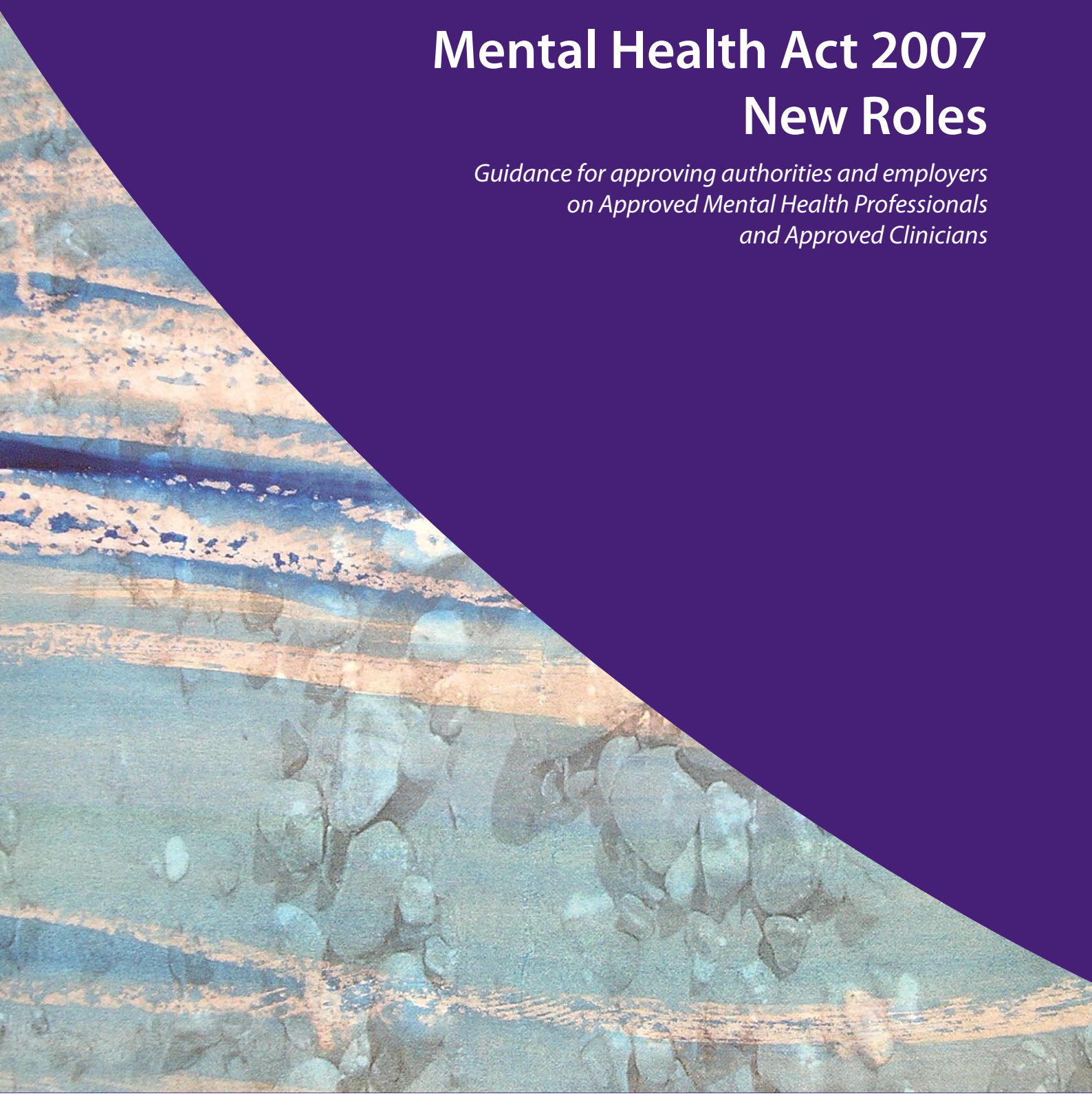
National Institute for
Mental Health in England

Mental Health Act 2007
New Roles

Guidance for approving authorities and employers on Approved Mental Health Professionals and Approved Clinicians



In collaboration with

directors of adass adult social services

AMHP Leads Network

BASW British Association of Social Workers

The British Psychological Society

College of Occupational Therapists

General Social Care Council

mhna Mental Health Nurses Association

Royal College of Nursing

UNISON the public service union

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Executive Summary

The Mental Health Act 2007 allows a broader range of professionals to carry out a range of functions under the Act. This guidance focuses on the new roles of Approved Mental Health Professional, Approved Clinician and Responsible Clinician.

The guidance is mainly for organisations that employ, authorise and approve these professionals. It supplements other guidance on the Mental Health Act, including the Code of Practice. It supports developments in New Ways of Working.

For each of the professional roles the guidance sets out:

- which professionals qualify and the functions of the roles;
- how they are to be approved and authorised (and when approval is to be ended or suspended);
- how potential candidates for the new roles may be selected, supported and trained;
- advice on workforce planning issues (including contracting and governance where appropriate).

Guidance on transitional arrangements for the approval of new professionals for staff already carrying out similar roles is also included.

Introduction

One of the most important changes the Mental Health Act 2007 makes to the Mental Health Act 1983 is to allow a broader range of professionals to carry out functions under the Act. This brings with it different responsibilities for organisations that approve or employ mental health professionals, and on whose behalf the professionals act.

This guide for England focuses on the new professional roles of the Approved Mental Health Professional, the Approved Clinician and the Responsible Clinician, and explains the flexibilities allowed in the Act to expand access to these roles by a wider range of professional staff.

Its purpose is to assist all those who approve, employ or have responsibility for staff who commission or deliver mental health services to understand their responsibilities and duties under the Act. It is aimed at Chief Executives and Directors of:

- local social services authorities;
- strategic health authorities;
- primary care trusts;
- mental health or care trusts; and
- independent hospitals that detain people under the Mental Health Act.

It will also be of interest to non-executive directors and elected members of the above organisations and to staff side representatives.

This guide is not a substitute for studying and understanding the legislation or the Mental Health Act Code of Practice. It is intended to be a useful reference tool that will bring together information from these sources, give an outline of the requirements, and signposting where further information is available. We have aimed to base the contents on the guiding principles that are set out in the Mental Health Act Code of Practice. For ease of reference they are replicated in Annex A of this guide.

A wide range of experienced professionals involved in delivering and commissioning mental health services in its development have been consulted in developing this guide. We have also involved professional organisations representing the groups who are eligible for the new roles of Approved Mental Health Profession and Approved Clinician; service users and carers, and other stakeholder groups.

This guide has the endorsement of the British Psychological Society; the College of Occupational Therapists; the General Social Care Council; the Royal College of Nursing and Midwifery; the Association of Directors of Adult Social Services; the AMHP Leads Network; the British Association of Social Workers; Unison and the Mental Health Nursing Association.

Throughout this guide, where the term 'the Act' is used, it refers to the Mental Health Act 1983, as amended by the Mental Health Act 2007. The term 'regulations' refers to the Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008; 'directions' refers to the Mental Health Act 1983 Approved Clinician (General) Directions 2008; and 'the Code of Practice' (CoP) refers to the revised Code issued under the Act which is to come into effect on 3 November 2008. Copies of the Act, regulations, Code of Practice and guidance on transitional arrangements can be accessed at the Department of Health website.

Context

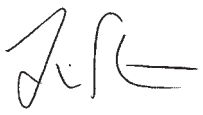
In recent years, we have seen changes in the working practice of professional staff of all disciplines. This has been brought about to resolve practical difficulties such as high caseloads and by the willingness of staff to extend their roles, such as non medical prescribers and psychological therapists. Most importantly, however, it is because people who use mental health services and their families have wanted timely and coordinated interventions by practitioners based on their capabilities and competences.

This process of change has been led by the NIMHE National Workforce Programme in partnership with all professional bodies and employers under the banner heading 'New Ways of Working'.

The opening up of the role of the Approved Mental Health Professional to occupational therapists, nurses and psychologists, and of the role of the Approved Clinician to psychologists, nurses, occupational therapists and social workers, underpins the strategy. It will help to address recruitment problems in some areas and support certain services to run more smoothly with more flexible access to the relevant professionals, for example crisis and home treatment teams, forensic services. Most importantly, it recognises that patients will have improved continuity of care where the key person with overall responsibility can also carry out roles under the Mental Health Act.

There is now every opportunity for organisations to open up these roles to a broader range of staff. It is likely that this will be a gradual process. Field testing is being carried out to explore and resolve the issues that arise in extending the roles to other professions; results will be shared in March 2009.

The new Mental Health Act roles further develop and modernise the workforce to create and enhance career paths for staff and to improve the experience of service users and carers.



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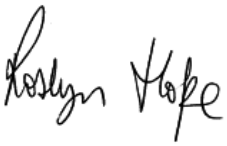

Roslyn Hope
Director, National Workforce Programme

Section 1
The Approved Mental Health Professional

1.1 Summary

The Act has opened up the range of registered mental health professionals able to undertake the functions previously carried out by Approved Social Workers (ASWs), with the new role of Approved Mental Health Professional (AMHP).

Local Social Services Authorities (LSSAs) are responsible for ensuring that sufficient AMHPs are available in their area to carry out their roles under the Act. They can contract with other organisations to help them meet this obligation.

LSSAs are responsible for approving individual AMHPs. They cannot delegate this responsibility to an NHS organisation through section 75 partnership arrangements.

The Act now distinguishes between being approved as an AMHP and being given permission (referred to in this guide as "authorisation") to carry out the functions of an AMHP on behalf of a particular local social services authority (LSSA).[1]

AMHPs must be approved by only one LSSA but they can be authorised to act on behalf of other LSSAs with whom they have an agreement.

Although AMHPs carry out statutory functions under the Act on behalf of a particular LSSA, this does not mean that the AMHP has to be employed by the LSSA who approved them or on whose behalf they are acting. Indeed, unlike ASWs, they do not have to be employed by an LSSA at all.

1.2 Introduction

This section lists those professions that can be approved as an AMHP; sets out the AMHPs functions; and considers all aspects of the AMHP approval and authorisation processes, including re-approval, warranting, and general governance arrangements.

Annex B contains guidance on the transitional arrangements for approving individuals already approved as ASWs to become approved as AMHPs from implementation of the Act. Further information about all aspects of the transitional arrangements can be found in the document '*Implementation of the Mental Health Act 2007: Transitional Arrangements*', *31st July 2008*, available on the DH website.

1.3 Who can become an AMHP?

The Regulations allow LSSAs to approve a range of registered and professionally qualified mental health professionals to act as an AMHP. These are:

- registered social workers;
- first level nurses whose field of practice is mental health or learning disabilities;
- registered occupational therapists; and
- chartered psychologists.

Registered medical practitioners (doctors) cannot become AMHPs, even if they also have one of the qualifications above.

These professionals will bring particular expertise from their different backgrounds, and will be expected to work within an established set of values and standards of practice whilst fulfilling the AMHP role.

1.4 Functions of the AMHP

The Act sets out the range of functions that an AMHP may undertake. The main functions of the AMHP are listed below, but this list is not exhaustive and reference should be made to legislation and the Code of Practice for guidance on particular circumstances.

Main AMHP functions

To enter and inspect premises (other than an NHS hospital) in which a mentally disordered person is living, if he has reasonable cause to believe that the patient is not under proper care (s115).

1. The Act gives the meaning of an AMHP as a person who is approved under section 114 (1) by any Local Social Services Authority (LSSA) whose area is in England (s114(10)). But it then goes on to say that (unless the context requires otherwise) references in the Act to AMHPs are to be read as references to AMHPs acting on behalf of an LSSA (s145(1AC). The effect is that an AMHP cannot apply for someone to be detained, or exercise any other power under the Act, unless they are acting on behalf of an LSSA.

To apply for a warrant to enter specified premises and remove a patient, if appropriate, to enable an assessment to be made (s135).

To interview and assess a person removed to a place of safety or move to another such place (s136/135).

To co-ordinate the process of assessment for the patients they assess for possible detention under the Act (unless different arrangements have been agreed locally between relevant authorities (CoP 4.40).

When considering the need to admit the patient to hospital either voluntarily or under compulsion, to reach an independent judgment about whether the use of compulsion is necessary, in all the circumstances of the case and to pursue alternatives to the use of compulsion wherever possible (s13(5) and (2)).

To make an application for admission to hospital or a guardianship application where the AMHP is satisfied that such an application ought to be made in respect of the patient and is of the opinion, having regard to any wishes expressed by relatives of the patient or any other relevant circumstances, that it is necessary or proper for the application to be made by him (s13(1A)).

Where the application is one for admission for assessment, to take whatever steps are practicable to inform the patient's nearest relative that the application is about to be, or has been, made and of the nearest relative's power to discharge the patient under section 23 (s11(3)).

To consider the case of a patient when directed to do so by the LSSA because:

- the LSSA have reason to think that an application for detention or guardianship should be made in respect of a patient in the LSSA's area (s13(1)).
- the LSSA have reason to think that an application under section 3 (for detention for treatment) should be made in respect of a patient who is detained for assessment outside the LSSA's area as a result of a previous application made by an AMHP on its behalf (s13(1B)).
- the LSSA is required to do so by a patient's nearest relative (s13(4)).

and (in the third case) to give the nearest relative their reasons in writing if they decide not to make an application in these cases (s13(4)).

To provide social circumstances reports (s14) where patients have been detained on the basis of an application by their nearest relative.

To apply to court for displacement of a patient's nearest relative, in circumstances where this is seen as appropriate (s29).

To apply to the county court for the replacement of an unsatisfactory private guardian (s10).

To convey patients to hospital once an application has been made (s6(1)).

To request an independent mental health advocate to visit a qualifying patient (from April 2009) (s130B(5)).

To agree (or not) to the making of a Community Treatment Order (CTO) (s.17A); the extension of a CTO (s20A); conditions to be included in a CTO (s17B); and revocation of a CTO(s17F).

To be consulted before an appropriate practitioner makes a report under section 21B confirming the detention or supervised community treatment of a patient who has been absent without leave for more than 28 days.

To take into custody a patient who is absent without leave and return that patient to hospital or place where s/he is required to reside (s18(1)).

Responsibilities under other legislation

AMHPs, as individuals with functions of a public nature, are bound by various duties on public authorities under the Human Rights Act 1998, the Mental Capacity Act 2005, the Equality Act 2006 and other anti-discrimination legislation; all of which contribute to the need for an AMHP to be independent in their decision-making and for their role in safeguarding the rights of the patient. Other legislation such as the Children Act 1989, the National Assistance Act 1948, the Care Standards Act 2000, the Disability Discrimination Act 1995 and the Equal Opportunities Act 2006 form the legal framework within which they must undertake their duties within health and social care.

1.5 The Approval Process

The following paragraphs summarise the essential points of the approval process for LSSA approving authorities. They contains details from the Act and regulations on the aspects of approval that LSSAs must comply with. They set out the duties placed on LSSAs and AMHPs themselves. They also include suggestions for how approving authorities may wish to carry out their statutory responsibilities, but this is guidance only.

General

Every AMHP must be approved by an LSSA (but not by more than one LSSA). That LSSA is responsible for ensuring that the AMHP is competent to practice as an AMHP.

LSSAs cannot delegate their responsibility for approving AMHPs to an NHS organisation through section 75 partnership arrangements.

Although approved by one LSSA, an AMHP may act on behalf of a number of English LSSAs. (To act as an AMHP on behalf of a Welsh LSSA a person must be separately approved in Wales.)

AMHPs must be approved for 5 years.

Approval Panels

LSSAs will make their own arrangements for approval panels, but it is suggested that panels be chaired by the Director of Adult Social Services or a senior manager acting on his behalf. The inclusion of a service user and a carer in the panel would demonstrate good practice.

Example of a possible approval panel composition

- A manager nominated by the LSSA who has been an AMHP or ASW themselves (for example, ASW lead officer)
- A senior manager in mental health (e.g at trust or LSSA Director level)
- An AMHP training or development officer
- A member of the prospective AMHP's own profession
- A service user and/or carer

Granting approval

In approving individuals to act as AMHPs LSSAs must be sure that applicants are competent to deal with persons suffering from a mental disorder. In doing this they must satisfy themselves that the applicant:

- meets at least one of the relevant professional requirements (see 1.3);
- has the appropriate competencies (AMHP regulations, Schedule 2); and
- if they have not already been approved or treated as approved as an AMHP (see Annex B transitional arrangements), have completed a GSCC or CCW approved training course.

Any individual who has previously been approved as an ASW in England or Wales, but was not treated as an AMHP from 3rd November 2008 under transitional arrangements as they were not approved as an ASW at that time, **will** have to complete the GSCC/CCW AMHP training if their ASW training was not completed in the 5 years before their approval to be an AMHP (but see 1.6 *Accrediting prior experience*).

Example

J completed her GSCC training as an ASW in January 2001 and was approved as an ASW until January 2006. She decided not to re-apply for approval as an ASW as she wanted to follow another career path. In December 2009 she decided that she wants to become approved to work as an AMHP. As she has never been approved previously as an AMHP, and has not completed her GSSC training in the five years before seeking approval, she will need to complete the GSSC approved training again to be approved as an AMHP.

If on completion of the GSCC approved training course, recommendations are made by the course tutors concerning the prospective AMHP's learning or development needs, LSSAs will wish to consider if these needs should be met before approval is granted.

Conditions of approval

An AMHP's approval is subject to the conditions that the AMHP shall:

- complete at least 18 hours training relevant to the AMHP role in each year of approval – the training to be agreed with the approving LSSA;
- notify the approving LSSA if they agree to act on behalf of another LSSA (authorisation), and when such authorisation ends;
- cease to act as an AMHP, and to notify the approving LSSA, if they are suspended by their professional body[2] ; and
- stop acting as an AMHP, and notify the approving LSSA, if they no longer meet the professional requirements (Schedule 1, AMHP Regulations).

Annual AMHP training

There is no national guidance on what the 18 hour AMHP training should contain. Approving LSSA may wish to review their ASW refresher training processes, and consider how these might be developed and broadened to support an AMHP's learning so that they can provide evidence of the development of their practice. An example might be training on childcare law and/or the Mental Capacity Act 2005, to enable AMHPs to feel confident in mental health assessments where this information would be important.

LSSAs and employers will wish to have clear policies about how they support AMHPs to ensure that they are able to demonstrate continuing competence during their period of approval. They may wish, for example, to ensure that the AMHP undertakes a certain number of mental health assessments over the year so that they are able to demonstrate their competence in this area.

Suspension of approval

AMHPs are required to tell their approving authority if they are suspended by their professional body (see *conditions* above). The individual's approval as an AMHP will then be suspended by the LSSA, and the AMHP must not act as an AMHP for any LSSA.

When the AMHP's suspension by their professional body is lifted the LSSA must also lift the suspension of their approval as an AMHP, unless they are not satisfied that the AMHP continues to have the necessary competencies to carry out the AMHP role. Their AMHP approval will then continue to run for any unexpired period of approval.

End of approval

LSSAs must end an AMHPs approval if the AMHP:

- comes to the end of their approval period;
- asks the LSSA to end their approval;
- no longer possesses the required competence to practice in the role;
- ceases to hold the required professional registration;
- is in breach of the conditions attached to their approval, (for example, the requirement to undertake 18 hours training annually) (see above); or
- is approved as an AMHP by another LSSA.

Approval may not be ended just because a person is not currently undertaking the functions of an AMHP, or is not currently authorised to act on behalf on any LSSA - for example if they are on a temporary management secondment or maternity leave. The underlying approval as AMHP will continue, even if authorisation to act on behalf of an LSSA is withdrawn or suspended (see 1.11 *Authorisation and warranting*).

Approving authorities will wish to consider providing opportunities for AMHPs on longer breaks to demonstrate their continuing competence, and to enable them to undertake the annual training required as a condition of approval if this is feasible. If this is not possible then the approval may have to be ended as the AMHP may fail to meet one or more of the conditions of approval (for example, competency).

In all cases if approval is ended, the LSSA must notify any other LSSA for whom it knows the AMHP is authorised to act on behalf of.

LSSAs may wish to ensure that local policies set out what should happen in situations where approval is ended and the AMHP disagrees. This may include what appeal policy and processes are available to the AMHP in cases of dispute.

If approval is ended as a result of the AMHP not continuing to meet the required competencies,

2. Professional body here refers to the bodies regulating, registering or listing the professionals listed in Schedule 1 of the AC Directions

the LSSA may wish to consider whether the details of the case might contravene the GSCC's or other professional body's code of conduct, or conditions of registration, and duly notify those organisations. In such situations, advice should be sought from local human resources departments on whether to make such a report.

Re-approval

The regulations make no distinction between approval and re-approval. Towards the end of their five year period of approval an AMHP must seek re-approval if they wish to continue acting in this role.

Where an AMHP acts on behalf of a number of LSSAs, it will usually be the LSSA that currently approves them which will have the responsibility for re-approval once the 5 year period of approval ends. But an AMHP can seek re-approval from another LSSA if they wish, for example because they have moved or they substantially work on behalf of that LSSA.

Records

LSSAs must keep a record of all AMHPs who have been approved including:

- their name;
- profession;
- date of approval;
- any period of suspension;
- details of their annual 18 hours training;
- details of any previous approvals (including approvals under transitional arrangements);
- names of other LSSAs for whom they act as an AMHP; and
- date of and reason for end of approval, if applicable.

These records shall be retained for five years from the day on which the AMHP's approval ended.

1.6 Preparation and training for AMHP approval

Selection criteria for AMHP training

The GSCC does not currently place any requirements on employers or individuals on the selection of candidates for approved AMHP training, beyond saying that a candidate must be recommended by an employer and meet the requirements of AMHP course providers.

Selection for AMHP training is the ultimate responsibility of the GSCC-approved University that is providing the Post-Qualifying award programme in which the AMHP training is incorporated. Employers and universities will be expected to work together on the relevant processes. For GSCC requirements, see Annex C.

Meeting AMHP competencies

LSSAs and other employers may want to consider together how to develop and deliver appropropriate multi-disciplinary training and development opportunities to help the different professionals develop and evidence the appropriate AMHP competencies.

The AMHP Leads Network[3], together with Association of Directors of Adult Social Services (ADASS) has developed guidance for its members on the selection and training of potential AMHP applicants (see Annex C).

Accrediting prior experience

Commissioners of AMHP training should work closely with universities to develop programmes that fit the specific needs of particular groups of staff. Universities should design AMHP training modules to be attractive to individuals from a wide range of different backgrounds and experiences.

Applicants should in principle be able to obtain accreditation of prior experiential and/or certificated learning and to offer claims for credit exemption for assessment against the learning outcomes specified for AMHP training modules. Where accreditation of prior learning is available programmes must advise prospective candidates about:

- the learning outcomes against which evidence must be presented;
- credit to which the candidate may be entitled for previous certificated education and training (APL) or non-certificated learning (APEL), which may be used as an alternative means of providing evidence against one or more learning outcomes;
- the process for gaining approval for credit via APL or APEL including details about the expected time-scale within which a portfolio should be completed; and arrangements for supporting candidates to prepare a portfolio for assessment.

3. The AMHP Leads Network represents the senior managers responsible for AMHP services and the trainers responsible for training

1.7 Workforce planning for the AMHP service

LSSAs are responsible for ensuring that there are enough AMHPs in their area and that arrangements are in place in their area to provide a 24-hour service that can respond to patients' needs (the AMHP service). There are a number of critical changes in the Act that are likely to necessitate a different approach to workforce planning for the AMHP service to that of the ASW provision. These include:

- the widening of the range of professionals who can become AMHPs;
- the broadening of the range of organisations that can employ AMHPs; and
- the introduction of the Deprivation of Liberty Safeguards (see Section 3).

This new approach to planning will mean that LSSAs will wish to work with partner health agencies to plan to meet their responsibilities. This section highlights some of the issues that LSSAs and partner agencies will wish to consider.

Encouraging professionals to train as AMHPs

To encourage the opening up of the AMHP role to non-social work professionals, LSSA and NHS employers of potential candidates may want to include willingness to train as an AMHP in the job requirements of posts for experienced staff in the qualifying professions. If they do so, they should ensure that there is clarity in the person specification, the job summary, desirable characteristics and key responsibilities. They should also ensure that a job evaluation is carried out on any revised post.

Providing an appropriate AMHP service

As prospective AMHPs may be drawn from a number of professions and organisations, if LSSAs want to make the best use of these flexibilities they will need to work collaboratively with other organisations such as PCTs and hospital trusts in considering these workforce planning issues, including training. In doing so, they may wish to make use of the various financial flexibilities available for working in partnership with Trusts to pay for the training of all staff who want to become AMHPs.

Partner agencies may wish to discuss and agree issues such as:

- how to organise staff nominations for training;
- internal support mechanisms for candidates through providing practice assessors and placements;
- representation on interview panels and selection processes.

Independent Hospitals

Arrangements for the local AMHP service will also have to take into account the needs of patients detained in independent hospitals and supervised community treatment (SCT) patients whose responsible hospital is an independent hospital. It should be emphasised that AMHP services are provided to patients, not to the hospitals themselves. So LSSAs may not charge for the provision of AMHP services, even where they are requested by independent hospitals.

AMHPs also acting as Best Interest Assessors

AMHPs and other specified professionals may also take on the Best Interests Assessor (BIA) role under the Mental Capacity Act (MCA). LSSAs will need to consider how these additional duties under the MCA (to be introduced from April 2009) will impact on the local AMHP service, and how they can maintain adequate numbers of AMHPs to meet the demand for assessments under both sets of legislation. See Section 3 of this guide for further information on the MCA.

Policies and guidance

The Code of Practice requires that the LSSA ensure that a number of policies are in place to support AMHPs in their area. They include:

- Information policy: LSSAs should have policies in place to support the giving of information to patients and nearest relatives with respect to Guardainship (CoP 2.44).
- Police assistance for people undertaking assessments with a view to applications under the Act: There should be locally agreed arrangements for the circumstances in which the police should be asked to provide assistance to approved mental health professionals (AMHPs) and doctors undertaking assessments (CoP 4.46).
- Displacement of nearest relatives: LSSAs should provide clear, practical guidance to help AMHPs decide whether to make an application to the county court for the appointment of an

acting nearest relative for a patient and how to proceed (CoP 8.16).

- Displacement of nearest relatives: LSSAs should provide clear practical guidance to help AMHPs decide who to nominate when making an application to displace a nearest relative (CoP 8.19).
- Warrants under section 135 of the Act : LSSAs should ensure that guidance is available to AMHPs on how and when to apply for a warrant under section 135 to permit the police to enter premises (CoP 10.7).
- Sections 135 and 136 of the Act: LSSAs, NHS bodies, police forces and ambulance services should have an agreed local policy in place governing all aspects of the use of section 135 and 136 (police powers and places of safety) (CoP 10.16).
- Conveyance of patients under the Act: Relevant authorities, including NHS bodies responsible for hospitals, ambulance services and the police, should agree joint local policies and procedures for conveying patients under the Act, setting out clearly the respective responsibilities of the different agencies and service providers (CoP 11.9-11.12).
- Receipt of guardianship applications : LSSAs should prepare a checklist for the guidance of those delegated to receive guardianship applications on their behalf (CoP 13.15).
- Guardianship patients absent without leave: LSSAs should have policies for the action to be taken when they, or a private guardian, become aware that a guardianship patient is absent without leave (AWOL) from the place they are required to live (CoP 22.12).
- Guardianship : Each LSSA should have a policy setting out the arrangements for the way in which it will discharge its responsibilities in relation to guardianship (CoP 26.15).

1.8 Ensuring provision of the AMHP services

As pointed out under 1.7 Workforce planning for the AMHP service, LSSAs are responsible for ensuring that there are enough AMHPs in their area to provide a 24-hour service. They may do this by employing AMHPs themselves, but the Act now allows that LSSAs do not have to employ or engage AMHPs directly; they can contract other organisations to do this if they wish.

There is no requirement in the Act for LSSAs to have a direct contractual relationship with each AMHP who acts on their behalf. However, LSSAs are free to decide to have a contract or agreement of some sort, even where the AMHP concerned is substantively employed by another organisation. That is a matter for each LSSA. The ADASS recommends that even if AMHPs are employed by another organisation the authorising LSSAs should have a direct contractual arrangements with the AMHPs they authorise to act on their behalf. ADASS and the NHS Confederation are planning to provide further guidance on this later in 2008.

Whatever arrangements are in place, it is essential that they make clear the nature of the relationship between the LSSA and individual AMHPs and – where another employing organisation is involved – the advice and support that each organisation will provide. LSSAs will want to ensure that these arrangements include:

- the provision of legal indemnity for AMHPs whilst working in the AMHP role;
- AMHPs being able to access legal advice relevant to their AMHP role;
- AMHPs (and their employers) being clear about the expectations of them in their role in terms of: days on duty; attendance at training; pay; any link between pay and governance requirements (for example, quality and availability of post-assessment reports and attendance on AMHP annual training).

Supporting AMHPs

All organisations employing AMHPs (and the LSSAs on whose behalf they act, if different) will wish to consider the following issues in supporting them in their role – that the AMHP has access to:

- professional supervision from an approved and experienced AMHP;
- information about AMHP practice in general;
- advice on any problems the AMHP might encounter (for example regarding access to beds, the police, or ambulance services); and
- advice and support on how to work to resolve problems with partner organisations.

Employers should also act in circumstances where an AMHP may require further training,

mentoring or support, for example after an unusual or controversial situation.

Supporting AMHPs' independence

Even before the changes brought about by the Act, with the formation of partnership arrangements in mental health services, some LSSAs do not currently employ any senior managers with responsibility for, or experience and knowledge of, the ASW (now AMHP) role.

To support the independence of the AMHP role, and to ensure that AMHPs are appropriately supported in undertaking their duties, LSSAs may wish to consider having at least one directly employed senior manager or lead officer who has direct knowledge and experience of the AMHP role or service. This would be one way of helping to ensure that AMHPs have:

- access to advice and support independent of the hospital to which the patient may be admitted or from which they may receive treatment;
- a senior level 'champion' to highlight any problems identified by the AMHP, and to protect the role's independence.

Legal advice

New flexibilities introduced by the Act on the arrangements for the provision of AMHP services will provide an opportunity for LSSAs and employers to review the legal advice service that is available to AMHPs (and other professionals) and how it can be organised across organisations. A clear pathway should be agreed locally, ensuring that the AMHP can access impartial advice in situations where there are conflicting views or opinions between different professionals and organisations.

Integrated services

LSSAs and NHS Trusts who co-operate to provide an AMHP service will need to consider and agree the following issues so that they are explicitly covered by their s75 and other agreements:

- details of how the daytime service will be configured, for example central AMHP service versus team based AMHP service;
- details of supervision and support arrangements, including access to senior support from the LSSA where serious issues arise, such as those related to conflicts of interest;
- agreement to release staff for initial and refresher AMHP training;
- agreement on governance issues (see below) including:
  - the collection of statistics on AMHP activity (whose responsibility it is to collect each set of information, and when and how this data will be reported, used and reviewed)
  - regular reporting to management, and how and in what circumstances to share feedback on issues of concern regarding services as a whole or on poor performance by an individual AMHP.

1.9 Authorisation and warranting

It is important to be clear about the difference between approval as an AMHP (see 1.4) and an AMHP being authorised to act on behalf of an LSSA.

Authorisation

An AMHP may be authorised to act on behalf of a number of different LSSAs, but can only be approved by one. It is for each LSSA to establish the arrangements by which people are authorised to act as AMHPs on its behalf and for what purposes. But whatever arrangements it establishes, the LSSA must be in a position to know who, at any time, is authorised to act on its behalf, and be satisfied that those who act on their behalf are competent to take on the role.

It is for LSSAs to decide on the processes they determine necessary for authorisation. But authorisation does not necessarily have to be a separate process from appointing staff, or engaging self-employed staff. For example, if an LSSA employs someone to work for it in a job that involves acting as an AMHP (either generally, or for a specific purpose eg assessing children or young people under the Act) then the LSSA could make the authorisation part of the job description. It would, however, need to be made clear that authorisation may subsequently be withdrawn or suspended – and what would happen in that case to any associated benefits, such as additional pay, which might be associated with work as an AMHP.

LSSAs must establish arrangements to ensure that:

- the people authorized to act on its behalf are competent to take on the role;
- the LSSA knows who, at any time, is authorised to act on its behalf.

Where an LSSA approves an AMHP which it also authorises, it clearly has a responsibility to satisfy itself of that AMHPs competency as part of the approval process, as well as when deciding if the AMHP should act on its behalf.

Where AMHPs are already approved by another LSSA, the authorising LSSA is also responsible for ensuring that the AMHP is competent to act on its behalf and for ensuring that appropriate arrangements are in place to support the AMHP (see guidance on contractual arrangements 1.8). LSSAs will, for example, wish to assure themselves that all the AMHPs authorised to act on their behalf have sufficient knowledge of local processes and resources and of the local community.

Authorising LSSAs should, as a matter of good practice, take steps to inform the approving LSSA if they feel that action needs to be taken with respect to the competence of the worker concerned.

Period of authorisation

An LSSA can, if it wishes, authorise AMHPs for a particular period. But in practice it is more likely that authorisation to act on behalf of the LSSA will be linked to the AMHP occupying a particular post or role (e.g. as a member of an emergency duty team, or an on-call rota).

AMHPs agreeing to act on behalf of an LSSA

It is a condition of approval as an AMHP that AMHPs inform their approving LSSA if they agree to act as an AMHP on behalf of another LSSA in England, or if such an arrangement ends.

As explained above, "agreeing to act" as an AMHP on behalf of an LSSA does not necessarily involve a distinct process. When an AMHP accepts a role or position in which they are expected to act on behalf of an LSSA they are, in effect, making an arrangement to act on behalf of that authority. Likewise, if they leave that role, the role changes so that it no longer involves acting as an AMHP on behalf of the LSSA in question, or they stay in the role but cease to be authorised to act on behalf of the LSSA (for whatever reason) – the effect is to bring to an end the agreement to act for that LSSA.

Warranting (section 115)

The Act allows AMHPs powers of entry to premises in particular circumstances (s115). It also requires that to exercise this right, they show an authenticated document confirming that they are an AMHP. This is commonly known as a warrant.

Current legislation prescribes that the issuing of such warrants is not a function that LSSAs can delegate to NHS bodies through s75 partnership arrangements. Each LSSA for whom the AMHP is authorised should provide this identification, rather than just the LSSA that approves the AMHP providing a single warrant card.

A warrant authenticating that the person is an AMHP should be signed by a member or officer of the relevant LSSA and contain the following information:

- Name
- Photo
- Expiry date
- Details of the LSSA on whose behalf the AMHP is acting on this occasion
- Details of the LSSA by whom the AMHP is approved
- Information about powers to enter and inspect premises and obstruction

1.10 Governance arrangements

All hospitals and LSSAs will have existing governance arrangements in place to scrutinise the discharge of the range of their responsibilities under the Act. The Act does not set out general requirements on governance so this is a matter for local determination.

With the widening of the range of professions able to undertake the AMHP role, and the growing likelihood that AMHPs within a given area will have different employers, these governance arrangements should be reviewed to ensure there

is an overview of the AMHP service at a senior level across all partner organisations. This may include regular reporting to the Health Scrutiny Panel or other joint health and social care senior forums and require oversight by Mental Health Partnership Boards.

Mental Health Partnership Boards

Mental Health Partnership Boards can play a key role in governance by reviewing reports on AMHP activity. LSSAs and health partners may wish to submit reports that identify how the flexibilities afforded by the new roles have been capitalised on, and whether any barriers to change remain that need to be addressed.

Mental Health Partnership Boards can oversee reviews of arrangements, which might include:

- reviewing joint commissioning frameworks to ensure that they include new partnership responsibilities around the AMHP role;
- integrating this framework into the wider mental health commissioning strategy and into Local Development Plans (LDPs);
- updating workforce planning across partner organisations to include new role specifications and descriptions of how responsibilities will be carried out;
- developing plans for service and role redesign and development, to enable responsibilities under the legislation to be undertaken successfully;
- updating information sharing protocols between LSSAs and trusts.

The latter point will be particularly important in urgent or serious situations. There should be agreement on the routes of reporting and speed of notification for different levels of incident, as well as clarity as to who has responsibility for investigating incidents where necessary. (see CoP chapter 3).

Local protocols and policies

Although the Act does not set out general requirements on governance, the CoP does make recommendations around some protocols and policy responsibilities, for example:

- the PCT's role in ensuring appropriate conveying of patients through their contracts with the ambulance service (see CoP 11.6 -12); and
- the need for jointly agreed local policies governing the use of s135 and 136 (see CoP 10.16-19).

Partner organisations should take account of the new arrangements for employing AMHPs in reviewing these.

Section 2
The Approved Clinician and Responsible Clinician

2.1 Summary

The Act has introduced two new roles of approved clinician (AC) and responsible clinician (RC) that may be filled by a range of mental health professionals.

Section 145 (1) of the Act gives the definition of 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".

An RC is the AC who has been given overall responsibility for a patient's case. ACs who are allocated as RCs will undertake the majority of the functions previously performed by Responsible Medical Officers (RMOs), whose role will end on the implementation date of the Act.

Hospital managers are responsible for ensuring local protocols are in place for allocating RCs to detained and SCT patients. LSSAs authorise ACs to act as RCs for guardianship patients.

Certain decisions, such as renewing a patient's detention or placing a patient on SCT, can only be taken by the patient's RC.

2.2 Introduction

This section sets out the functions of the AC and RC; outlines requirements of the approval process and provides some guidance on workforce planning and governance arrangements.

Annex D contains guidance on transitional arrangements for treating some doctors as ACs from 3rd November 2008. Further information about all aspects of the transitional arrangements can be found in the document '*Implementation of the Mental Health Act 2007: Transitional Arrangements', 31st July 2008*, available on the DH website.

2.3 Functions of Approved Clincians and Responisble Clincians

The Act sets out the range of functions of the AC and RC. The main functions are listed below, but this list is not exhaustive and reference should be made to legislation and the CoP for guidance on particular circumstances.

Functions of the approved clinician

For the most part, only an AC can be in charge of treatment given under the Act to a patient who either cannot, or will not, consent to it. In particular:

- treatment without consent (and without a second opinion appointed doctor (SOAD) certificate) under s63 of the Act can only be given by or under the supervision of the AC in charge of the treatment (whether or not the AC is also the RC) – this includes treatment given under s63 because it is "immediately necessary" as defined by s62;
- there must be an AC in charge of medication given to a detained patient who cannot or will not consent to it but which has been approved by a (SOAD) under section 58;
- similarly, there must be an AC in charge of ECT (Electro Convulsive Therapy) given to a detained patient who cannot consent to it but which has been approved by a SOAD under the new section 58A;
- it is only the AC in charge of the treatment who can decide under section 62 or 62A that treatment can be continued to avoid serious suffering to the patient while steps are taken to obtain a new certificate under section 58 or 58A;
- where an SCT patient who has not been recalled to hospital is unable to consent to treatment because of a lack of capacity or competence (and no one else with authority has consented on their behalf) treatment can only be given if there is an AC in charge of the treatment and it is given by or under the supervision of that AC (see Part 4A of the Act).

Also, it is the AC in charge of treatment who:

- must submit periodic reports under section 61 to the Mental Health Act Commission[4] regarding medication and ECT supported by a SOAD certificate under section 58 or 58A;
- must submit reports to MHAC as required on treatment given to SCT patients on the basis of

4. Soon to be Care Quality Commision

a SOAD's "Part 4A certificate"; and
- can sign a certificate under section 58 or 58A of the Act certifying that the patient has consented to medication or ECT (respectively).

In all these cases, the AC does not also need to be the patient's RC. And the RC cannot do these things unless the RC is also the clinician in charge of the particular treatment in question. So, for example, an RC who is not qualified to prescribe medication, could not direct a patient to be given medication without consent. There would have to be another AC in charge of the medication.

Functions of the responsible clinician – detained patients

All patients detained for assessment or treatment under Part 2 of the Act must have an RC to perform various functions under the Act. The same applies to patients detained under Part 3 of the Act, except patients remanded for report under section 35.

The role previously undertaken by the RMO will now largely be replaced by that of the RC. That is, the RC will take on the functions performed by the RMO, for a particular patient in respect of compulsion under the Act. These include:

- Having overall responsibility for the patient's case. But this does not mean that the RC personally supervises all the medical treatment provided to the patient under the Act. The RC will, however, have overall responsibility for the patient's care, working with the input of a multi-disciplinary team.
- Being responsible for reviewing the patient's progress. In particular, the RC should, at regular intervals, assess whether the patient still meets the criteria for detention.
- Having the power to grant patients leave of absence, to discharge them and to block discharge by nearest relatives.
- Having the power to renew detention, except that the RC will now require the agreement of another professional who has been involved in the patient's treatment and who is from a different profession.

Responsible clinician's responsibilities for supervised community treatment

RCs have a number of responsibilities for SCT. They may:

- make a CTO (Community Treatment Order) if they are satisfied the criteria are met, and an AMHP agrees the patient meets the criteria and that a CTO is appropriate;
- include conditions in the CTO, with the agreement of an AMHP;
- subsequently vary the conditions or temporarily suspend any of them at any time, without the agreement of an AMHP;
- recall an SCT patient to hospital if they believe the patient needs to receive medical treatment for their mental disorder in hospital, and that, if they were not recalled to hospital, there would be a risk of harm to the patient's health or safety or to other people;
- recall a patient who fails to comply with one of the mandatory conditions to attend for examination;
- discharge SCT patients (including Part 3 SCT patients) at any time, by making a written order;
- veto the nearest relative's decision to discharge a patient if they consider that, if discharged from a CTO, the patient is likely to act in a manner dangerous to other persons or themselves;
- extend the period of SCT, with the agreement of an AMHP.

Responsible clinician's role under guardianship

Like the RMO role now, the RC role for guardianship patients is slightly different. They are not formally in overall charge of the patient's case, and can be appointed by an LSSA either to take a particular decision, or on a continuing basis.

An RC must decide whether to provide a report to the responsible LSSA to renew a patient's guardianship (unless the patient has a private guardian, and therefore a doctor appointed by that guardian as their nominated medical attendant).

An RC can discharge a patient from guardianship.

Approved clinicians responsibilities under other legislation

ACs (and therefore RCs) are also bound by various duties on 'public authorities' under the Human Rights Act 1998, the Mental Capacity Act 2005, the Equality Act 2006 and other anti-discrimination legislation, all of which will

contribute to the need for their independent decision-making and for safeguarding the rights of the patient. Other legislation such as the Children Act 1989, the National Assistance Act 1948, the Care Standards Act 2000, the Disability Discrimination Act 1995 and the Equal Opportunities Act 2006 form the legal framework within which they must undertake their duties.

2.4 Who can become an Approved Clinician?

The Directions allow SHAs (Strategic Health Authorities) to approve a range of registered and professionally qualified mental health professionals to act as an AC. These are:

- registered medical practitioners (doctors);
- chartered psychologists;
- first level nurses whose field of practice is mental health or learning disabilities;
- registered occupational therapists; and
- registered social workers.

These professionals will bring particular expertise from their different backgrounds, and may be able to work to demonstrate the necessary competencies to carry out the AC role. Opening up this role to professions beyond doctors will mean that local health and LSSA employers will wish to work together to consider workforce planning and training across these professionals of the AC role (see 2.5).

The Approval Process

The following paragraphs summarise the essential points of the approval process for approving authorities. They contain details set out in the Directions on how approval is to be carried out and the duties placed on approving authorities and ACs. They also give guidance for approving authorities on how they may wish to carry out their statutory responsibilities.

General

Approval is granted by a Strategic Health Authority (SHA), but SHAs may delegate the function of approving ACs to PCTs. They may not delegate the approval of section 12 doctors[5] (though they can delegate processes, for example administration).

Approval by one SHA (or PCT) is approval for the whole of England.

Doctors (and doctors only) approved as ACs are also automatically approved as s12 doctors. ACs and s12 approved doctors who are approved to act in England can be treated as approved in Wales, and vice versa.

There are no requirements in the Act or Directions about how approval panels should be established or composed, but we give some guidance below. Approval is for five years.

Approval Panels

The National Advisory Group for AC Training (NAGACT[6]) recommends that AC approval panels be built upon the current arrangements for the approval of section 12 doctors. SHAs should review their existing S12 panel arrangements to ensure they are suitable to take on the enhanced responsibilities for AC approval. New panel arrangements should reflect the multi-disciplinary origins of ACs, with one panel members from the same profession as the applicant. The panel should also include user and carer representation, demonstrating good practice.

As well as discharging their statutory responsibilities for approving ACs approval panels may wish to undertake the following tasks:

- ensuring that appropriate AC training is available and accessible to meet local needs;
- taking responsibility for overall governance – auditing the quality of the AC training and the calibre of the candidates being put forward.

Approval panels undertaking these aspects of quality assurance will wish to provide reports to nominating employers and be prepared to offer feedback to individual applicants.

Granting approval

An approving authority may only approve a person to be an AC (where they have not previously been approved or treated as approved as an AC in the previous five years) where that person:

- fulfils at least one of the professional requirements (Schedule 1, AC Directions);
- is able to demonstrate that they possess the relevant competencies (Schedule 2 AC Directions) and
- has completed within the last two years a course for the initial training of ACs.

5. Doctors approved under Section 12(2) of the Mental Health Act (1983)
6. NAGACT: Established through NIMHE/CSIP to bring together key stakeholders and representatives of the professions affected

Where they have been approved, or treated as approved, in the 5 years before seeking approval ACs do not need to complete a course for the initial training of ACs to gain re-approval.

Nominating candidates for approval

There are no criteria laid down by the Act as to which individuals from the qualifying professionals should be nominated for approval as an AC. This is a matter for local determination, based on local need. It is expected that professionals applying for approval will usually have been nominated by their employer on the basis of having the necessary competencies for the role of AC (see Developing and demonstrating competencies, below). NAGACT has developed guidance for potential applicants and nominating employers at Annex E(1).

Developing and demonstrating competencies

The Directions do not stipulate how evidence on competencies is to be provided. It is suggested that it might consist of a portfolio, a test on the law, one or two case studies, and colleague and/or service user and carer testimony. NAGACT has developed guidance on the range of evidence that might be provided by applicants for AC approval to demonstrate their competence (see Annex E(2)).

Eligible professionals' professional bodies may wish to consider issuing guidance on the competencies they would expect from their members seeking AC approval. The British Psychological Society (BPS) has already undertaken this task, and has identified the required competencies, the training needs and the registration mechanisms.

Initial training of approved clinicians

Directions set out that all professionals who have not been approved as an AC in the previous 5 years must complete a course for the initial training of ACs within the 5 years before approval. In this document we refer to this as AC "initial training" to reflect the terminology used in the Directions. This is not to be confused with any training that may be developed nationally or locally to prepare potential ACs to demostrate competencies (see above).

The Directions do not specify the content or length of this AC initial training. This is for determination by each approving authority. However, NAGACT have developed guidance for approving authorities on course standards and content (see Annex F).

Conditions of approval

Approval is subject to the condition that the AC continues to meet the professional and competency requirements of approval. There is also an obligation on ACs to notify the approving authority if they are suspended by their professional body, and to stop working as an AC while they are suspended.

Directions also allow approving authorities to set other conditions as they think appropriate. This is for local determination but such other conditions might include: requiring evidence of on-going professional development; periodic updating on mental health/capacity case law; training on new or changing equalities legislation.

There is no requirement for SHAs to set conditions for AC on-going training, but it is reasonable to expect that ACs would attend appropriate training to meet their profession's requirements on continuing professional development. Their employers may wish to ensure that at least part of that training would be relevant to their AC and/or RC role.

Suspension of approval

If an AC has their registration or listing, as required by their professional body to qualify for eligibility to act as an AC, suspended, then the approving authority must suspend their approval to act as an AC for as long as the registration or listing is suspended. They may not act as an AC until the suspension is ended.

Once the suspension is lifted the approving authority must end the suspension of the approval as an AC, unless it is not satisfied that the person possesses the relevant competencies or meets any other conditions attached to their approval.

Once the a suspension has ended, then the approval should continue to run for any unexpired period of time, unless the approving authority decides to end it earlier under direction 8 (See below) (Direction 7 of the Mental Health Act 1983 Approved Clinician Directions 2008)

End of approval

The approval or re-approval of an AC lasts until the end of the period of approval except in the following circumstances, if the AC:

- decides not to carry out this role any longer and requests in writing that the approving authority end the approval;
- does not meet any of the conditions attached to their approval;
- no longer continues to possess the relevant competencies;
- no longer meets the professional requirements.

Where an approving Authority ends the approval of an AC under any of the conditions above, they must immediately notify that clinician in writing of the date of the ending of approval and the reason. (Direction 8 of the AC Directions).

Re-approval

The Directions make no distinction between approval and re-approval. SHAs may set conditions for re-approval if they wish. This may include update training. However, there is no requirement for ACs to complete a course for the initial training of ACs to be re-approved (but see AC transitional arrangements, Annex 3, for certain groups of doctors who have been treated as approved).

Register of approved clinicians

The approving authority (that is the SHA or, where this is delegated, the PCT) must keep a record of all ACs that it approves, including:

- their name;
- their profession;
- the date of approval;
- the conditions attached to their approval;
- details of the completion of any training for the initial training of ACs;
- details of any previous approvals; and
- the date and reason for the ending of their approval, if applicable.

2.5 Workforce planning for the Approved Clincian and Responsible Clincian roles

SHAs and employers responsible for patients detained under the Act will wish to undertake a review of local need and resources to ensure effective workforce planning for ACs and RCs. Any review should aim to ensure that an appropriate number of ACs is available, and also that ACs from a range of professions are able to act as RCs to meet the requirement that the RC is the most appropriate available clinician for any particular patient. Reviews should also consider factors such as:

- local gender, cultural and language needs;
- need for prescribing out-of-hours when changes to a patient's medication may be required (not all ACs will be able to fulfil this requirement); and
- any other local need (e.g. geographical spread in rural areas).

2.6 Allocating a Responsible Clinician

The CoP (Chapter 14) gives guidance on the allocation of an RC to a patient, stressing that hospital managers should have local protocols in place for allocating responsible clinicians to patients. This is particularly important when patients move between hospitals and/or services.

A patient's responsible clinician should be the available AC with the most appropriate expertise to meet the patient's main treatment needs. Careful consideration will also have to be given as to how the allocation is managed when the patient moves from an in-patient setting to live in the community, particularly when they are on SCT.

Hospital managers should maintain a register of ACs employed by or contracted to them and ensure they have local protocols in place that:

- ensure that the patient's RC is the most appropriate available AC to meet the patient's main treatment needs;
- give ready information about who is a particular patient's RC;
- give clear guidance on cover arrangements in place when the responsible clinician is not available (for example during non working hours, annual leave etc);
- regularly review the appropriateness of the allocated RC.

The choice of responsible clinician should be based on the individual needs of the patient concerned. For example, where psychological therapies are the main basis of the patient's

treatment, it may be appropriate for a psychologist to act as the RC.

It may be necessary to allocate a temporary responsible clinician in the first instance, to ensure that a patient has a responsible clinician promptly upon detention in hospital. However, as soon as possible, once the patient's main treatment needs are known, a responsible clinician should be allocated who is most appropriate to meet the patient's needs.

Change of responsible clinician

As the needs of the patient will change over time, it is important that the appropriateness of the responsible clinician is kept under review by the hospital managers. It would be appropriate for the patient's responsible clinician to change during a period of care and treatment if such a change enables the needs of the patient to be met more effectively. This might, of course, also apply if the patient was moved to another treatment centre.

2.7 Governance

It is important that each Trust or independent hospital develops robust local policies and protocols regarding all aspects of the AC and RC role. They may wish to consider such issues as:

- 24 hour care, especially with regard to the consultant rotas senior consultant rotas – will there be sufficient care for patients 24/7? For example, is it just AC doctors who will be expected to provide the out-of-hours decisions and care, or will other ACS need to be on call as well?
- Local staffing situations/skill mix.
- Ensuring the Trust has a list of s12 doctors, including ACs who will be s12 approved, to the LSSA for AMHPs use.
- how they will work with their commissioners, who may wish to include specifications about the range of options for ACs in their contracts.

Appointment arrangements for RCs that include transferring the role; delegation; and cover arrangements. This will be informed by the regulations, Code of Practice and the Principles of the Code.

Case examples showing changes of RC

Mrs Georgiou had spent several years on s3, progressing to s17A (SCT) in a recovery-based service. Initially her consultant psychiatrist is her RC, as medical treatment and prescribing are the primary focus of the care plan and this meets the patient's needs at this time. However later, although there will be a continuing need for a degree of compulsion, Ms Georgiou's primary treatment may be habilitation and rehabilitation, so therefore it may be appropriate to allocate an RC who is an occupational therapist (OT). As she would still have prescribing needs, her psychiatrist would be the AC in charge of her medication, but the OT would be the RC in overall charge of Ms Georgiou's case.

Anna S was an in-patient detained under Section 3. She was treated primarily with medication initially, and therefore the most appropriate person to act as her RC was the psychiatrist, Doctor Shah. Anna agreed with this decision. However, as her condition improved, she began to see a psychologist, Ms Phillips regularly, and when she was being considered for leave, and then discharge to the community, it was agreed between Anna's care team and herself that the Ms Phillips would be the most appropriate AC to take on the role of RC for her at this stage of her treatment.

Anna requested that, as she did not know any other members of the team well, when Ms Phillips was on leave Dr Shah would take on the temporary role of her RC. Again, the team agreed this was appropriate. In that particular hospital, the policy is that out of hours, the duty AC is responsible for any emergency decisions regarding Anna's treatment that would require urgent RC assessment or consent.

Section 3

The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards

3.1 The Mental Capacity Act

The Mental Capacity Act 2005 (MCA) was developed with the intention of ensuring that individuals who lack capacity are the focus of any decisions made, or actions taken, on their behalf. Staff are obliged to make efforts to enable vulnerable people to make as many decisions as possible for themselves. The MCA prioritises the interests of the individual who lacks capacity rather than the views and convenience of those around them or the establishment in which they may reside.

Mental capacity, within the context of the MCA, means the ability to make a decision. A person's capacity to make a decision can be affected by a range of factors such as a stroke, dementia, a learning disability or a mental illness. People with a mental illness do not necessarily lack capacity, but people with a severe mental illness at times lack capacity to make decisions about their care and treatment.

The MCA legislation confirms the presumption that adults have full legal capacity to make their own decisions unless it is shown that they do not, therefore assessment of capacity to make a decision is an integral part of any assessment about mental health care or treatment.

Employers should ensure that members of their professional staff are aware of the basic principles of the MCA, particularly where it may apply to someone with a mental illness. (See chapter 13 of the Mental Capacity Act Code of Practice)

3.2 MCA Deprivation of Liberty (DOL) Safeguards

MCA Deprivation of Liberty (DOL) Safeguards (formerly known as the Bournewood Safeguards) were introduced into the Mental Capacity Act 2005 through the Mental Health Act 2007, and it is planned that they come into effect from 1st April 2009.

The DOL safeguards are intended to prevent arbitrary decisions to deprive a person of their liberty (other than under the Mental Health Act 1983), and to provide legal protection for those vulnerable people who need to be so deprived, by giving them representatives and rights to challenge deprivation of liberty authorisations.

The safeguards apply to anyone aged 18 and over who suffers from a mental disorder – such as dementia or a profound learning disability and lacks the capacity to consent to the arrangements made for their care and / or treatment and for whom deprivation of liberty (within the meaning of Article 5 of the European Court of Human Rights (ECHR)) is considered after an independent assessment to be necessary in their best interests to protect them from harm and to provide that care and/or treatment.

The safeguards cover people in hospitals and in care homes (registered under the Care Standards Act 2000), whether placed under public or private arrangements. People should be cared for in a way that limits their rights or freedom of action as little as necessary. Where their rights or freedom of action are significantly limited, the safeguards could apply.

The new procedures cannot normally be used to detain people in hospital for treatment of mental disorder in situations where the Mental Health Act 1983 could be used instead if they are thought to object to being in hospital or to treatment for that mental disorder.

This will mean that people who object, will be treated in broadly the same way as people with capacity who are refusing treatment for mental disorder and who need to be detained as a result.

Supervisory bodies

LSSAs will be new statutory Supervisory Bodies under the 'DOL Safeguards', receiving requests from Managing Authorities (registered care homes) and be required in urgent cases to

organise, complete and respond to a request for assessment in seven days. The time limit in standard or non-urgent cases is 21 days. PCTs are Supervisory Bodies, with the same legal responsibilities under the DOL Safeguards in relation to hospitals as LSSAs are in relation to registered care homes.

The six statutory assessments

The safeguards require six statutory assessments:

- an age assessment and a no refusals assessments which can be carried out only by best interests assessors
- a mental capacity assessment which can be carried out by either a best interests assessor or a doctor
- a mental health assessment which can only be carried out by a doctor (as required by the European Convention on Human Rights).
- an eligibility assessment that can only be carried out by either a S12 doctor or an AMHP
- a best interests assessment that can only be carried out by a best interests assessor.

The assessors

The DoL best interests assessor can be an AMHP, suitably qualified social worker, nurse, occupational therapist or chartered psychologist who a supervisory body is satisfied has undertaken training approved by the Secretary of State and has the necessary skills and experience, and meets the other regulatory and legislative requirements including being two years post registered.

The best interests assessment must be carried out by a professional who is not involved in providing care or in making decisions about the person's care. Not all of the assessors need to be unconnected with the person's care – it may be useful for the mental health and/or mental capacity assessments to be carried out by someone who knows the person.

Mental health assessors must be either s12 doctors or three years post registered with the necessary experience in the diagnosis and treatment of mental disorder and meet the other regulatory and legislative requirements.

The regulations require best interests and mental health assessors to be insured in respect of any liabilities that might arise in connection with carrying out any assessment.

In considering the DoL Safeguards, similar Conflict of Interest rules apply as to assessments under the Mental Health Act.

Employers need to note particularly that:

- A minimum of two assessors will be required to assess under the DOL Safeguards, with the mental health assessment and the best interests assessment being undertaken by different people.
- Every assessment will require a doctor and at least one of an AMHP, a nurse, an OT or a psychologist.
- An eligibility assessment can only be carried out by either a S12 doctor or an AMHP therefore every assessment requires at least one or other of these professionals.

Role of LSSAs and PCTs

LSSAs and PCTs will be expected to:

- develop a system that receives and processes applications from Managing Authorities;
- appoint suitably trained staff to undertake the series of six statutory assessments in relation to each application, and provide these within certain specific timescales;
- establish an authorisation process that will consider the outcome of such assessments;
- comply with a range of statutory responsibilities in communicating the outcome of each assessment to a range of defined parties;
- determine, following any recommendation of the best interests assessor, the length of the deprivation of liberty, the identification of a person's representative (as defined in the 'Deprivation of Liberty Safeguards'), and any conditions that should be imposed;
- ensure that there is an adequate service providing Independent Mental Capacity Advocates (IMCA), who have new additional duties under the safeguards; and
- ensure there is an adequate number of representatives to support those deprived of their liberty who have no family or friends
- develop adequate administrative arrangements established to ensure that reviews and renewals occur as required
- scope the number of cases that may need assessments. This will probably mean undertaking some preliminary research with local registered care homes, and hospitals. The Department of Health has

developed an implementation tool to assist with this task. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084204

There will need to be a close partnership between LSSAs and local NHS partners to ensure that there are sufficient best interests assessors and s12 doctors trained and available in sufficient numbers to meet local needs, which is potentially a significant issue in terms of workforce planning and implementation.

Training

The training for best interests assessors will be provided by or approved by certain Higher Education Institutions (HEIs) who are already approved by the GSCC to provide either adult or mental health social work post-qualifying training, and one-off development funds will be available to those HEIs that provide this training.

The training for mental health assessors will be available free on-line and via local training providers using a standard course of study that will be made available by the Royal College of Psychiatrists. Some one-off central government funding will be available to support the administration and delivery of face to face training.

IMCAs will be trained by a centrally coordinated and funded programme as a one off activity prior to implementation.

A summary of the Mental Capacity Act is available to download at http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityAct2005/DH_064735

The MCA Code of Practice is available at http://www.opsi.gov.uk/acts/acts2005/relatedukpgacop_20050009_en.pdf

Further background information on the Mental Capacity Act Deprivation of Liberty Safeguards is available, including a 'Frequently Asked Questions' document, at http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/

Annex A
Code of Practice: Guiding Principles

Chapter 1 of the code of practice provides the following set of guiding principles which should be considered when making decisions about a course of action under the Act.

Purpose principle

1.2 Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and wellbeing (mental and physical) of patients, promoting their recovery and protecting other people from harm.

Least restriction principle

1.3 People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty, having regard to the purpose for which the restrictions are imposed.

Respect principle

1.4 People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination.

Participation principle

1.5 Patients must be given the opportunity to be involved, as far as is practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other people who have an interest in the patient's welfare should be encouraged (unless there are particular reasons to the contrary) and their views taken seriously.

Effectiveness, efficiency and equity principle

1.6 People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken.

The code of practice gives the following guidance on the use of the principles:

Using the principles

1.7 All decisions must, of course, be lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998.

1.8 The principles inform decisions, they do not determine them. Although all the principles must inform every decision made under the Act, the weight given to each principle in reaching a particular decision will depend on the context.

1.9 That is not to say that in making a decision any of the principles should be disregarded. It is rather that the principles as a whole need to be balanced in different ways according to the particular circumstances of each individual decision.

Annex B
Transitional Arrangements for AMHPs

This guidance on transitional arrangements for AMHPs has been extracted from the guidance on all aspects of the transitional arrangements: *Implementation of the Mental Health Act 2007: Transitional Arrangements*, 31st July 2008, available on http://www.dh.gov.uk/publications

Decisions made by an ASW

Any decision or action taken by an ASW before 3rd November 2008 shall be treated as made or taken by an AMHP. This will ensure that such decisions made before 3rd November are still legally valid after that date. (Paragraphs 4 and 5 of the Schedule to Commencement Order No. 7 of the Act).

Approved Social workers

Individuals who are already approved as ASWs will be treated as if they are approved as AMHPs from 3rd November 2008 for as long as their ASW approval lasts. For example someone who is currently approved as an ASW until the end of January 2010 will automatically be treated as approved an AMHP until the end of January 2010. (Paragraphs 6 to 11 of the Schedule to the commencement order).

Suspension

Any ASW whose registration as a social worker is suspended on 3rd November 2008 will be treated as an AMHP whose approval is suspended for as long as the social work suspension lasts. If the suspension as a social worker is lifted the AMHP suspension should also be lifted.

Conditions

The approval of ASWs who are treated as AMHPs through transitional arrangements will be subject to the same conditions as the approval of new AMHPs. These conditions are set out in The Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008. LSSAs should make AMHPs aware of these conditions and ensure that processes are in place to record actions and activities. The conditions are that the AMHP must:

- undertake at least 18 hours of relevant annual training agreed with the LSSA that approves them;
- notify the LSSA if they agree to act on behalf of another LSSA (or if such an agreement ends);
- notify the LSSA if they are suspended from the register of social workers
- stop working as an AMHP and notify the LSSA if they cease to meet their professional requirements (that is cease to be registered as a social worker or as another professional eligible to be an AMHP).

Recording information

LSSAs will already hold records of ASWs and it should be a straightforward process to record their approval to act as AMHPs. There is a requirement to record the date of approval as an ASW and the date the approval expires. Additional information that should be recorded includes any suspensions or conditions that need to be met. LSSAs will also want to check if an AMHP is also treated as approved by another LSSA (for transitional arrangements only – see below).

ASWs approved by more than one LSSA

In general, AMHPs may only be approved by one LSSA in England although they may work of behalf of more than one.

There may be a number of ASWs who are currently approved by more than one LSSA. If so, they will be treated as approved as an AMHP by each separate authority through the transitional arrangements, unless or until:

- they ask one or more of those authorities to end their approval;
- they are formally re-approved by an LSSA as an AMHP at the end of their transitional approval, in which case that LSSA must inform the other LSSAs concerned who must end their transitional approval.

Although not a requirement, ASWs who are currently approved by more than one LSSA may wish to agree with the LSSAs that they will be approved by one only from 3rd November 2008 (or when practicable). This would simplify, for example, discussions around meeting requirements for annual update training and avoid duplication.

Annex C
Approved Mental Health Professional training & Preparation

This guidance has been developed by the AMHP Leads Network, together with ADASS, in line with guidance from the GSCC.

General Social Care Council Guidance

Background

Under the AMHP Regulations LSSAs can only approve professionals who have successfully completed AMHP training approved by the GSCC.

The GSCC has duties under Section 54 of the Care Standards Act 2000 to approve, monitor and inspect provision for social work education and training. Section 19 of the Act extends these to the approval of AMHP training. The GSCC approves AMHP training also on behalf of the Nursing and Midwifery Council (NMC), the Health Professions Council (HPC) and the British Psychological Society (BPS).

Selection and entry to approved AMHP training

To be eligible for entry to an AMHP training programme, candidates must:

(i) hold a recognised professional qualification in social work, nursing, occupational therapy or psychology and be a Registered Social Worker, nurse, occupational therapist or chartered psychologist;

(ii) demonstrate that they already have the level of professional competence, capacity and ability to undertake and complete an AMHP training programme at the PQ Higher Specialist Social Work Award level as recognised by the requirements set out in the GSCC PQ framework (see below).

(iii) be nominated by a local authority or other employer.

GSCC PQ framework

The required level of competency is described in the generic requirements of the framework in Post-qualifying framework for social work education and training (GSCC, 2005), and the core mental health specialist requirements and standards set out in Specialist standards and requirements for post-qualifying training social work education and training in mental health services (GSCC, 2007).

Admissions officers must ascertain whether an individual can provide convincing evidence of the kind of achievements that would indicate that they were able to undertake successfully and benefit from AMHP training programmes at the Higher Specialist level.

AMHP Leads Network and ADASS Guidance

The following guidance was developed to help employers to select appropriately skilled and experienced staff to under take AMHP training. It forms part of a longer briefing note from ADASS and the Leads Network due out later in the year.

Principles for selection for entry onto an AMHP course

(i) Experience of working with people with mental disorder.
(ii) Experience of working in a community setting.
(iii) A basic understanding of the key aspects of mental health law, mental capacity and consent, human rights, children and adults safeguarding, and of other relevant statutes, common law, codes of practice, and related guidance, policies and procedures.
(iv) A broad understanding of the social perspectives of mental disorder and the ability to view people holistically, taking account of social, physical, environmental and developmental factors.
(v) An understanding of the value base of the AMHP role, and the ability to work within it.

(vi) An ability to work assertively and constructively in a multidisciplinary context.
(vii) An ability (or potential) to make independent decisions.
(viii) The ability to work in an anti-racist, anti-oppressive and anti-discriminatory manner.
(ix) The ability to benefit from performing at a post-graduate level.
(x) The written endorsement from their operational manager, employee development and training section, and their employer as well as the LSSA that will approve them.

In addition to the above practitioners nominated for AMHP training ought to have working competence in:

(xi) The Ten Essential Shared Capabilities for professional practice.
(xii) The Mental Capacity Act Code of Practice Principles.
(xiii) The Mental Health Act Code of Practice Principles

The above principles were developed with support from AMHP training leads to help establish a national set of standards against which those needing to select appropriate candidates should make judgements. They should be used to influence the evidence that is requested at interview, and to judge individual 'readiness' for training.

The requirements for AMHP training are detailed in Section 3 of the specialist standards and requirements for post qualifying social work education and training: Social work in mental health (GSCC: 2007) available at http://www.gscc.org.uk/NR/rdonlyres/A3103CAA-C5D0-41B2-966C-17D24108F788/0/GSCC_MH_LR.pdf. Further information is available from GSCC, Social Work Education Group, Myson House, Railway Terrace, Rugby CV21 3HT, telephone 01788 532400

Developing Courses to support the access of different professionals into the AMHP training

In order to meet those requirements, staff from different professional backgrounds will have different learning needs, and new pathways will need to be established to support their development. This is because once on the AMHP course, all candidates need to work to demonstrate what are, in effect, social work values and practice.

A recent analysis of the different emphasis in the competences expected from nursing and OT's as opposed to social work trainees at the point of qualification identified the following:

1. **developing a social perspective:** The National Occupational Standards (NOS) for Social Work identify 21 units of competencies, to which nine of those units refer to *working with individuals, families, carers, groups and communities as well as the service user*, in various ways. There is more emphasis in Social Work practice to engage with carer's and families of Service Users and work in partnership. This is endorsed in The National Occupational Standards For Mental Health (NOSMH), *Working and Supporting individuals, carers and families* as well as The Ten Essential Shared Capabilities. User and Carer involvement is an integral part of social work practice and prominent in the revised PQ Framework. Social Workers are also trained to consider other issues contributing to mental illness such as abuse, discrimination and social and environmental factors.

2. **developing an understanding and ability to apply anti- discriminatory and anti – oppressive practice:** Social Workers are trained from a sociological perspective. An understanding and ability to apply ADP and AOP perspectives within a sociological view of the world is unique to Social Workers who, unlike Nurses and OT's, are the only Mental Health Professionals with Social Science Training (Crae et al 2005). That is not to say that other professionals do not consider these issues, rather than the emphasis within social work is probably more challenging and proactive at all levels and is based upon an understanding of the individual within their family, culture, local and national society.

3. **developing an understanding of legislations and it's requirements on services:** Each of the professions receive some training in legislation, i.e. Mental Health Act 1983, Children Act 1989/2004

and Human Rights Act 1998. However, it is expected that Mental Health Social Workers also have an extensive knowledge of other legislation such as Mental Capacity Act 2005, National Assistance Act 1948,The NHS and Community Care Act 1990, The Carers Act 1995/2004 and Safeguarding Vulnerable Groups Act 2006. Social Workers are expected to have access to and knowledge of local policies on Child Protection and Adult Protection procedures and have the skills to identify such vulnerable groups.

4. **developing advanced reflection and critical analysis skills:** Reflection and critical analysis are fundamental to Social Work practice, is embedded in pre qualifying and post qualifying programmes and is necessary to ensure continual professional development and good practice. Nurses and OT's do not appear to be expected to demonstrate 'reflection' as intensely as Social Workers.

Any training that is expected to include non – Social Workers therefore needs to help ensure people have access to development in these areas of practice.

Recommendations

1. That all staff interested in undertaking AMHP training should be able to provide evidence of competence against a standard set of competences.
2. An accredited course for 'pre-AMHP' training should include the ability to APEL in relevant experience, as long as ***evidence of competence*** in that area is also available.
3. that all staff should have 2 years post qualifying experience in a community setting, where they take individual responsibility for cases (even if they also work within a joint team)
4. that the competences should be based on those developed for the Social Work Consolidation Module in Mental Health and
5. Any courses developed that are intended to have a multidisciplinary intake should be able to evidence how they will support non-Social Workers to evidence competence in areas of experience not traditionally part of their role.

Annex D
Transitional Arrangements for Approved Clinicians

This guidance on transitional arrangements for ACs has been extracted from the guidance on all aspects of the transitional arrangements: *Implementation of the Mental Health Act 2007: Transitional Arrangements*, 31st July 2008, available on http://www.dh.gov.uk/publications

Decisions made prior to 3 November 2008 to be treated as decisions of approved clinicians

Decisions made by RMOs (and, in certain cases, other doctors) before 3 November are to be treated as though they had been made by an approved clinician (AC) and/or a responsible clinician (RC) – whichever is applicable. This will ensure that such decisions made before 3 November 2008 are still legally valid after that date. Details of where such decisions may have been made, and by whom, are set out in the commencement order.

Arrangements for treating some doctors as approved clinicians from 3 November

To ensure continuity of service provision for patients subject to the Act, Directions provide for the transitional approval of certain groups of doctors as ACs from 3 November. The following three groups of section 12 doctors will be approved as ACs from 3 November 2008 under the provisions of Part 3 of the Directions.

Group 1

Section 12 doctors who have carried out the functions of an RMO in the 12 month immediately prior to 3 November. For this group the following points should be noted:

- Approval as AC under the transitional arrangements will run until the end of the current section 12 approval. If this is less than 12 months after 3 November, then approval will last 12 months from 3 November.

Examples

A doctor from this group whose approval as a section 12 doctor runs until 31 July 2010 will be treated as approved as an AC until 31 July 2010.

A doctor from this group whose approval as a section 12 doctor runs until December 2008 will be treated as approved as an AC until 2 November 2009.

- A doctor does not have to have been working at consultant level as an RMO to be treated as an AC under these arrangements. ACs will normally be consultant level (as were RMOs) but there is no legal restriction on non-consultant doctors being ACs.
- Whether a doctor has acted as an RMO in the last 12 months will be a matter of fact. If at any time a doctor has carried out any duties that fell to an RMO under 1983 Act then they will have "carried out the function of an RMO". They do not need to have carried out the function for the whole 12 months – just at some time during the 12 months.
- Having acted as an RMO is a matter of fact for the individual. Even if an employer's policies set out that they should be prepared to undertake RMO duties as part of on-call duties, doctors who may have been on-call will only be treated as an AC for the purposes of these transitional arrangements if they have actually taken decisions that fall to an RMO at some point in the 12 months prior to 3 November 2008.
- After this period of transitional approval doctors in this group will need to apply for approval under the general approval arrangements (see paragraph 81). They will not have to undertake a course for the initial training of ACs to receive general approval as they will satisfy Direction 4(c)(ii) in being treated as approved as an AC (if this is within the 5 year period). They will, of course, have to met the other requirements of the general approval arrangements.

Group 2

Section 12 doctors who do not fall within group 1, but who have been in overall charge of the medical treatment for mental disorder of a person in the 12 months prior to 3 November.

It is envisaged that doctors from this group will mainly be psychiatrists working in community teams who have not had RMO responsibilities within the 12 months prior to 3 November (or ever). They may, however, need to be available to make decisions that fall to an AC (or RC), particularly for patients discharged onto Supervised Community Treatment. For this group the following points should be noted:

- Doctors in this group will be expected to complete a course for the initial training of approved clinicians in the first year after 3 November 2008. **If the course is completed** the doctor will be approved to be an AC under transitional arrangements for a further 2 years from 3 November 2009.

- After this further 2 years doctors in this group will need to apply for approval under the general approval arrangements. They will not have to complete a course for the initial training of ACs again. They will, of course, have to meet the other requirements of the general approval arrangements.

- **If the course is not completed** by 2 November 2009, approval will not be extended under the transitional provisions and will end on 2 November 2009. Doctors in this group who have not completed the training by 2 November 2009 will have to apply to the SHA to be approved as ACs through general approval arrangements (see paragraph 81). They will have to complete a course for the initial training of approved clinicians to be approved under general arrangements as they will not be treated as being an AC in this period. (Direction 14(b) applies)

Group 3

Section 12 doctors who do not fall within groups 1 or 2, but who have been appointed to the post of consultant psychiatrist within the period of 18 months ending on 2 November 2009 (that is 6 months before 3 November 2008 and 1 year after).

For this group the following points should be noted:

- Transitional approval will be until 2 November 2009.

- To gain further approval after this period of transitional approval doctors from this group will have to apply to the SHA to be approved as an AC through general approval arrangements. They will have to complete a course for the initial training of ACs to be approved under general arrangements as they will not be treated as being an AC in this period. (Direction 16(b) applies)

Suspension

Any doctor approved under Part 3 of the Directions who at, or after, approval is suspended by the General Medical Council (GMC) will be suspended from being approved as an AC for as long as the GMC suspension lasts. If the GMC suspension is lifted the AC suspension should also be lifted.

Section 12 approval

No changes have been made to provisions for section 12 doctors in the Act. All doctors who are approved as ACs under the transitional provisions in Part 3 of the Directions must also be section 12 approved. We understand that there may be a few doctors who may be otherwise eligible to be approved as an AC under these directions but who are not currently section12 approved. These individuals will not be able to be approved as ACs through these transitional arrangements unless they apply for and receive section 12 approval before 3rd November 2008. Individual doctors and organisations should be aware of this and take any necessary action to avoid disruption of patient care and service delivery.

Other doctors

Any doctor who does not meet the transitional arrangements in Part 3 of the Directions but wishes to be approved as an AC, will need to be approved by the relevant SHA under the general approval arrangements (Part 2 of the Directions).

Recording approved clinicians

SHAs will need to ensure that they have an up to date record of all ACs. All doctors approved as ACs under transitional arrangements in Part 3 of the Directions should from 3rd November

2008 be on SHA section 12 registers or lists (as all these doctors will be section 12 approved). However, it is important to emphasise that not all section 12 doctors will meet the criteria to be approved as ACs. SHAs will wish to ensure that their records are updated to add relevant details of individuals approved as ACs through the transitional arrangements, in particular the length of approval and the requirement for certain individuals (group 2. above) to undertake AC training in the first year. SHAs may wish to liaise with Mental Health Trusts, or any other providers who employ doctors with duties under the Act, to co-ordinate the collection of this information.

Trust Boards will need to ensure that the criteria within Directions have been applied to each of the medical practitioners who are being treated as ACs when the Act comes into force. To ensure this is the case, Boards will need to review each doctor's status and experience and decide whether the criteria are met. If the criteria are met then each name can be placed on the SHA's AC list. If the criteria are not met then arrangements need to be made for the individual practitioner to access appropriate training. Medical directors are likely to have a key role in this important process.

Annex E (1)
National Advisory Group for Approved Clinician Training Guidance

Guide to becoming an approved clinician

Introduction

This guidance has been produced by the National Advisory Group for Apporved Clinincisn (NAGACT). It is for applicants and approval panels. It outlines how applicants can achieve and demonstrate the competencies necessary to be approved as an approved clinician.

It covers non-medical applicants and medical applicants who are not on the Specialist Register for psychiatry. Doctors accreditation to the Specialist Register are considered to have demonstrated sufficient evidence of the competencies required to be an AC.

Initial approved clinician training

As well as being able to demonstrate they have the necessary competencies to be an AC, Directions require that all applicants must also have completed a course for the initial training of approved clinicians in the two years before seeking approval (see Annex F for suggested standards and content of initial AC training). This will be in addition to any preparatory training towards developing the competencies that is organised locally.

Identifying potential applicants for approval

Potential applicants for 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. Employers should actively identify such individuals and nominate them as potential applicants for approval as an AC.

Employers may wish to consider adopting a staged process to identifying and supporting potential applicants not on the Specialist Register, with the most experienced eligible non-medical professionals being identified in the initial stages to provide supervision for succeeding cohorts.

Nominating employers will need to:

- Make a commitment to the ongoing support of the potential applicant, including identifying the resources necessary during the period of development. Organisations may be asked to provide evidence that they have committed to supporting the individual appropriately.
- Agree to inform the approving panel of any issue that may affect the ACs competence or ability to carry out the role.

Developing and demonstrating the competencies

Annex E(2) provides guidance for potential applicants on how they may develop and demonstrate their existing skills and competencies to achieve the full range of competencies required for the AC role.

There is currently no nationally recommended training course that sets out to help potential candidates develop their competencies. There are underway some local initives to develop such training – for example, Northumberland Tyne and Wear NHS Trust are developing a programme of training and development for potential ACs.

Accreditation of competencies by professional bodies

There is currently no uniform process across the professional bodies that would allow for some form of pre-approval scrutiny of an applicant's portfolio. Establishing such a quality assurance process across the professional groups could take various forms. The aim would be to enhance the consistency of applicants' submissions and provide advice to SHA approval panels by considering the relevant weight of evidence subkmitted by applicants with regard to their prior skills, training and experience.

Developments could build on existing national professional structures (for example, the national assessors' panel of the British Psychological Society. Or local/regional pre-approval panels could be established comprising senior clinicians from adjoining trusts to consider the submissions and act in an advisory capacity to the SHA approval panels.

Further discussion on this matter will take place through NAGACT, in discussion with SHA as approving authorities, with a view to producing further guidance.

Submitting the portfolio

On completion of these development and training activities the employer should submit the applicant's portfolio to the approval panel.

The portfolio submitted to the approval panel should include:

- Documentary evidence of professional qualification.
- Documentary evidence of current registration with the appropriate registration body.
- Evidence to demonstrate competence – see below.
- Evidence of completion of initial training for the AC role within the last 2 years.
- Confirmation from the employer of their support for the applicant, and agreement to provide information to the panel on competency issues.
- Declaration by the applicant of agreement to comply with the conditions of approval required by regulation 6(1) of the AC Directions, that is:
  - notification if requirements of approval no longer met;
  - stopping work as an AC and notifying the approving authority if suspended; and
  - agreeing to any other condition that the approving authority thinks appropriate.

Evidence of competence

When applying for approval, applicants are required to demonstrate a comprehensive understanding of the role of the AC, including the role of the responsible clinician, legal responsibilities and key functions.

Applicants may draw on a range of evidence to demonstrate competence but as a minimum they should provide:

- A summary of their experience as relevant to the role of AC.
- A minimum of two anonymised case reports relating to their involvement in the care of a detained patient. The hypothetical case report (an actual report will not be possible until they are approved) prepared by the applicant should be appended to, and provide an explanatory commentary on, a statutory report (eg. for MHRT; Section renewal). The case report should include and reflect upon the key areas of competence: Mental Health legislation and policy; assessment; treatment; care planning; leadership and multi disciplinary working; treatment; equality and diversity; and should show an appreciation of the principles of the Code of Practice.
- Two testimonies from suitably qualified professionals in a senior role that can validate the applicant's aptitude for the AC role. One of these should be from a different profession from the applicant.
- A 360 degree appraisal that may include user or carer feedback and should include the applicant's immediate line manager/ supervisor, and multi-disciplinary team colleagues.

Annex E (2)

National Advisory Group for Approved Clinician Training Guidance

Specific required competencies, their attainment and sources of evidence

This guidance has been produced by the National Advisory Group for Approved Clinicians (NAGACT). It is intended to be neither exhaustive not prescriptive but aims to aid applicants, employers and approval panels in considering how potential applicant might acquire and demonstrate the competencies required for approval as AC.

In the tables below, examples of possible existing skills, knowledge and experience of the required competencies are above the midline: and those that may need to be acquired are beneath. It is not suggested all of the examples of evidence will be needed to to demonstrate competence. This will, of course, vary for each individual.

1. The role of the approved clinician and responsible clinician

A comprehensive understanding of the role, legal responsibilities and key functions of the approved clinician and the responsible clinician.

HOW ACQUIRED	EVIDENCE
Existing professional skills, knowledge and experience	• Professional qualification • Curriculum vitae (CV) including, e.g. publications, committee work • Continued Professional Development (CPD) logs • Specific experience and training • Anonymised reports; documents
Shadowing AC/RC/AMHP Suitable coursework, Seminars, teaching. Learning set membership Specific training	• Certificate • Testimonial/log • Certificate & CPD approved by profession • Reflective log/journal • Certificate • 360 degree assessment

This is an overarching competence. The AC and RC competencies will build on existing professional competencies. Additional skills, knowledge and experience should be acquired, where these are lacking, to demostrate the full range of AC/RC competencies.

2. Legal and Policy Framework

(a) Applied knowledge of the Mental Health Act 1983, related Codes of Practice and national and local policy and guidelines

HOW ACQUIRED	EVIDENCE
Existing knowledge	• CV • CPD log
Training by appropriate provider (Law school, accredited body)	• Certificate
Shadowing AC/RC/AMHP	• Anonymised statutory reports based on supervised practice/ shadowing

(b) Applied knowledge of other relevant legislation, codes of practice, national and local policy guidance, in particular, relevant parts of the Human Rights Act 1998, the Mental Capacity Act 2005, and the Children Acts.

HOW ACQUIRED	EVIDENCE
Existing knowledge	• CV • CPD log
Training by appropriate provider (Law school, accredited body)	• Certificate
Shadowing	• Anonymised reports

(c) Applied knowledge of relevant guidance issued by the National Institute for Health and Clinical Excellence (NICE).

HOW ACQUIRED	EVIDENCE
Knowledge of evidence-based practice relevant to likely patient group (AMH, LD, CAMS, Autism, PD, OP) about whom decisions will be made.	• CPD • Learning set work • Evidenced knowledge of - professional guidelines - NICE - National Service Frameworks - policies

In the above paragraph "relevant" means relevant to the decisions likely to be taken by an approved clinician or responsible clinician. Where national or professional guidance is not available the applicant should use other evidence-based sources relevant to the patient group likely to be subject to their decisions.

The applied component should be underpinned by shadowing RMO/AC/RC and ASW/AMHP and by evidenced reflective practice in learning sets.

3. Assessment

Demonstrated ability to:

a. identify the presence of mental disorder;
b. identify the severity of the disorder; and
c. determine whether the disorder is of the kind or degree warranting compulsory confinement.

HOW ACQUIRED	EVIDENCE
Professional training and experience	• Training curriculum • Professional body accreditation of these specific competencies • Job Description (JD) • CV • Statutory report and a linked case report • Relevant publications by applicant
Specific training (e.g. assessment tools for different patient groups)	• Certificate • CPD log

Whilst the relative seniority of many applicants should ensure a high degree of existing competency in assessment, evidence of shadowing of RMO/AC/RC and ASW/AMHP is vital to demonstrate especially c. above. This evidence should also be demonstrated in reflective learning set logs/journal.

Workshops on mental health assessements preparatory to detention with practicing RMOs/ACs/RCs and ASWs/AMHPs is recommended.

3.2 Ability to assess all levels of clinical risk, including risks to the safety of the patient and others within an evidence-based framework for risk assessment and management.

HOW ACQUIRED	EVIDENCE
Professional training and experience	• Professional body accreditation • CV • CPD • JD
Training in relevant risk assessment and management tools and processes.	• Certificate • Anonymised reports; care plans. • Learning set logs • Application of formal risk management tools

3.3 Demonstrated ability to undertake mental health assessments incorporating biological, psychological, cultural and social perspectives.

HOW ACQUIRED	EVIDENCE
Professional training and experience	• Professional body accreditation • CV • CPD • JD
Shadowing AC/RC/AMPH	• Testimonial; reflective log/journal • Evidence of MHA assessment involvement/ case reports

All the above evidence should be relevant to the patient group/s the applicant is likely to be making decisions about.

4. Treatment

Understanding of:
(a) mental health related treatments, i.e. physical, psychological and social interventions;

HOW ACQUIRED	EVIDENCE
Professional training and experience	• Professional body accreditation • CV • CPD • JD
Commissioned didactic/seminar courses in areas of identified knowledge – need (e.g. ECT, psychopharmacology, psycho-surgery)	• Certificate of attendance • CPD log

(b) An understanding of different treatment approaches and their applicability to different patients.

HOW ACQUIRED	EVIDENCE
As above	As above • Reports and care plans

Applicants can be expected to have an existing competency base at least in non-medical areas of treatment.

The CPD and specific training will be pertinent to professions, for example nurse applicants may be registered on non-medical prescribing courses.

4.2 Demonstrated high level of skill in determining whether a patient has capacity to consent to treatment.

HOW ACQUIRED	EVIDENCE
Professional training and experience	• Professional body accreditation • CV • CPD • JD
Workshops on MCA; consent to treatment	• Certificate • Awareness of professional guidelines

4.3 Ability to formulate, review appropriately and lead on treatment for which the clinician is appropriately qualified in the context of a multi-disciplinary team.

HOW ACQUIRED	EVIDENCE
Professional training and experience	• JD • Reports/care plans • Testimonial, Multi-disciplinary team (MDT) • 360 degree appraisal

4.4 Ability to communicate clearly the aims of the treatment, to patients, carers and the team.

HOW ACQUIRED	EVIDENCE
Professional training and experience	• JD • Professional body accreditation • 360 degree appraisal

5. Care Planning

5.1 Demonstrated ability to manage and develop care plans which combine health, social services, and other resources, ideally, but not essentially, within the context of the Care Programme Approach.

HOW ACQUIRED	EVIDENCE
Professional experience Undertaking care co-ordination	• JD: CV; CPD • Anonymised care plan/ service specification reports
Attendance at CPA case reviews Shadowing RC Appropriate workshops/training	• Job plan – certified • Evidence of contribution to a care plan • As before • Certificate

6. Leadership and Multi-Disciplinary Team Working

6.1 Ability to effectively lead a multi-disciplinary team.

HOW ACQUIRED	EVIDENCE
Professional and experience	• CV; JD
Leadership training Team-work training	• certificate • certificate • 360 degree appraisal

6.2 Ability to assimilate the (potentially diverse) views and opinions of other professionals, patients and carers, whilst maintaining an independent view.

HOW ACQUIRED	EVIDENCE
Professional training and experience	• CV; JD: CPD • Anonymised care plans • 360 degree appraisal

6.3 Ability to manage and take responsibility for making decisions in complex cases without the need to refer to supervision in each individual case.

HOW ACQUIRED	EVIDENCE
Professional training and experience	• CV; JD: CPD • Anonymised care plans • 360 degree appraisal

6.4 Understands and recognises the limits of their own skills and recognises when to seek other professional views to inform a decision.

HOW ACQUIRED	EVIDENCE
Via supervision and reflective practice	• Evidence of clinical supervision • 360 degree appraisal

7. Equality and Cultural Diversity

7.1 Up to date knowledge and understanding of equality issues, including those concerning race, disability, sexual orientation and gender.

HOW ACQUIRED	EVIDENCE
Knowledge of policy and legislation	• Attendance at appropriate courses - manager's training - commissioned (law school)

7.2 Ability to identify, challenge, and where possible redress discrimination and inequality in all its forms in relation to approved clinician practice.

7.3 Understands the need to sensitively and actively promote equality and diversity.

7.4 Understanding of how cultural factors and personal values can affect practitioners' judgments and decisions in the application of mental health legislation and policy.

HOW ACQUIRED	EVIDENCE
Values-based practice of legal knowledge	• JD • Annual job appraisal process • 360 degree appraisal • Practice supervision records • Anonymised correspondence and reports/plans

Reflective learning set activities should reflect this area. Evidence of policyies and models dwarn on should be specific to patient group (e.g. Valuing people, normalisation with LD).

8. Communication

8.1 Ability to communicate effectively with professionals, patients, carers and others, particularly in relation to decisions taken and the underlying reasons for these.

HOW ACQUIRED	EVIDENCE
Professional training and experience	• JD • 360 degree appraisal

8.2 Ability to keep appropriate records and an awareness of the legal requirements with respect to record keeping.

HOW ACQUIRED	EVIDENCE
Knowledge of law and policy	• CPD log

8.3 Demonstrates an understanding of and has the ability to manage the competing requirements of confidentiality and effective information sharing to the benefit of the patient and other stakeholders.

HOW ACQUIRED	EVIDENCE
Professional training and experience	• JD • Professional requirements • Knowledge of Trust policy • Reports/ care plans/ recorded entries to notes

8.4 Ability to compile and complete statutory documentation and to provide written reports as required of an approved clinician.

HOW ACQUIRED	EVIDENCE
Professional experience Formal AC training Shadowing AC//RC/AMHP	• Anonymised reports • Certificate • Testimonial/log

8.5 Ability to present evidence to courts and tribunals.

HOW ACQUIRED	EVIDENCE
Professional experience	• CV • Anonymised reports
Specialist course attendance (MHRTs; court work) Shadowing	• Certificate • Testimonial/log

Apart from 8.3 – 8.5 the seniority of most eligible applicants should ensure competency.

Annex F
Conflicts of Interest

AMHPs may not make an application for admission to hospital or for Guardianship if they have a potential conflict of interest as defined in the Mental Health (Conflicts of Interest) (England) Regulations 2008 and described below. An application made by an AMHP who had a potential conflict of interest would mean that patient's detention was not legal.

Similarly, doctors may not give a medical recommendation either for admission or for guardianship if they have a potential conflict of interest, as described below. An application that relied on a recommendation made by a doctor who had a potential conflict of interest would also be invalid.

The Act recognises situations that could give rise to a conflict of interest for an AMHP when making an application for the admission of a patient to hospital for assessment under section 11 (1) of the Mental Health Act 1983, or for a doctor making a medical recommendation for the purposes of making an application to admit a patient to hospital for treatment under section 12 (1) of the Mental Health Act 1983.

These are in 4 categories:

- Financial
- Business
- Personal relationships
- Other

Employers must be aware of these to avoid placing employees in a situation where they could be considered to be in a conflict of interest. Details of these conflicts of interest are clearly laid out in the Mental Health (Conflicts of Interest) (England) Regulations 2008.
http://www.opsi.gov.uk/si/si2008/uksi_20081205_en_1

Financial conflicts

These mainly arise when a professional making an assessment of a patient could benefit financially if they chose to recommend admission for a patient, whether by a payment for the actual admission to a particular establishment or by benefitting from the ongoing maintenance of the patient.

This clearly would not apply to the situation of a medical practitioner being paid a fee for undertaking a medical examination or to an AMHP who is paid a fee for making an assessment, as that fee would be paid irrespective of the outcome of the examination or decision, i.e. whether or not admission was applied for or recommended.

Business

This applies when the AMHP works under the immediate direction of or is closely involved in the same business venture as either of the doctors, or the nearest relative. In the case of the medical practitioner, it would apply if he was employed by, works under or is closely involved in a business venture with the other doctor making the recommendation, or the person making the application who could of course be either the AMHP or the nearest relative.

This means that it would be advisable that those involved in making applications or recommendation for admissions to hospitals were required to declare any relevant business interests, such as being the member of a Board of a particular hospital, so that employers are aware of possible conflicts of interest.

Personal Relationships

The relationships which would cause a conflict of interest for professional involved in assessments of applications for admission are laid out in the Regulations, and cover cousins, aunts, etc as well as immediate family, and a person with whom the assessor is living as though they were a spouse.

It should be noted that they also extend to former relatives, i.e. former spouses, as well as current relatives, and that they also include relationships of adoption and step-relationships. "In-law" relationships are regarded to include relationships based on civil partnerships as well as marriage,

but do not include relationships based on people living together as if they were married or in a civil partnership.

Other

Conflicts could arise in other circumstance, as laid down in the Regulations, including when the AMHP is a member of the same team organised to work together for clinical purposes on a routine basis with both the doctors making the recommendations on which the application is based, or when the doctor is in the same team as the other doctor and the AMHP.

Also, there is a conflict if the doctor is on the staff of an independent hospital to which the patient is to be admitted on the basis of the application and so is the other doctor making a recommendation.

For the above situations, there are exceptions for urgent cases – see below.

Independent hospital managers should note that no two doctors on their staff may make a recommendation in support of an application for admission to that hospital.

All hospital managers should note that the professionals involved in an application may not all be in the same clinical team (as described above).

Urgent Cases

The rules on not all the assessors being part of the same clinical team do not apply if there would otherwise be delay involving serious risk to the health or safety of the patient or others.

However, even in such urgent cases, two doctors on the staff of the same independent hospital may not make a recommendation for admission to that hospital.

Annex G

National Advisory Group for Approved Clinicians Guidance

Introduction

It is for individual SHAs to determine what initial training they require ACs to undertake to be approved.

This guidance has been developed by NAGACT to support SHA approving authorities in the development of courses for the initial training of ACs. It suggests standards and course content. SHAs may wish to consider this guidance together as a national group to agree common standards and approaches to AC initial training.

Directions set out that the course for the initial training of approved clinicians must be completed within the two years prior to seeking approval.

Approved Clinician Training Course Standards

Course Approval

Approved Clinician training courses should be approved on a regional basis. SHA may wish to establish a regional AC training course panel to do this. It would be good practice for this training, once approved by one regional panel, to be offered and recognised anywhere in England. The panel should issue certificates confirming completion of approved training as evidence for SHA/PCT approval panels.

Target Audience

The AC initial training will be developed for a multi-disciplinary audience comprising of:

- Medical staff: psychiatrists (including those within one year of achieving their Certificate of Completed Training (CCT).
- Non-medical staff: all other eligible mental health care professionals who meet the AC criteria and are able to demonstrate that they have the necessary competencies.

Length

The AC initial training will be a two day attended programme with recommended pre-course reading.

Doctors who will also acquire s12 approval as a consequence of their AC approval will also be expected by AC approval panels to attend a separate s12 one-day training course.

Teaching Team

The teaching team should be multi-disciplinary including, where possible, input from: psychiatrists; psychologists; nurses; occupational therapists; social workers; lawyers and service users and carers.

Content

Guidance on the Standard Content for the Approved Clinician Training Course is set out below.

Course Evaluation

Course providers should be required to ensure that each course is fully evaluated by the delegates who attend. The analysis of the evaluations will be compiled by the course provider and should be submitted to any regional AC training course panel and will inform the panel's quality assurance process.

Guidance on the Standard Content of an AC Initial Training Course

The Training Courses will adopt a variety of teaching and learning methodologies:

- Prepared reading
- Presentations
- Case scenarios / vignettes
- Quizzes
- Large group discussion
- Small group discussion
- Feedback

Presentations are recommended on the following key topics:

The Legal Framework: Mental Health Law
- Mental Health Act
- Mental Capacity Act
- Introduction to Deprivation of Liberty Safeguards
- Human Rights Act

Capacity and consent
Grounds for detention

The Clinical Team: roles and responsibilities
- Approved Clinician / Responsible Clinician
- Doctor
- Nurse
- AMHP

The Partners in Care:
- Service user
- Carer

Nearest relatives, IMHAs and IMCAs
Mental Health Review Tribunals (MHRT) and Managers Hearing
Supervised Community Treatment
Guardianship

Other topics include:

Part 3
Documentation
Responsibilities in relation to Section 136
Moral, ethical and legal dilemmas
Children and young people
Learning disability, autism and personality disorder
Role in relation to SOAD
Advocacy
Report writing

Course materials

Courses should include the following materials as a minimum:
Recommended pre-course reading list
Presentation hand-outs
Case vignettes
Samples of relevant forms / documentation
Evaluation forms

Glossary
of acronyms and abbreviations

AMHP	Approved Mental Health Professional (2007 Act)
AOT	Assertive Outreach Team
AWOL	Absent Without Leave
BME	Black and Minority Ethnic
C C-O	Care Co-ordinator
CoP	Code of Practice
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CTO	Community Treatment Order
ECHR	European Convention on Human Rights
ECT	Electro Convulsive Therapy
GP	General Practitioner
IMHA	Independent Mental Health Advocate
LSSA	Local Social Services Authority
MCA	Mental Capacity Act
MHA	Mental Health Act
MDT	Multi-Disciplinary Team
NIMHE	National Institute for Mental Health in England
OT	Occupational Therapy/Therapist
PCT	Primary Care Trust
RC	Responsible Clinician
RMO	Responsible Medical Officer (old terminology)
s	Section of an Act
SHA	Strategic Health Authority
SCT	Supervised Community Treatment
SOAD	Second Opinion Appointed Doctor
STR	Support, Time and Recovery Worker
Tribunal	Mental Health Review Tribunal

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