



## opinion & debate

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### The mental health practitioner – bypassing the recruitment bottleneck

Lack of resources has been a major restriction on the development of mental health services. However, even with the resources currently available there are insufficient numbers of trained medical, nursing, occupational therapy, psychology and social work staff to maintain services to adequate levels in many areas. This seriously interferes with provision of services, especially in acute wards but also in other areas. It certainly restricts developments and the use of skills attained through training (e.g. from THORN psychosocial intervention courses (Gournay & Birley, 1998)). The introduction of crisis resolution and early intervention teams, as described in the *NHS Implementation Guide* (Department of Health, 2001a), looks likely to simply deprive in-patient wards and community teams of staff, making the new teams ineffective through lack of core services. This will occur directly by recruitment of staff from them, or competitively through taking new entrants from nursing and social work programmes. Solutions proposed have included increasing numbers of support workers and administration staff; recruitment from abroad; or increased delegation of tasks, but there remains a need for more appropriately-trained professional staff.

#### Do we not just need more staff from the professions currently employed?

This has been an issue for decades. Recruitment into nursing, psychiatry and social work (i.e. more of the same) has persistently failed to meet needs and there is no reason to believe that this will change. Initiatives by government to increase recruitment into these professions may eventually have an effect but they seem unlikely to meet the growing need. As always, demand and expansion in other areas of health and social care can be expected to absorb many of the new doctors, nurses and social workers recruited.

#### What about generic mental health workers?

There has been a major change in the roles of doctors, nurses, occupational therapists, psychologists and social

workers engaged in mental health services over the past 50 years. Although these professions have adapted to the changes, there has been regular discussion about whether a new form of mental health worker should be developed (Bouhoutsos, 1970; Pattison & Elpers, 1972; Munro, 2000; Morgan & Harding-Price, 2001). Some new forms have emerged, for example counsellors, but these have had a marginal impact, if any, on the care of people with severe mental illness. In the USA there is a variety of trained mental health workers, for example graduates often form part of case management teams. Since the 1970s there have been reports describing training programmes for them and their value to teams. The major argument for these developments has been that there are many generic tasks in mental health services that such a worker can perform, if given appropriate training.

#### Are there new sources for recruitment?

An even stronger argument for the development of such workers is that they could be recruited from groups who currently do not enter mental health services, but who might be very interested in doing so and have the potential to be effective practitioners. Specifically, graduates in social sciences and psychology often express a general interest in 'working with people'. Many of the latter apply for the relatively few clinical psychology courses and psychology assistant posts (and again have been a recruitment source in the USA (Pattison & Elpers, 1972)). Application rates for these posts are very high and those who fail in their attempts tend not to pursue other avenues into mental health services, for example through training in one of the mental health professions. Some will work on wards as health care assistants and some in the community as support workers. However, neither area can provide career progression or even adequate professional training and so most move on.

#### Why do they not enter mental health services through conventional routes?

There seems to be a number of reasons why, anecdotally, graduates do not currently enter mental health services:



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- (a) As described, recruitment opportunities are limited into medicine or clinical psychology. Some with first or upper second class degrees apply and still fail to get in; others simply will not bother (with good reason).
- (b) Retraining for these and other professional qualifications takes time, usually 3 years but sometimes 2 with, for example, accelerated nursing courses.
- (c) The older professions and their training do not appeal:
  - (i) If you wish to become a doctor, nurse, occupational therapist or social worker, your training involves working in roles in hospitals or generic social work that may not be attractive if your desire is to work in mental health services.
  - (ii) During that generic training work in mental health services is derided, implicitly or explicitly, and many recruits leave or are diverted to other areas.
  - (iii) Recruitment into generic training probably favours those who are not proposing to work in mental health services.
  - (iv) The image of a nurse in particular, but also of some other professions, may not be attractive. Unfortunately, the image has probably not yet become that of an independent practitioner (despite the efforts made by the profession itself).

- (b) develop a care plan collaboratively with the patient, carer and other team members;
- (c) participate in implementing that care plan to the extent that he/she is equipped by his/her training;
- (d) ensure that follow-up occurs and that the relevant information is disseminated to those involved in the plan, including the general practitioner.

Such tasks are relevant whether the patient is in the community, hospital or other residential setting. In a hospital or residential setting, coordination of individual care can utilise the patient's in-patient stay effectively for assessing and managing those issues that led to admission and which prevent or delay discharge. This would involve practical tasks (sorting out benefits and accommodation and identifying relevant interpersonal issues) and risk management (observing, escorting and interacting with patients). Other non-clinical aspects of care will also be developed, as recommended by the Kennedy Inquiry (Department of Health, 2001b), in the following 'six key areas in the education, training and continuing professional development of healthcare professionals':

- (1) skills in communicating with patients and with colleagues;
- (2) education about the principles and organisation of the National Health Service (NHS) and about how care is managed and the skills required for management;
- (3) the development of teamwork;
- (4) shared learning across professional boundaries;
- (5) clinical audit and reflective practice;
- (6) leadership.

They will also have skills training in a range of areas that may include developing, or at least understanding, a basic cognitive behavioural approach to individuals and families (as increasingly being provided by nursing courses and to greater depth by THORN psychosocial training courses (Gournay & Birley, 1998)). This will be offered to the level required for entry into professional work in mental health services. This is consistent with, and is being guided by, the description of the qualities of 'a capable practitioner' (Sainsbury Centre for Mental Health, 2001), who is able to implement the requirements of the National Service Framework for Mental Health. These include:

- (a) a performance component that identifies 'what people need to possess' and 'what they need to achieve' in the workplace;
- (b) an ethical component that is concerned with integrating a knowledge of culture, values and social awareness into professional practice;
- (c) a component that emphasises reflective practice in action;
- (d) a capability to effectively implement evidence-based interventions in the service configurations of a modern mental health system;
- (e) a commitment to working with new models of professional education and responsibility for lifelong learning.

## The mental health practitioner

In Southampton and west Hampshire, in common with many areas, we have significant recruitment and retention issues and are using a variety of means to overcome this major problem. As part of this programme we are engaged in a feasibility study to recruit and train a cohort of 'mental health practitioners' (MHPs). The Chief Executive of the trust is leading the multi-disciplinary implementation group in consultation with the Workforce Federation (who took over from the Educational and Training Federations in 2001). The proposal was for recruitment to begin in June 2002 for training to commence in September 2002. The intention is to pay, during training, a salary sufficient to attract high quality candidates and to undertake recruitment through university contacts and career fairs and the local media. Although it is expected that most entrants will be graduates, non-graduates who have the potential to meet the requirements of the training and posts will be considered. Accreditation of the course is being sought through university channels.

## What will the training involve?

Training will be for 1 year. It will involve a taught component (averaging 1 to 2 days) and placement with in-patient wards and community teams. The aim is to develop a professional who is able to undertake the following key tasks of the Care Programme Approach (Department of Health, 1999):

- (a) perform and document a full psychosocial assessment, including a basic assessment of risk;



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## What will be their career pathway?

This is a very important issue and one that has hampered developments in the USA (True *et al*, 1974). It is proposed that MHPs will join acute wards, residential services or community teams on the same level as an entrant from nursing or occupational therapy. They will then be able to progress in the same way through a grading structure to become senior mental health practitioners and, eventually, if they wish, to apply for team or ward management posts and above. Professional support and supervision for other professions will have to be available as necessary and as currently provided in many teams for nurses, social workers or occupational therapists where the team leader is from another professional background.

## Will they affect the work of psychiatrists?

Although this group will have its largest impact on nurses by working with and providing support for them, it is likely that they will also reduce consultant workloads. This could be primarily through taking on much of the work that doctors undertake in care coordination, because there are too few members of the community and in-patient teams to take this role. This is especially the case with people who do not fully meet criteria for severe mental illness but can still benefit from mental health management, and so are seen in out-patient clinics. Basic assessments of all patients referred to mental health teams, routinely or as emergencies, could be done by MHPs, reducing the amount of time required for the psychiatric assessment. Support with assessing, drafting and processing welfare benefits claims, especially for Disability Living Allowance and housing applications, could significantly reduce workloads. Availability of sufficient personnel would also allow the development of duty teams to support out-of-hours calls that often come to doctors because there is no one else available at those times in an emergency. The situation where, when beds are full, we struggle to maintain patients in the community, with insufficient community support (e.g. where at least daily visiting is needed), would no longer be limited by lack of trained staff (although financial resources would still be an issue).

## What will they not be able to do?

There are certain legal responsibilities held by doctors, nurses and social workers that could not be taken on by this group. These include prescribing and duties under the Mental Health Act. There are also responsibilities for which the training planned would not equip them. This would probably include monitoring and dispensing of medication. It might also include care of those with a combination of physical and psychological disorders who might be better cared for by nurses who have at least a basic training in physical health care. The MHPs will be provided with a basic understanding of psychological treatments but would need further training to develop proficiency in delivery.

## Do they not need to be part of a professional group with professional accountability mechanisms?

The development of clinical governance provides a protective framework for the accountability of MHPs, according to advice that we have received from a range of sources. It means that individual trusts are responsible for ensuring that individuals would be capable of performing the tasks expected of them in their job description. If the proposal is successful, it may be that there will be benefits for the MHPs as a group to develop professional networks, but these are not essential for accountability reasons.

## Discussion

Mental health practitioners are a new breed of mental health professional. They could make a substantial difference to those currently using and providing mental health services. Overload is a major cause of stress (Rathod *et al*, 2000) and even retirement from psychiatry (Kendell & Pearce, 1997) and other professions. Not only could MHPs provide practical support in the long term but also hope of improvement in individual workloads in the short term, which is currently lacking despite government commitment to increasing recruitment.

Generic mental health workers have been proposed for UK development over many years and they exist in the USA. Recently, the Report by the Workforce Action Team (Department of Health, 2001c) proposed 'support, time and recovery' (STR) workers. These may be equivalent to mental health practitioners but the report separates out two sections of the workforce – essentially current professionals groups and non-professionals – with the danger of producing an 'underclass'. Concern has been expressed that 'if training of STR workers is not properly resourced, and they are not fairly remunerated for their work, it could continue to result in a two-tier workforce of (reasonably) well-paid professionals providing the 'high tech' interventions on top, and a pool of poorly paid, poorly trained 'dogsbodyes' (or perhaps 'dogstars?') doing menial and mundane tasks' (Williamson, 2001). Again, similar issues have arisen in the USA (Madenlian *et al*, 1980). To be fair, this is probably not what is intended by the Workforce Action Team but the term STR implies an expansion of support workers rather than independent professionals. Our proposal is very specifically for a new professional group.

Perhaps the reason that implementation of this new profession has not occurred previously is that managers have feared that other professions would feel threatened by them and have been concerned about the potential complications of such a development, especially regarding accountability. This has led services and government to pursue the same lines that have failed mental health services for the past 50 years. In the current situation, where reinforcements are desperately needed, the professional groups in west Hampshire have been supportive of this development. Representatives are working as part of the team to implement it. The



development of clinical governance has clarified accountability in the NHS and this is a major reason why such a development can now occur. It has the potential to revitalise services, rescue them from collapse and take them forward.

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## Declaration of interest

None.

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