provide insight into whether the issues identified are the same for both groups and would enable a further exploration of the meaning of distributed leadership. Similarly, non-medical ACs claims for the effectiveness of their roles and resulting enhanced therapeutic relationships and increased clinical effectiveness should be interrogated using outcome metrics and service user views. Finally, the preponderance of non-medical ACs in one area of the UK means that 'the national picture' is skewed. Further research on the promotion and implementation non-medical clinical leadership within the MHA across a range of organisations and geographic areas is warranted.

5. Conclusion

The initial survey gives an account of the collective identity and preoccupations of non-medical ACs, proposing directions for future work. Despite almost ten years since its introduction, the application of the non-medical AC role is still in its infancy, with limited take up. This survey offers some insights into why this might be the case. The current cadre of non-medical ACs see themselves as clinical leaders, with the AC status being one aspect of their leadership role. This leadership is in the direction of psychologically informed and multidisciplinary care, and participants believe themselves to offer patients a different approach to the statutory relationship under the MHA than they may have had previously with medical ACs. Some, but not all ACs had gathered evidence of their effectiveness in terms of impact on discharge and readmission rates, and feedback from service users and colleagues. The argument for more mental health trusts adopting the non-medical AC role would be strengthened by a more systematic approach to gathering evidence of effectiveness, with particular reference to evidence of increased shared decision making with both patients and MDT colleagues.

The interpretation and implementation of statutory roles and responsibilities in mental health care is an under-researched area. This survey is a starting point. We aim to repeat the survey in two years to track changes in the characteristics and experiences of this group. More in-depth qualitative research is warranted, to explore some of the dilemmas and challenges that ACs face. Comparative work with medically trained ACs would provide a useful counterpoint to this study. Patients and family/carers views of the value and effectiveness of extended AC role should also be investigated.

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Table 1: Participant Demographics

Gender	Male	51.28% (n 20)
	Female	48.72% (n 19)
Ethnicity	White British	89.74%(n 35)
	Mixed	2.7%(n 1)
	Other	8.11%(n 3)
Education	Doctorate	64.10% (n 25)
	Post grad degree	30.77 %(n 12)
	First degree	5.13% (n 2)
Profession	Psychologist	64.86% (n 24)
	Nurse	24.32% (n 9)
	Social worker	8.11% (n 3)
	Occupational therapist	2.7% (n 1)
	Profession not given	5% (n 2)

Table 2: Geographical representation in the survey - National numbersresponses

Approvals Panel area	National numbers*	Survey responses	Response rate	Medical ACs*
North (was North and North East)	29	21	72%	1708
Midlands and East	9	6	67%	1708
London	4	3	75%	1463
South	7	3	43%	1467
Wales (was Betsy Catwaldr)	7	4	57%	not known
not given	n/a	2	n/a	n/a
Total	56	39	70%	n/a

*figures supplied by Dept of Health
in July 2017