Qualitative Interviews Exploring the Views of Healthcare Professionals Working in a Mental Health Trust in England on Pharmacists as Future Approved Clinicians

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Abstract

Background

The Mental Health Act 1983 was amended in 2007 introducing the role of the Approved Clinician (AC) which could be assumed by individuals from several professional groups. Although the role of mental health pharmacists have undergone significant transformation over the past few decades, pharmacists remain ineligible to train and practise as an AC. There is a paucity of research on non-medical ACs and there are currently no known studies exploring the potential of mental health pharmacists to be considered for the role of AC in future.

Aim

This qualitative research explored the views and attitudes of a range of healthcare professionals towards the role of the mental health pharmacist, and whether they could and/or should be enabled, via a legislative change, to become ACs in the future.

Method

Recruitment based on systematic purposive sampling principles took place at one mental health trust in England. Six pharmacists, five medical ACs and two experienced mental health nurses participated in digitally audio-recorded semi-structured interviews between June-November 2020. The recordings were transcribed verbatim before being inductively coded and thematically analysed.

Results

Notwithstanding the wide recognition among participants of several key skills possessed by mental health pharmacists, various obstacles were also identified to their becoming ACs in future, including prevalent conventional models of pharmacy services delivery restricting adequate patient access, as well as insufficient training opportunities to acquire advanced clinical skills particularly in diagnosis and assessment. Participants also highlighted wider concerns with current uptake of the non-medical AC role which could influence the success of pharmacists' involvement, including legislative restrictions and a lack of perceived training support.

Conclusion

Changes to the skill mix within multidisciplinary mental health teams as well as to the training of staff may be required to equip pharmacists with essential skills to be able to transition towards the AC role. Further research is required to gain a better understanding of the challenges facing the clinical development and enhanced utilisation of highly specialised mental health pharmacists across services.

Impact Statement

- Mental health trusts should make better use of the advanced clinical skills of their pharmacists and support them to fully integrate into multidisciplinary teams;
- Leadership organisations must work together to create a nationally recognised unified credentialing framework for mental health pharmacists encompassing the skills and competencies required by approved clinicians under the Mental Health Act;
- Policymakers should re-evaluate the current make-up of multidisciplinary teams and consider enabling pharmacists to train and qualify as approved clinicians under the Mental Health Act.

Introduction

The Mental Health Act (MHA) 1983 is the predominant statutory legislation with respect to the powers and lawful processes governing the detention and treatment of people diagnosed with a mental disorder in England and Wales. The 2007 amendment to the MHA instituted several key changes concerning the responsibilities and powers of professionals, and introduced the roles of Approved Mental Health Professionals (AMHPs, who were traditionally only social workers) and the Responsible Clinician (RC, traditionally only medical doctors). Simultaneously, both of these roles were opened up to several additional non-medical professionals that were previously not considered by the Act. This meant that medical doctors, social workers, mental health and learning disability nurses, chartered psychologists and occupational therapists could all take on the role of the AMHP or the RC [1-3]. Since the 2007 amendment, the list of professionals permitted to qualify and lawfully exercise these powers has remained unchanged.

Of these two roles, the RC is the professional in charge of taking overall responsibility for directing all aspects of patient care, including treatment, release, discharge, as well as community treatment orders (CTOs). As set out by the MHA 2007, before one may become a particular patient's RC, they are first required to obtain the professional status of Approved Clinician (AC).

Whilst the MHA permits a range of professionals to qualify as an AC, there remain key differences between those from a medical and non-medical backgrounds which are summarised in Box 1.

Box 1. Summary of Key Differences between medical and non-medical ACs

Routes of Qualifying
Non-medical professionals (as well as medical doctors who are not on the GMC Specialist Register in Psychiatry) wishing to become an AC may only qualify via the portfolio route. This is an extensive process; one that is 'grounded in a critical engagement with human rights based interpretations of the law' [3]. In order to achieve AC status, psychiatrists, however, have the opportunity to forego the portfolio route and complete a distinctly shorter medico-legal induction course (lasting for as little as two days), whilst also automatically receiving section 12 approval - an additional set of powers under the MHA [25].

Legal Powers
There are also notable differences between the powers of medical and non-medical ACs. For instance, only a medical AC can provide medical recommendations for guardianship as well as for sections 2, 3 and 4 under the MHA, and only they are permitted to determine capacity to consent to treatment and to authorise emergency medical treatment. Furthermore, only a medical AC - when acting as responsible clinician jointly with a second medical doctor - can initiate detention under the MHA. Fennell attributes these inconsistencies to fundamental differences in the clinical training of physicians and non-medical professionals, reasoning that only 'doctors with the broad diagnostic skills should decide whether people should be detained' [26].

There are also pronounced differences in the numbers of medical and non-medical ACs. According to the first national survey conducted in England and Wales in 2017, only 56 non-medical ACs had been appointed, which is in stark contrast with over 6000 medical ACs [3]. This survey highlighted several reasons for this discrepancy, including the training route being too confusing and laborious for non-medical AC candidates. A previous survey by Ebrahim identified additional contributing factors, such as a lack of protected clinical time allocated towards training by employers [4].

Over the years the combination of purposeful integration of evidence-based practice and increased complexity of drug therapy has given birth to the concept of clinical pharmacy and this has meant that increasingly pharmacists have been released from the logistics of the dispensing process with the help of new technologies and improved skill-mix. These changes have not only facilitated pharmacists' progression towards establishing a vital oversight of medicines management [5-6], but also contributed to the creation of the more holistic, patient-centred practice of medicines optimisation [7]. The introduction of the non-medical prescribing (NMP) qualification has not only enabled improved access to medicines but also enhanced the management of medicines as well as patient safety [8]. For example, a study by Turner, Kennedy & Barrowcliffe conducted at a large NHS acute trust found that pharmacists made significantly fewer prescribing errors than doctors [9]. The College of Mental Health Pharmacy (CMHP) and the Department of Health have jointly stated that individuals with mental health problems are particularly suitable for management by non-medical prescribers [10].

Furthermore, patients often value pharmacists' knowledge above that of doctors and appreciate pharmacists promoting shared-decision making to a greater extent [10]. There is also increasing evidence supporting the use of pharmacists to support the management of patients with mild to moderate mental health conditions in primary care [11]. Harms et al. have demonstrated that clinical pharmacists can improve common primary outcomes associated with such conditions whilst also advocating interdisciplinary collaboration and improving standards of documentation and necessitating regular follow-up. Several prior studies have also highlighted the unexploited potential of specialist mental health pharmacists within a multidisciplinary environment [13-18].

Despite the aforementioned transformations of pharmacy services in pharmacists assuming increasingly patient-facing and clinical roles, as of 2021 the MHA has not been reviewed with respect to considering this group of professionals for the role of the non-medical AC. Furthermore, the role of pharmacists has thus far not been reviewed in the published literature in relation to assuming the role of the AC. The aim of this research was therefore to explore, in the context of current non-medical AC role provision and service delivery challenges, acceptability toward and feasibility of potential inclusion of mental health pharmacists as non-medical ACs in future.

Aim

This qualitative research explored the views and attitudes of a range of healthcare professionals towards the role, skills and competencies of mental health pharmacists, and whether they could and/or should be enabled, via a legislative change, to become approved clinicians under the Mental Health Act in the future.

Ethics Approval

The study team obtained ethical approval (The University of Manchester Division of Pharmacy & Optometry Pharmacy School Panel Project Ref: 2020-8199-15765) on 16/12/2019 and Health Research Authority (HRA) approval (IRAS Research ID: 276141) on 21/04/2020.

Methods

Recruitment

For the purpose of recruiting participants for this study the method of systematic purposive sampling was selected; all candidates who took part were invited via the trust's internal email and provided with the participant information sheet and consent form. These documents informed the participants about the research being undertaken for attainment of a Master of Science degree.

Determining the pool of potential candidates was influenced by the lack of non-medical ACs employed at the hosting organisation. Thus eligibility criteria were determined based upon candidates' respective professional affiliation as follows: 1) medical ACs, 2) mental health pharmacists, and 3) other mental health professionals of notable relevant experience - that is, any individual employed at Agenda for Change (AfC) band 8 or above, preferably those currently working towards the AC qualification or having significant expertise in the subject.

The numbers and proportions of professionals recruited as well as their corresponding inclusion criteria are summarised in Table 1.

Data Collection

Each participant attended one semi-structured interview with the researcher (BA), lasting up to one hour in duration. Most of the participants shared a working relationship with BA. The interviews took place between June and November 2020; some

were conducted in person on trust premises while others were held virtually via Microsoft Teams. An interview schedule was prepared and used flexibly thereby allowing each participant to share their opinions freely on all of the topics discussed. Interviewees were encouraged to reflect on the perceived benefits, current status and practical utilisation of non-medical ACs before considering the possibility of mental health pharmacists being enabled - via a legislative change - to qualify and practise as ACs in the future. They were asked for their opinions on the advantages and disadvantages of pharmacists hypothetically assuming this role; to name and dissect the various discrepancies between the skills required by a pharmacist and an AC; and finally to propose ways to bridge the gap dividing these, as well as to share their thoughts and to put forward suggestions on ways in which pharmacists could and should develop further. The pharmacists were asked additional questions in order to learn their opinions about how organisations and departments could potentially facilitate pharmacists transitioning into the non-medical AC role in future. Please refer to Figure 1. for the Interview Schedule (abridged).

Data Analysis

Each interview was audio recorded using trust-approved equipment and corresponding verbatim transcripts were produced by BA using the application Pages by Apple. The transcripts were analysed by BA following the six-phase thematic analysis methodology laid out by Braun and Clarke [19]. Transcripts were not checked by the participants themselves; RNK reviewed six transcripts to confirm the coding framework. Responses to each interview question were initially coded using succinctly-worded ‘labels ’which served to be meaningful representations of the answers given. These were then arranged, and common patterns in responses were grouped together to form an early set of themes. The original themes were continually reviewed and adjusted as necessary in order to describe the dataset with increasing precision before the final report was generated.

Results

A total of 13 interviews were conducted. No candidates approached refused to take part in the study and no participants dropped out. The participants included six mental health pharmacists, five medical ACs (four consultant psychiatrists and one associate specialist) and two mental health nurses (of which one was currently working towards becoming an AC and the other being a nurse consultant). The level of experience working in the field of mental health varied widely among the participants: from 2.5 to 37 years.

Opinions expressed by the participants were evenly distributed among the three professional groups and each group was able to list several points both in favour and against mental health pharmacists potentially acting as ACs in the future. The themes generated through analysis are detailed in the following sections.

The role and benefits of mental health pharmacists

Interviewees were asked to reflect on the role of mental health pharmacists, in particular on their potential benefits to the wider multidisciplinary teams. Of the common themes (summarised in Box 2.), almost all participants regarded the pharmacists’ clinical knowledge, particularly their expertise in medication as one of the most obvious and useful benefits:

“Well, you [pharmacists] are a font of all knowledge! You know more about drugs than me, you've got it off the top of your head more than me… You know the interactions, you know the monitoring requirements … You've got that knowledge and you know how to lay your hands on knowledge that I don't. So, yes, it's useful to have you in the team.”

Box 2. Key Themes on the Role and Benefits of Mental Health Pharmacists

Themes
Specific knowledge of medication
Clinical knowledge and evidence-based practice
Ability to prescribe (dependent upon an additional qualification)
Medicines reconciliation and interface working with GPs and other primary care colleagues
Education and training responsibilities
Medication counselling role
Provision of a safety net to colleagues

[Psychiatrist 01]

In addition to acknowledging the highly regarded educational services that pharmacists ordinarily delivered to both colleagues and service users on psychotropic medications, several participants volunteered that pharmacists not only contributed a different perspective to patient care - on occasion even challenging clinical decisions - but they particularly valued their unique viewpoint, which was not only seen as grounded in evidence-based practice but one which often provided fertile ground for clinical discussions and improved treatment for patients:

“I'm very much in favour of mental health pharmacists as part of MDTs, and particularly, in the inpatient setting. My opinion is that every MDT and every ward should have its own mental health pharmacist and, again, my opinion would be that ideally the mental health pharmacist should form part of every ward round … The ability to have a discussion between prescriber and pharmacist, I think, it really adds as a sum of a force multiplier, in terms of the effectiveness of the prescribing as well as increasing safety.”

[Psychiatrist 02]

Lastly, there was an acknowledgement, shared by many, of the unique position of the pharmacist - compared to others within the MDT - with regards to supporting service users, too:

“Also, patients tend to be a lot more honest with us from what I've seen … patients might open up to a pharmacist because they don't see us in the same way as they might see the consultant; that we are often seen as a problem solvers rather than problem makers by the patient.”

[Pharmacist 03]

Skills and competencies of Mental Health Pharmacists

Several of the interviewees were able to draw on their experiences of working with pharmacists to deduce key skills and competencies relevant to those of the AC. In particular relation to skills and competencies required by an AC it was argued by most that pharmacists did share a number of these; nevertheless, these were commonly thought to be unlikely to meet the perceived higher standards required for ACs. These included: clinical knowledge relating to pharmacological treatments, leadership and MDT working, as well as up-to-date knowledge of policies and relevant parts of the legal framework:

“Pharmacists also have got a knowledge of the Mental Health Act, in terms of different sections and that kind of thing, which would apply very well to being an RC [or an AC].”

[Psychiatrist 04]

In particular, there were several important points that both pharmacists and non-pharmacists made with regards to pharmacists not having enough experience in undertaking assessments and managing care plans:

“Assessing risks - and this is something that if you have not had experience with this, it may be difficult to master in a short period of time. It requires seeing many cases, following them up, seeing what happened with them… to understand why, when we say this person is at risk of harming themselves, why we say that. And it's not just about doing a one-off assessment.”

[Psychiatrist 05]

“I don't think we have the skills in - I think - diagnosis … I'd be inclined to say that given that doctors go through - is it six years specialist training to become a psychiatrist? - I am not sure that this is something that pharmacist should or could be doing, actually.”

[Pharmacist 01]

A few, in contrast, whilst recognising the fundamental differences between pharmacists and the other groups, were also keen to stress the similarities in terms of the common challenges faced by different professionals working towards the AC qualification:

“So, what I'm saying is if psychologists can do it - they won't have had a vast amount of training in their undergraduate qualification on diagnosis - because they are more into therapeutic interventions - and that's probably the same for pharmacists - so there is a bit of a gap but they’re all in the same place, aren’t they… Nurses - well, they won't have been used to making diagnoses … and they've had to learn that on their job through experience - so, none of these things are insurmountable.”

[Pharmacist 05]

There were notable concerns expressed across professional groups about the apparent lack of sufficient patient interactions pharmacists might have, and what was commonly viewed as a predominantly 'background role' was thought to be a significant contributor to this perceived shortage of relevant skills (e.g. in-depth clinical, diagnostic and assessment skills), practical experience and on-the-job training opportunities:

“On the negative side, I don't think pharmacists interact with patients one-to-one as much as doctors, nurses or psychologists do … For me, what is lacking is that sort of patient contact; a diagnostic curiosity."

[Psychiatrist 03]

Many explained that this was in part caused by a discernible shortage of mental health pharmacists, and some criticised the conventional organisational structures within mental health trusts for the way pharmacists were seemingly continuing to be utilised:

"It’s important that pharmacists are part of a team - but, of course if they are stretched and have to visit five more wards then they're not able to be part of the team … And this does limit their ability.”

[Psychiatrist 03]

Pharmacists and ACs - bridging the gap

There were several proposals made towards enabling pharmacists to take on increasingly clinical roles within mental health in order to start acquiring those requisite skills and competencies; some of these plans involved exploring hitherto

uncharted territories and ideas about creating innovative roles, primarily through embedding pharmacists into existing multidisciplinary inpatient and community teams:

“Get them more involved in the care planning and in the assessment process… so, maybe there can be a role that is created that incorporates both and then they could build upon that pathway for the approved clinician bit.”

[Nurse 01]

All of the pharmacists interviewed, when asked to proffer solutions to achieve some of the key AC-specific competencies, were united in their response to campaign for better integration into clinical teams:

“I think they [pharmacists] would [have to] be a lot more integrated into a team; they would probably have a bit of responsibility of managing other people and they would certainly have a clinical leadership role within the team and they would clinically be leading a multidisciplinary team.”

[Pharmacist 06]

Recognising the considerable challenges and pronounced obstacles in the way of pharmacists moving towards becoming ACs in future, some chose to abandon the idea altogether and instead proceeded to advocate that employers should be exploiting already existing formal development frameworks offered by professional bodies.

“There may well be things like credentialing or more advanced practice - so whether through a formal process or through using or reflecting on things like the advanced pharmacy practice framework, or the multi professional advanced clinical practitioner framework, or the College of Mental Health Pharmacy credentialing - this, sort of, almost helps assure people that you do practise at a certain level; and it would help assure you, I think, as well.”

[Pharmacist 05]

As a means of professional development for pharmacists to obtain skills required by an AC, some of the participants focused on formal certifications exclusively, including non-medical prescribing and advanced clinical practice; whilst some concentrated on a combination of relevant qualifications alongside of various means of demonstrating competencies on the job.

“I think pharmacists meet many of the requirements for being responsible clinician as it is… but they would have to have a job that is set up for development - where people are going to have to spend maybe two years on getting clinical cases, and also maybe do a kind of an exam on top of some kind of a Masters of Psychiatry or similar plus clinical cases - a portfolio of cases, and that kind of thing. So it’s doable but it would need to be organised.”

[Psychiatrist 04]

Almost all of the participants, however, agreed that any proposed change to improve the clinical development opportunities of mental health pharmacists would likely be a slow and gradual process, one that would typically involve creating a unified and standardised training approach within mental health pharmacy - in particular, one that is recognised across organisations - whilst also acknowledging that this new pathway may or may not eventually lead to the enablement of the approved clinician role for pharmacists in future.

Discussion

Statement of Key Findings

This qualitative research explored the views and attitudes of a range of healthcare professionals towards the role of the mental health pharmacist, and whether they could and/or should be enabled, via a legislative change, to assume the role of AC in the future. This is the first study of its kind to draw comparisons between the increasingly clinically trained mental health pharmacists and non-medical approved clinicians; the juxtaposition of these professional roles is entirely novel in this field of research.

Strengths and Weaknesses

Key strengths of this research include the exploration of a novel subject area, as well as the attainment of data saturation in this cohort of participants. Conversely, two significant limitations were identified. Firstly, no qualified non-medical ACs were employed at the participating trust to be recruited for this research; their accounts could potentially have introduced unique insights not expressed by other participants. Secondly, some of the participants shared a close working relationship with and belonged to the same professional network as the author; though this was mitigated by explicitly explaining to each interviewee the importance of providing honest and impartial responses to questions, the risk of acquiescence bias cannot be ruled out.

Interpretation

Discussions about mental health pharmacists generated a number of salient themes, including on their role and scope of practice, wider contributions to patient care as well as their unexploited potential. As reported in the literature the under-utilisation of mental health pharmacists remains commonplace [20], despite there having been several recommendations made by key stakeholders and bodies on how to facilitate the transformation of pharmacists into advanced roles [21-22]. Specifically, The NHS Long Term Plan also highlights the necessity of up-skilling mental health pharmacists and promoting their wider deployment across services [23]. The particular recommendation by participants of this research to fully embed pharmacists into multidisciplinary clinical teams corroborates existing findings on the topic [12]. Participants also highlighted the need for an overhaul of pharmacists' day to day roles and responsibilities so as to provide them with sufficient relevant experience. In addition to the requirement to update current legislation to legally allow pharmacists to train to be an AC, there were also suggestions on the creation of bespoke training pathways to equip pharmacists with the required knowledge, skills and competencies, particularly in the domains of care planning, leadership and multidisciplinary working, diagnosis and assessments - something which could be incorporated further into future accreditation standards of specialist mental health pharmacists. Presently, several organisations require mental health pharmacists to complete set postgraduate courses, such as the one offered by Aston University entitled Psychiatric Therapeutics, and there exists also the opportunity to further demonstrate expertise in the field of mental health pharmacy through credentialed membership of the College of Mental Health Pharmacy. Naturally, the central focus of these is pharmacotherapy, and whilst there is some overlap, the requisite knowledge, skills and competencies are not designed to align closely with those required by an AC. In particular, although there is an emphasis on communication and MDT working in order to become a credentialed member, there is no requirement for candidates to showcase their knowledge of the legal and policy framework or to demonstrate advanced clinical skills. In order to attain these, pharmacists may be required to undertake additional training thus becoming independent prescribers and/or advanced practitioners. The latter is currently receiving renewed attention following the recent release of the first ever national curriculum and capabilities framework for mental health advanced practice by Health Education England, which appears - putatively - to map capabilities most closely to those required by an AC [24]. Nonetheless, to date there is not one unified framework, credential or qualification available for mental health pharmacists as there is for the professionals presently enabled by the MHA to train to be ACs.

Further Research

This study has shown that there is scope to carry out further qualitative research to gain a better understanding of the challenges facing the clinical development and enhanced utilisation of highly specialised mental health pharmacists across services. In particular, national surveys as well as interviews and focus groups could be valuable to deepen

understanding on this subject and it is recommended that these works be conducted with professionals from various geographical areas, including mental health pharmacists delivering patient-facing clinics as well as those in consultant and other leadership posts. Additional studies exploring the views of individuals involved in making decisions about the MHA (such as those currently working on the white paper 'Reforming the Mental Health Act') may also provide further insights and facilitate progress towards mental health pharmacists being permitted to become non-medical approved clinicians in the future.

Conclusion

This work explored collegiate views about the role of the mental health pharmacist: not only discussing its current state of affairs and unexploited potentials but also attempting to explore opinions on how it could be further transformed, enhanced and better utilised, and how it could potentially be supported towards being permitted under the MHA to be eligible to become an AC in future. Although there is an abundance of recommendations by several prominent bodies and organisations on how to improve the up-skilling and deployment of pharmacists in various mental health settings, any such undertaking will not only require a truly multi-professional input but will also demand an influential pharmacy leadership that can withstand the resistance by stalwart advocates of the current status quo, as demonstrated by one of the research participants below:

I don't understand why a pharmacist or anybody else would want to be an AC unless we all change our mindset as to what an AC is … I don't know if it [this system] is the best - it's what we've got … I'm sure in 50 years time we would be having a completely different conversation, because things will evolve, and maybe 2007 was the start of it … [but] I think it's too big a leap for 2020.

[Psychiatrist 01]

Declarations

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Conflicts of interest

None declared.

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Tables

Table 1. Breakdown of participants into professional groups

Group		Recruited	
		Participant Numbers	% of Total Participants
1	Medical ACs	2	16%
2	Mental Health Pharmacists (AfC band 7 or above)	6	46%
3	Other experienced mental health professionals (AfC band 8 or above)	5	38%
Total		**13**	**100%**

Figures

MANCHESTER 1824
The University of Manchester

Exploration of the Views of Healthcare Professionals Working in a Mental Health Trust in England on Pharmacists As Future Approved Clinicians

Interview Schedule
- Abridged Version -

SECTION I

- What key skills and competencies do you believe are required to be a competent AC?
- What qualifications do you think are required to become a medical AC?
- What qualifications do you think are required to become a non-medical AC?
- What do you believe to be the key barriers and drivers to a non-medical professional to become an AC?

SECTION II

- What do you believe to be the key benefits to multidisciplinary mental health teams of having a pharmacist?
- If pharmacists were permitted by law, do you feel that they could be effective as ACs? Please explain your answer.
- What key skills and competencies do you feel that pharmacist possess and lack at present that are required to become a competent AC?
- What do you think would be the key advantages and disadvantages of having pharmacists as qualified ACs? [...to service-users / teams / the profession]
- How do you think pharmacists working as ACs would change their role and duties within the MDT and on the ward?
- [PHARMACISTS ONLY] What organisational and departmental changes do you feel would be necessary to allow pharmacists to practise as an AC?

SECTION III

- Do you feel that the above mentioned requirements are justified? Please explain your answer.
- Do you think that pharmacists already meet or could meet some or all of these requirements? Please explain your answer.
- [PHARMACISTS ONLY] What qualifications and experience would you suggest as requirements for pharmacists before they can be considered as an AC?

Figure 1

Interview Schedule (abridged)