# Approved / Responsible Clinician Roles: Exploring the Gap for Occupational Therapy.

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## Abstract

Changes to the Mental Health Act (MHA) in 2007 enabled non-medics to undertake Approved Clinician / Responsible Clinician (AC/RC) roles. Occupational Therapy is the only Allied Health Profession (AHP) identified in the multi-professional roles able to undertake this opportunity. Nationally uptake has remined low, with one Occupational Therapist in England working in this role. This report contributes new information about the perspectives of Occupational Therapists, primarily in the South East and builds on findings from Billings 2020.

## Background

“An **Approved Clinician (AC)** is “a person approved by the appropriate national authority to act as an approved clinician for the purposes of the Mental Health Act”

**Responsible Clinician** (RC) is the ‘Approved Clinician who has overall responsibility for a patient’s case’*.* In simple terms, Responsible Clinicians are ‘recruited’ from a pool of Approved Clinicians”.

**HEE 20203**

“An RC can grant and revoke section 17 leave; renew detention; initiate holding powers; discharge from detention; discharge onto community treatment orders (CTOs); extend, revoke and discharge CTOs; and oversee Guardianship Orders”.p52

**Oates et al 2018**

Multi-Professional Approved Clinicians (MPAC):

The Mental Health Act 1983 provides the legal framework in England & Wales which underpins the compulsory assessment, treatment, and rights of a person with a mental disorder of a nature or degree which warrants urgent intervention to protect the health or safety of the individual or others. In 2007 it was reviewed to expand who could implement aspects of the Act – mental health professionals working as Social Workers, Psychologists, Learning Disability & Mental Health Nurses and Occupational Therapists were now eligible to undertake training and gain approval from the appropriate national authority to be an Approved Clinician. This decision recognised eligibility based on competency rather than profession and the value of a broader range of approaches to better meet the treatment needs of a service user.

Benefits of Multi-Professional Approved Clinician Roles:

Within the reform the duty of Hospital Managers includes the allocation of an Approved Clinician with ‘appropriate expertise to meet the service user's main assessment and treatment needs’ (Department of Health, 2015a, para 36.3). Whilst “’medical treatment’ is defined as including nursing, psychological and specialist mental health habilitation, rehabilitation and care” (Code of Practice, 2015, p. 24.3). Thus, for many people who access services, a psychologically enhanced and / or increased focus on functional aspects of living, may align better with the approach of a multi-professional (non-medical) RC. Two surveys of Multi-professional Approved Clinicians (Ebrahim 2018 & Oates et al 2018) found a recurring theme that they felt they “offer service users a different approach to the statutory relationship under the MHA than they may have had previously with medical ACs”p56. Study participants also cited greater ability to influence the therapeutic focus of the team, enhanced clinical leadership and ability to change culture.

 **Eight Competency areas of the Multi-professional AC Framework** (from HEE 2020)

* Comprehensive understanding of the AC role, legal responsibilities and key functions of the AC and RC role
* Applied knowledge of legal and policy framework/codes of practice/ NICE guidelines
* Assessment
* Treatment
* Care Planning
* Clinical Leadership & MDT working
* Equality and Diversity
* Communication

**HEE 2020 3**

The case for the economic value of these roles is growing in grey literature (Wainwright 2018) and the HEE 2020 report ‘Multi-Professional Approved/ Responsible Clinician: Implementation Guide’ summarises results from four pilot studies, which although not statistically reliable indicate some positive improvements in Key Performance Indicators such as reduced length of hospital stay in Multi-professional Approved Clinicians roles.

All three studies reference the benefits which Multi-professional Approved Clinicians identify in terms of offering senior clinical developmental opportunities. This is confirmed in Thompson-Boy’s view (as the only AC/RC Occupational Therapist working in England) that the role enables Occupational Therapists to work in “high profile clinical leadership roles and contribute to a shift in organisational culture” (2019, p10).

Challenges for Multi-Professional Approved Clinician Roles:

With the NHS Long-Term Plan (2019), greater emphasis on the need to widen the roles and extend the upper capabilities of NHS staff in order to meet future population need was highlighted. In mental health the shortage of psychiatrists and imminent retirement bulge for the workforce amplifies this need. In response the 2019/2020 Health Education England Mandate included:

‘supporting the delivery and expansion of innovative, recently created roles in mental health by implementation of agreed priority work streams which have been identified as having the greatest impact in mental health services in transforming the workforce.’p2.

By July 2019 just 63 Multi-professional Approved Clinicians were in role – the majority being psychologists and only one an AHP (HEE 20202). Exploring the views of those who had taken the opportunity, Oates et al 2018 & Ebrahim 2018 identified barriers including: 1) the training process (lack of time, ambiguity about the portfolio process, 2) difficulty accessing mentoring and exposure to breadth of cases to develop the relevant competencies and 3) workforce infrastructure issues such as remuneration, indemnity, redeployment and 4) in several cases lack of organisational support in particular from psychiatry colleagues.

In response the HEE 2020 2 Implementation Guide collates emerging evidence, provides examples with advantages and disadvantages of different organisational implementation strategies and individual case studies highlighting a range of clinical areas and personal experiences of the role. HEE have provided focussed support with funding for individuals, developing workforce infrastructure with organisations and established an Approved Clinician Collaborative in order to support this work.

The British Psychological Society (BPS) has extended their support to multi-professional aspirant and current AC/RCs. It holds a Forum register of Approved Clinicians; offers a regional multi-disciplinary peer review panel prior to submission of the portfolio plus regular Continuing Professional Development & legal updates. Other Professional Bodies are broadly supportive and offer personalised advice rather than providing specific guidance. HCPC has issued guidance about the professional expectations of those undertaking Approved Mental Health Professional (AMHP) roles.

The uptake of AC/RC roles by Occupational Therapists specifically was explored by Billings 2020 in an AHP Career Pathways HEE Trailblazer project. The report included exploration of readiness to undertake Multi-professional Approved Clinician and Approved Mental Health Professional (AMHP) roles as part of developing the upper career pathway of Allied Health Professions in mental health. Findings included limited exposure to Mental Health Act training as undergraduates and post registration, a perception of having less opportunity to develop into senior roles (compared to nurse colleagues), stereotypes about AHPs which hindered progression and a series of workforce readiness recommendations were made.

Billings (2020) identified the following misconceptions:

• AHPs will want to see people for a long time and cannot work at pace

• AHPs often hold back and don’t volunteer for opportunities or their opinions

• AHPs are not experienced at risk assessments.

The HEE South East Mental Health Programme 2020-21 identified a focus on increasing multi-professional uptake of AC/RC roles as part of redesigning how services meet the needs of local populations. The first intake of HEE supported-funding for Multi-professional Approved Clinicians in the South East did not generate uptake by an Occupational Therapist. Given the national profile of Occupational Therapists in this role it might be assumed that this role is not an attractive career choice for this profession. In response, this report explores the views of Occupational Therapists in the South East and makes a series of recommendations towards next steps.

## Approach

The above approaches were combined in order to inform this report.

Given the absence of Occupational Therapist Approved Clinicians in the region and the gap in literature exploring this, the report set out to explore roles which could be viewed as aligning to the Approved Clinician in order to explore if this could offer new insight. Identified aligned roles were the Approved Mental Health Professional (AMPH) and Best Interest Assessor (BIA). Whilst there are limitations in this analogy, both roles have statutory power to exercise functions of the Mental Health Act and/or Mental Capacity Act and require Level 7 education (equivalent to Masters level). Therefore these roles were considered to offer commonality in the core role and clinical reasoning, potentially offering a progression route to Approved Clinician and therefore worthy of exploration. Both AMPH and BIA roles may be considered to offer direct challenge to the misconceptions highlighted in the Billings 2020 report.

## Findings

### Eligibility in the South East

An AC/RC is required to be ‘a senior professional, sufficiently experienced to capably, and with authority, exercise the autonomous decision making required of an Approved Clinician’ (HEE 20202). Assurance that the required level of competence is achieved is via the portfolio and panel review process.

In order to consider the current state of readiness of the Occupational Therapy workforce in the South East a loose criteria for ‘senior professional’ was sought. Interviews plus a review of the literature indicated that the beginning of a career progression to AC/RC journey might begin at Band 7 or equivalent, with progression into the role at Band 8B/C and above. The BPS have recommended:

“Given the competencies and experience required, the BPS recommends that only consultant psychologists (bandings 8c and above) are considered by employers as potential candidates for AC approval (BPS, 2009, p. 5). Deployment as an RC requires a very high level of autonomous decision-making and indeed authority. Preparation can however take a number of years and it may well be that a career development pathway will encompass the acquisition of competencies for the AC role from much earlier than consultant level”.p5

It is useful to note that the Advanced Practice Mental Health competencies exclude an expectation of AC / RC at the Advanced Practice level. “Please note that the capabilities required to undertake the role of the Responsible Clinician sit outside this Framework”p7 HEE 20201.

The South East Electronic Staff Record identified 41 Band 8a and above Occupational Therapists employed in mental health & learning disability NHS Trusts in the South East in November 2020 (Figure1). This number excludes Acute Trusts, independents and Local Authority employed Occupational Therapists. Whilst the data has not been triangulated and may include limitations in accuracy it offers an acceptable overview of senior leadership in the profession. Only a proportion of this number will meet the criteria of being a ‘mental health professional’. For the most senior roles, 8c and above - the grade recommended to be the starting point for Multi-professional Approved Clinicians roles by the British Psychological Society - this number drops to 13 for the region. It is noted that the majority of these roles will focus on senior operational and strategic responsibilities, with reduced capacity for clinical intervention.

Figure 1. Senior Occupational Therapy Roles in South East Region.

### Level of Interest:

In February a survey of Occupational Therapists in the South East was completed by 52 respondents. An explanation of the AC/RC role was provided and a series of questions about awareness and interest posed. Respondents included health and local authority employed Occupational Therapists working with people across a range of age groups, mental health & learning disability services. Three-quarters of respondents were aware that Occupational Therapists could train to become an Approved Clinician.

47% of all respondents were very interested or wanted to know more about this role, with more than 50% in most grades interested (slightly lower in Band 7s at 35%). (Figure 2).

88% of respondents felt increasing multi-professional ACs would benefit service users , services (87%) and professionals (79%). (Figure 3)

Figure 2: Interest in the Approved Clinician role by Current Grade

Figure 3: Perceived Benefit of the Approved Clinician role

Respondents were asked if they prefer to work in an AC/RC or AMHP role. 41% indicated Approved Clinician, with reasons including “I enjoy planning care”; “this is closer to my role”.

35% indicated Other, with requiring more information about the roles being the most frequently given reason. Figure 4.

Figure 4: Hypothetical Career Choice

Answers provided in the free text of the survey and discussions in the focus groups and individual interviews were collated and highlighted common themes. Findings are presented in order from highest to lowest frequency of survey response (the number of participants citing each is given in brackets). Detail from the focus group and interviews is combined in order to provide anonymity and is added in the relevant sections.

### Perceived Barriers:

Absence of Information (33**).** The most consistently cited barrier to Occupational Therapists becoming Approved Clinicians was the absence of information about these roles. Respondents identified they had not heard about it via their registration nor in role since. They cited a lack of role models as Approved Clinicians or in senior clinical roles. They perceived a gap in awareness raising to promote the possibility or value of the role (to them as professionals or to service users) and that language had not been altered to reflect changes in opportunities (ie ‘doctor’ used interchangeably with Approved Clinician). The absence of position statement on the AC/RC role from the Royal College of Occupational Therapy (RCOT) as the Professional Body was noted.

Limited Career Pathway (21). A perceived ceiling limiting clinical development as an Occupational Therapist at Band 7 (or equivalent) was repeated across the survey, focus group and interviews. Role progression was felt to be diverted into management or away from clinical positions. Inequity in comparison with other professions (Psychology, Social Work, Speech & Language Therapy and Art Therapy were cited) as having more senior roles, opportunities and status, with stifled progression for Occupational Therapy in some settings. An absence of career pathway or potential routes to other roles was described. Several cited a lack of investment in services which prevented a more creative vision, capped the number of senior roles and restricted time available to undertake training or develop additional roles. Several answers indicated an assumption that Occupational Therapists in this role would be lower paid than colleagues from other professions.

**Insufficient Training & Support (18).** Respondents noted that their own pre-registration training, and that of their students, did not prepare them for an in-depth understanding of the Mental Health Act or the potential for Approved Clinician or Approved Mental Health Professional roles. Post registration, opportunities to train in related areas were felt to be limited. On reflection, participants identified that availability may be less of a barrier than managers’ limited awareness of Occupational Therapist eligibility or interest. This translated into a lack of exploration in supervision and progression reviews. Within the interviews and focus groups participants noted that their progression in to the roles they had was opportunistic rather than part of a planned career plan. A number of practical challenges in accessing training (or time to attend) across Local Authority / Health employers or work setting were cited.

**Perceived Conflict of Values (13).** Survey respondents identified the Approved Clinician role may be perceived as ‘too medical’, a clash with or moving away from Occupational Therapy values for example ‘restricting someone’. Focus group participants and interviewees recognised this as the most common misconception and felt their experience did not reflect this.

**Perceived Low Support from other professions (9).** Respondents felt that ‘traditional’ roles, medically-led decision making and lack of understanding of Occupational Therapists’ potential in this space could contribute to a lack of awareness / low support for this role. Potential challenges in accessing supervision whilst undertaking Approved Clinician training or shadowing in preparation prior to this were noted.

**Limitation in Occupational Therapy Skill (4).** The inability of Occupational Therapists to prescribe was highlighted as a potential barrier. One person felt that the level of risk to manage might be off-putting to Occupational Therapists.

**Infrastructure Challenges.** Within the interviews and focus group more detailed feedback identified pragmatic challenges divisions between Local Authority and the NHS employment. Whilst there might be shared need in terms of serving overlapping populations and aspects of training, the focus group attendees (representing four different Integrated Care Systems across England) felt that awareness of training opportunities and career progression were considered within employing organisations (only 1 of the 4 members were aware of the option to train as an Approved Clinician). Transition between employers led to different employment conditions (loss of leave / reductions in salary). Whilst working across both organisations on a rota basis entailed some challenge in terms of host employer priorities, being released for training and a subsequent reduction in the number of health employed BIA / AMHPs retained in roles.

The need for employer organisations to ensure access to skills and aspects of the Approved Clinician role which a Multi professional cant undertake was noted as a resolvable challenge and reliant upon positive relationships between ACs (for example recommendation for Section 3, prescribing).

### Perceived Facilitators:

Possible facilitators to encourage Occupational Therapists to become Approved Clinicians grouped into three themes.

**Increase Awareness about Opportunity & Value (28).** Answers ranged from practical detail about the process to become an Approved Clinician and level of pay, to broader awareness raising. In particular hearing from a person working in this role, understanding the added value of an Occupational Therapist and how this might benefit a service user and their family were most frequently highlighted. Much of the focus group and interview discussion focussed here and is included below.

**Organisational Structure and Career Pathway (25).** Recommendations to create a career pathway which eases ‘the great leap’ required to become an Approved Clinician and raises expectation and possibility of senior clinical roles being undertaken by Occupational Therapists were frequently repeated. Respondents highlighted the need to increase resource in order that the fundamentals of Occupational Therapy provision is retained in addition to these senior roles (rather than instead of). The raising of the status and aspiration of Occupational Therapists was linked to this development.

**Training & Support (25).** Increased education and exposure to these roles for students, their educators, current Occupational Therapists and their managers was consistently highlighted. Suggestions of clinical placements, opportunities to shadow tribunals, AMPHs and RCs, plus use of appropriate e-learning modules (relating to AMHP roles) were made. Organisational awareness and support of multi-professional access to training and opportunities across Local Authority, NHS and work setting were noted.

### Experience of Occupational Therapists in Roles with MHA & MCA at the core

**Approved Clinician**

At interview the one Occupational Therapist Approved Clinician was clear about the ‘fit’ between her Occupational Therapy skills and Responsible Clinician responsibilities. Her strengths in rehabilitation, enhancing social connectedness, routine and identity were more closely aligned with the recovery of many – perhaps more so than factors such as medication management. From a shared case study the following highlights are offered to exemplify the added value of Occupational Therapy:

|  |
| --- |
| Case Study Responsible ClinicianAt the time I started working with J she had had 12 hospital admissions in the previous 9 years, with six of these being during the previous 18 months. She was discharged from hospital on a Community Treatment Order (CTO) and I took over her care, as Responsible Clinician….She continued to refuse her antipsychotic medication and after a period of continued stability we were able to stop all anti-psychotic medication and review her diagnosis, which was very significant and empowering for J…..I worked with J to slowly reduce her dependency on her prn medication. She understood that her high use of benzodiazepines had a direct relation on her not being allowed to drive and she was motivated to address this…. I discharged her off her CTO, and a short time later the DVLA reinstated her driver’s licence…. J has since taken a more active role in caring for her Mum and continues to remain safe and well in the community. |

**Approved Mental Health Professional and Best Interest Assessor Roles**

Members of the focus group felt that these roles could form one career pathway through to Approved Clinician roles. They described the autonomous, complex decision making they undertook with interpretation and application of the Mental Health Act and Mental Capacity Act at the core of the role. They described their training, development and maintaining of case law awareness as interesting and challenging and the role as “gritty and exciting”. They enjoyed being able to advise colleagues as they were seen to have clinical specialism within their team. The development of clinical leadership was highlighted as a benefit:

*“it’s quite a good feeling that in law my clinical reasoning ‘trumps’ other decisions...though I feel uncomfortable to say it there is status with the role” [BIA].*

AMHPs valued working with a service user in crisis and noted their role had clear boundaries, which was experienced as ‘refreshing’ in comparison to previous roles:

*“It has clarity, a clear end point, guidance and process to work through. It is one assessment, and although this can be lengthy for a number of reasons – there is one decision to be made at the end of it” [AMPH].*

The group discussed the weighty decision to detain and whether this was at odds with Occupational Therapy. The group reflected on examples where the decision to intervene preserved dignity, increased quality of life on discharge through avoiding catastrophic decision making when unwell and literally preserved life – they were assured of the synergy of their role with their profession. The ability to maximise independence throughensuring the least restrictive principle was central to this discussion. One participant described:

*“I can use environmental and activity analysis skills to underpin my decision. I can weigh up if a service user intends to do X yet doesn’t have performance skills to be able to do so. I can assess what someone is able to do and consider if this transfers to other settings” [BIA].*

|  |
| --- |
| Case Study Best Interest AssessorP was subject to one to one support for community access because they were previously deemed to lack capacity to complete this task unsupported. As a BIA with an OT professional background I will always consider what interventions have been put in place to compensate or minimise risk to P. I felt a compensatory approach could be further considered and made a recommendation to the managing authority to request an OT assessment for community access. P was allocated an OT with short term involvement, resulting in P being independent for community access and ultimately reducing restriction on her liberty. This was a great outcome for P. Im confident my awareness as an OT enabled me to identify this course of action. |

## Findings

**Finding 1**. The number of Occupational Therapists employed in the more senior roles across the South East is limited. Those with clinical responsibility at this grade is estimated to be smaller still. The data has limitations; however these findings indicate a ceiling which reduces the pool from which Approved Clinicians might develop. The workforce pipeline through to these senior roles is not currently in place.

**Finding 2:** Occupational Therapists across grades (Band 5-8 plus Local Authority equivalents) in the South East showed a higher level of awareness (80%) and interest (47%) in the Approved Clinician role than anticipated based on the national profile of AHPs in these roles. However detail about what the role entails was limited and interest to know more was noted consistently in free text answers across all grades. Given a hypothetical choice, Occupational Therapists preferred the idea of working as an Approved Clinician compared to an Approved Mental Health Professional. Published literature (Oates 2018, Thompson-Boy 2019) and this report, highlights that the longer relationship within the Multi-professional Approved Clinician role to facilitate recovery is a key aspect of this.

**Finding 3:** Perceived barriers to these roles were fairly homogenous, with those participating in the survey predicting similar issues to those who were already working in one of the three related roles. This may indicate that the challenges identified are fairly predictable. The relatively low number of respondents (25%) identifying a clash with Occupational Therapy values is notable and resonates with findings by Knott & Bannigan 2013 exploring Occupational Therapy and the AMHP role.

**Finding 4:** Barriers identified in the published literature to date (Ebrahim 2018 & Oates 2018) and solutions (HEE 20203) focus on barriers specifically in relation to the training and workforce infrastructure to support Multi-professional Approved Clinician roles. The barriers identified in this paper match more closely with the Billing’s 2020 paper – specifically that workforce preparation needs to be focussed at earlier stages of Occupational Therapy careers in order to create a pool of senior clinical leads from which Approved Clinicians might develop.

**Finding 5:** Inclusion of related roles (AMHP and BIA) in exploring potential barriers to Approved Clinician roles has served to dismiss some myths about Occupational Therapists which may be held and added detail about cross-organisational barriers. This approach has also offered a possible career progression pathway and identified a potential source from which to develop awareness raising materials.

## **Recommendations**

### National: Arms Length Bodies (HEE& NHSEI), Professional Body (RCOT)

1. Creation of materials to promote, inspire and inform Occupational Therapists, managers and educators are recommended. These should recognise that changes in the MHA and creation of the Multi-professional Approved Clinician roles have taken place after the registration of many our current senior influential staff.
2. Collation of role models and case studies in mental health and learning disability settings to dispel myths & raise awareness and promote the value of Occupational Therapists as Multi-professional Approved Clinicians – to the service user, their family and the professional - is essential in encouraging the pull to take up these roles.
3. With a limited pool from which to develop case studies, the inclusion of aligned roles (AMHP & BIA) with appropriate attention to caveats, may offer a wider source of experience and clinical scenarios to draw upon.
4. A greater focus within HEI curriculums and Clinical Placements on whole career pathways within mental health and learning disability, which includes senior clinical roles such as the Multi-professional Approved Clinician is proposed.
5. Collaborative work between the HEE National AHP Mental Health Advisor and RCOT to inspire uptake of roles within mental health & learning disability services, with an increased expectation that Occupational Therapists will take up senior roles is suggested.
6. The development of an RCOT Informed View on the Multi-professional Approved Clinician role would serve to demonstrate support and increase awareness of the role. This would also serve as an exemplar of the contribution which Occupational Therapists in senior clinical leadership roles make in supporting the rehabilitation of service users during vulnerable stages of their recovery as well as influencing the culture of care.
7. This paper has been developed from a regional perspective and identifies the scale of change which is required by multiple stakeholders across the workforce development journey if the ambition of the New Roles in Mental Health are to be realised. It is proposed that this work is further developed at a national level for example via an HEE National Fellowship in order to ensure momentum and progress.

### Regional / Integrated Care System

1. Collaborative working between members of Regional Mental Health Board, Regional Head of Allied Health Professions and Advancing Practice Faculty in order to understand local nuance and enable readiness across the Occupational Therapy workforce.
2. Place-based discussions (potentially within AHP faculties) between Health, Local Authority and HEI partners about the implications of current MCA changes and MHA reform; agree whole workforce requirements to meet future population need and minimise structural barriers to enable career progression within / across organisations.
3. Explore potential to increase sole / shared clinical placements across health and Local Authority.
4. AHP communication plan to raise awareness and aspiration of Occupational Therapists in Local Authority and Health settings.
5. Employers to develop career pathways reflecting choices available and including advanced practice, Approved Mental Health Professional and Best Interest Assessor roles as possible stepping stones.

### Individual

1. Occupational Therapists currently in Approved Mental Health and Best Interest Assessor roles may consider increasing opportunities they offer to students on clinical placement or interested colleagues to shadow.
2. Individuals considering Approved Clinician or related roles to explore continuing professional development such as [AMHP Training (skillsforcare.org.uk)](https://www.skillsforcare.org.uk/Learning-development/social-work/Mental-health-social-work/AMHP-Training.aspx), in-service Mental Health Act training and shadowing opportunities including Tribunals and clinical leadership opportunities.
3. Individuals interested in these roles to highlight this via appraisal systems in order that gaps in employer’s development, education and training opportunities are collated and addressed.

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