



The
British
Psychological
Society

Professional Practice Board

Guidance on Mental Health Act *for the*

Approved Clinician Peer Review Panel

Regarding submissions made by registered psychologists for approval as approved clinician under the Mental Health Act 1983 (as amended by the Mental Health Act 2007)

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Glossary

AC	Approved Clinician
'the Act'	Mental Health Act 1983
AMHP	Approved Mental Health Professional
BPS	The British Psychological Society
CoP	Code of Practice 2008
CPD	Continuing Professional Development
CPA	Care Programme Approach
CTO	Community Treatment Order
DoH	Department of Health
MCA 2005	Mental Capacity Act 2005
MHA 2007	Mental Health Act 2007
MDT	Multi-Disciplinary Team
NICE	National Institute for Health and Clinical Excellence
NIMHE	National Institute for Mental Health in England
PCT	Primary Care Trust
RC	Responsible Clinician
RMO	Responsible Medical Officer
SHA	Strategic Health Authority
SCT	Supervised Community Treatment
Tribunal	Mental Health Review Tribunal

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1. Purpose of the guidance

This guidance is for the Approved Clinician Peer Review Panel members who are considering submissions made by registered psychologists for approval as approved clinician under the Mental Health Act 1983. This panel has, explicitly, an *advisory and formative function* and is neither regulatory nor summative in purpose. Approval and judgement of competency resides solely within the powers of the statutory approving authority.

Note. The guidance in this document builds on and incorporates material contained in the Society's *Interim Supplementary Guidance for Chartered Psychologists Seeking Approval and Acting as Approved Clinicians* (BPS, 2009).

2. Introduction

The Mental Health Act 2007 (MHA 2007) amends the Mental Health Act 1983. Thus, the Mental Health Act 1983 ('the Act') remains in force. The MHA 2007 has introduced two new roles of Approved Clinician (AC) and Responsible Clinician (RC) that may be filled by a range of mental health professionals.

The MHA 2007 in section 145(1) defines an AC as 'a person approved by the appropriate national authority to act as an approved clinician for the purposes of the Mental Health Act 1983'. RCs are ACs who have overall responsibility for an allocated patient's case and will undertake most of the functions previously performed by Responsible Medical Officers (RMO).

3. Professional requirements of Approved Clinicians

The secondary legislation MHA 1983 Approved Clinician (General) Directions 2008 gives directions to Strategic Health Authorities (SHAs) to approve a range of registered and professionally qualified mental health professionals. Schedule 1 of the Directions sets out the professional requirements for ACs. In summary the requirements are that a person is:

- a registered medical practitioner;
- a psychologist registered in Part 14 of the register maintained by the Health Professions Council;
- a first level nurse, whose field of practice is mental health or learning disabilities;
- a registered occupational therapist; or
- a registered social worker.

4. Relevant competencies of Approved Clinicians

The revised *Code of Practice for the Mental Health Act 1983* (CoP; DoH, 2008) makes it clear that non-medical ACs need to be prepared to assume the *functions* of ACs not the competencies of another profession (in this case psychiatry). The eligible professions come with many of the required competencies as a function of their professional training and experience, and may need to further develop some competencies through a continuing professional development (CPD) programme.

Schedule 2 of the AC Directions (pp. 7-8) details the relevant competencies required of ACs. In summary, the competencies are as follows (emphases added):

- i. A *comprehensive understanding* of the roles, legal responsibilities and key functions of the AC and RC. (**Note.** This can be considered as an *overarching* competency.)
- ii. An *applied knowledge* of mental health legislation, related codes of practice, policy and guidance, and other relevant legislation, codes, policy and guidance.
- iii. A *demonstrated ability* to assess: the presence of mental disorder; the severity of the disorder; whether the disorder warrants compulsory confinement; clinical risks, including risks to the safety of patients and others; and the biological, psychological, cultural and social aspects of a patient's mental health needs.
- iv. An *understanding* of mental health related treatments (physical, psychological and social), different treatment approaches and their applicability to different patients; skills in determining a patient's capacity to consent to treatment; an ability to formulate, lead and review on treatment for which the clinician is appropriately qualified; and an ability to communicate the aims of treatment to patients, carers and the MDT.
- v. A *demonstrated ability* to develop and manage care plans within the context of the Care Programme Approach (CPA).
- vi. An *ability* to lead a multi-disciplinary team effectively; including the ability to assimilate the views of others and to manage and take responsibility for making decisions in complex cases.
- vii. *Contemporary knowledge* and *understanding* of equality issues, including those concerning race, disability, sexual orientation and gender; and an *ability* to identify, challenge and redress discrimination and inequality in relation to the practice of an AC.
- viii. The *abilities* to: communicate effectively at all levels, keep appropriate records, understand and manage the competing requirements of confidentiality and information sharing; compile and complete statutory documentation and to write reports as required; and present evidence to courts and tribunals.

5. Identification of potential candidates for approval

The Act and AC Directions do not provide criteria concerning which individuals from the qualifying professions should be nominated for approval as ACs. However, *Mental Health Act 2007 New Roles* (NIMHE, 2008) provides policy guidance for approving authorities and employers. The guidance indicates that professionals applying for approval as an AC will usually have been nominated by their employer on the basis of having the relevant competencies for the role. The guidance at Annex E (1) is that “... applicants for the AC approval will be very experienced, well-qualified professionals who, given the necessary additional training and development opportunities, should be able to demonstrate the full range of competencies to be approved as an AC” (p. 35).

6. Developing and demonstrating the relevant competencies

The AC Directions do not stipulate how applicants for AC approval can provide evidence of their competencies. Annex E (2) of the New Roles guidance (NIMHE, 2008) provides a framework and examples of how potential ACs can develop and demonstrate evidence of existing competencies to achieve the full range of competencies required for the AC role (pp. 37–44). It is acknowledged that AC and RC competencies will build on *existing* professional competencies developed through pre- and post-qualification training and experience.

There is currently no nationally recommended training course for potential ACs to develop their competencies in preparation for application for AC approval. However, in order to demonstrate the full range of AC/RC competencies, psychologists may need to acquire additional skills knowledge and experience through CPD and access to appropriate training. The need for additional training and development will vary for individual psychologists seeking AC approval.

7. Initial training for Approved Clinicians

In addition to demonstrating that they have the required competencies for AC approval, the AC Directions require all applicants to have completed a formal ‘initial training’ course for ACs. This is in addition to any preparatory training towards developing the required competencies that they might have completed. This AC initial training must be completed within the two years prior to seeking approval. AC initial training courses should be approved on a regional basis and the New Roles guidance suggests that these courses are overseen by AC Approval Panels that are the responsibility of SHAs. The guidance is that the initial training should be a two-day attended course with recommended pre-course reading and the suggested standard content of such a course is set out in Annex G (pp. 47–48).

8. Approval of Approved Clinicians

Applicants applying for approval are required to demonstrate a comprehensive understanding of the role of the AC, including the role of the RC, legal responsibilities and key functions. In demonstrating competence applicants may draw on a range of evidence, but as a minimum they should provide:

- i. A summary of the applicant's skills and experience relevant to the AC role. It is recommended that a matrix such as that set out in Annex E (2) (pp. 37-44) of the New Roles guidance (NIMHE, 2008) is used to detail the applicant's skills and experience relevant to each competency, how these were acquired and the supporting evidence.
- ii. A minimum of two anonymised case reports relating to the applicant's involvement in the care of a detained patient. These will need to be hypothetical reports appended to, and provide an *explanatory commentary* on, a statutory report (e.g. Tribunal or Section renewal report) that demonstrate awareness, understanding and reflection on key areas of AC competence (see section 4 above) and the five guiding principles of the CoP (pp. 5–6).
- iii. Two testimonies from suitably qualified senior professionals that can validate the applicant's capacity for the AC role. One referee should be from a different profession from that of the applicant.
- iv. A 360 degree appraisal that should include (where appropriate) service user/carer feedback as well as the applicant's immediate line manager/supervisor, and MDT colleagues.

Once an AC applicant has completed a programme of preparation and development, the *employer* should submit the applicant's portfolio to the Approval Panel established by the Strategic Health Authority (SHA). The portfolio should include:

- Documentary evidence of professional qualification.
- Documentary evidence of current registration with the appropriate registration body.
- Evidence to demonstrate competence (see i-iv above).
- Evidence of completion of AC initial training within the last two years.
- Confirmation from the employer of their support for the applicant, and agreement to provide information to the Approval Panel on competency issues.
- Declaration by the applicant of agreement to comply with the conditions of approval required by the AC Directions.

9. Approved Clinician Approval Panels

AC approval is granted by SHAs, but an SHA may delegate the function of approving ACs to Primary Care Trusts (PCTs). There are no requirements in the Act or AC Directions about how Approval Panels should be established or composed though the New Roles guidance recommends that the panels be built upon current arrangements for the approval of Section 12 doctors. These panel arrangements are to be reviewed to ensure they are suitable to take on the enhanced responsibilities for AC approval. New panel arrangements should also reflect the multi disciplinary origins of ACs, with one panel member from the same profession as the applicant.

10. Accreditation of AC competencies by professional bodies

The DoH New Roles guidance, at Annex E(1) suggests that the non-medical professional bodies could allow for some form of ‘pre-approval scrutiny’ of an applicant’s portfolio (p.35). The guidance states that the establishment of such a *quality assurance process* across the professional groups could take various forms. The aim is to enhance the consistency of AC applicants’ submissions and to provide advice to SHA approval panels by ‘considering the relevant weight of evidence submitted by applicants with regard to their prior skills, training and experience’.

The guidance further exemplifies the British Psychological Society as an organisation with existing national professional structures that could be utilised for this purpose. Because the Approval Panels are being re-configured and will be finding their way in dealing with applicants from professions other than medicine, an additional quality assurance process, via professional bodies, will help to establish and maintain a consistently high quality of applicants seeking AC approval. This is particularly important as the Directions do not stipulate *how* evidence of the required competencies is to be provided.

11. Pre-approval scrutiny by the Society

Because of the statutory changes within the psychology profession and the structural changes within the Society it is appropriate that such a scrutinising and advisory function be under the aegis of the Standing Committee for Psychologists in Health and Social Care (SCPHSC) and, via this, to the BPS Professional Practice Board. This function would be undertaken by an *AC Peer Review Panel*, which would be chaired by a delegated member of the SCPHSC.

The Peer Review Panel would scrutinise the applicants’ submissions and advise the employers of psychologist AC applicants (as well as the SHA Approvals Panels). This is in keeping with the New Roles guidance which indicates that it is the responsibility of employers to nominate applicants for approval to the SHA delegated authority on the basis of them having the relevant competencies for the role (p. 35).

The Society supports this position. In its supplementary guidance for psychologists seeking approval as and acting as ACs (BPS, 2009), the Society recommends that psychologist AC applicants should submit their portfolio of evidence of required AC competencies to the Society for ‘pre-approval scrutiny prior to submission to a formal AC Approval Panel’ (p.6). The use of a panel overseen by the SCPHSC is entirely consistent with the BPS supplementary guidance indication that a pre-approval scrutiny panel will employ an advisory framework, but that the detail of how such a system will operate is yet to be decided.

12. Establishment of a Society AC Peer Review Panel ('the panel')

The proposal is for a panel to be created that includes senior psychologists with experience and knowledge of mental health and related legislation and practice. These will, in the main, be very senior clinicians with extensive managerial experience and many will have been national assessors. Members of the panel will be referred to as ‘*Scrutineers*’, in keeping with their role of subjecting submitted portfolios to a methodical evaluation against a set of competencies. The evaluation will be formative to the individual and advisory to the employer and approving authority. The adjudication of competency lies strictly within the discretion of the approving authority.

Scrutineers will be expected to have a sound understanding of the specific required competencies, their attainment and sources of evidence as set out in both primary and secondary legislation as well as relevant guidance. Training should be provided to new Scrutineers joining this panel.

It is proposed that initially senior clinicians with relevant experience are encouraged to join the panel and receive preparatory training as Scrutineers. As the early implementation field test sites are seemingly located in forensic and learning disability services then recruitment of Scrutineers from those specialties to the panel should be a priority. In the first instance the panel should include the Chair of the SCPHSC to ensure governance and safety.

13. Outline Society AC–peer review panel procedure

The following steps are recommended for Scrutineers who are considering an application from a registered psychologist for AC pre-approval scrutiny.

Step 1

The psychologist AC applicant *submits a portfolio* to the panel administrator comprising:

- An application form containing relevant personal details.
- A brief curriculum vitae (using a standard pro forma) giving information concerning educational and professional qualifications, current and previous posts, relevant training, CPD, skills and experience.
- Current job description and KSF outline.

- A summary of the applicant's skills and experience relevant to the AC role using the matrix set out in Annex E (2) (pp. 37-44) of the New Roles guidance (NIMHE, 2008) (see section 8 i above).
- Two anonymised case reports relating to the applicant's involvement in the care of a detained patient (see section 8 i above).

Step 2

The application is *allocated to two Scrutineers* from the panel list by arrangement with the administrator. The applicant's portfolio is then sent (electronically when possible) to the allocated Scrutineers for review.

Step 3

The allocated Scrutineers consider the application independently in the first instance. The Scrutineers will look for a *reasonable match* between the competencies as set out in Schedule 2 of the AC Directions and the candidate's competence as reflected in:

- their professional qualification;
- curriculum vitae;
- continued professional development;
- specific experience and training; and
- job description, and KSF outline.

The Scrutineers' evaluation should be based on a *consideration of the relevant weight of evidence* submitted by applicants with regard to their prior and acquired skills, training and experience. Perusal of the submitted case studies should also give Scrutineers an indication of the applicant's applied competence, especially with regard to:

- assessment – including mental health and risk assessments; and
- treatment including – an understanding of biological, psychological and social interventions; skill in determining capacity to consent; and the ability to formulate, review and lead on treatment in the context of a multi-disciplinary team.

Because the AC/RC is a *function*, not a post, psychologists will be bringing existing demonstrable professional *capabilities* to that function. In practice, as an AC/RC they will assume *all* of the responsibilities, associated with that function, for which that psychologist has competence. In considering the case studies Scrutineers should have regard to the *distinctive contribution* that a registered psychologist can bring to bear on the case and how they demonstrate their competencies in the application of psychologically derived models, theories and evidence based practice. They should also consider that the focus of the role of AC/RC should be on *clinical leadership* and that the submission by applicants should reflect this capability.

Step 4

The Scrutineers will then confer (usually telephonically or via e-mail) about their evaluations and *agree a recommendation*. The recommendation will be set out in a brief report (using a standard pro forma) that will indicate the Scrutineers' recommendation (in the form of a formative evaluation and advice e.g. *the applicant's claims of competency and*

the contents of the portfolio are generally consistent with their declared skills, knowledge and experience. Areas to be considered for clarification are...). Essentially the task is one of professional governance based on professional experience and to provide feedback as required, including areas of competence that require further development.

Step 5

The Scrutineers' report is sent to the applicant by the administrator, ideally within 8 weeks of the application being received and acknowledged. The applicant can then forward the Scrutineers' report, with recommendations, to the employer and *include the report in the portfolio submitted* to the AC Approval Panel as evidence of prior skills, training and experience relevant to required AC competencies.

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