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Discussion paper

Is there a need for professional regulation for primary care mental health workers?

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ABSTRACT

Primary care mental health (PCMH) workers need not have a professional qualification. The development of the role of these workers highlights the influence of a number of factors that provide a framework that offers assurance of the protection of the public and the promotion of quality of care. Factors such as legislation, codes of practice, stringent recruitment procedures, clinical supervision, employing evidence-based practice, and training all play an equal part in determining safe and good practice. Together, these factors formulate standards of practice which limit the need for professional regulation.

The training of PCMH workers is guided by a national curriculum and other requirements. Practice of these workers is governed by various legislative frameworks and guidance. The requirement for clinical supervision for PCMH workers is a crucial element in promoting safe and effective care. In addition, stringent recruitment procedures ensure unsuitable candidates are not selected for the positions. This paper argues that professional regulation is not needed as there are other systems with similar significance that promote quality of care and can offer protection to the public.

Keywords: mental health workers, primary care, regulation

How this fits in with quality in primary care

What do we know?
The role of professional regulation contributing to the protection of the public and quality of care in primary care is well known.

What does this paper add?
This paper discusses the development of primary care mental health workers who need not have a professional qualification. It highlights the contribution of factors that influence protection of the public and the quality of care, thereby limiting the need for professional regulation.

Introduction

This paper aims to discuss the development of mental health workers' role in primary care and the regulations that govern their practice. Standards two and three of the *National Service Framework* (NSF) *for Mental Health*[1] indicate that people suffering from common mental health (MH) problems should have their needs met 24 hours a day, 365 days a year. They should have 'first class' advice and be referred onto specialist services if warranted. The report on the implementation of the NSF five years on suggests that primary care trusts (PCTs) have made funding of services provided by acute trusts more of a priority

than developing community MH provision. It also suggests that 'more could have been done' and that 'a vision of MH in primary care that can guide service development ...' is needed.[2]

In an attempt to implement standards two and three of the NSF, two new cadres of workers were introduced, i.e. the gateway worker (GW) and the graduate mental health worker (GMHW). Despite an intention to have 500 GWs and 1000 GMHWs respectively by 2004,[3,4] the numbers have not materialised.[5] The development of MH services in primary care has been patchy across England.

More recently, there is new momentum in the development of mental health services in primary care under the Improving Access to Psychological Therapies (IAPT) initiative.[6] As a result of the publication of the Layard Report,[7] funding has been agreed for services under the IAPT arrangement. PCTs are being supported by their local strategic health authority (SHA) to implement the IAPT agenda over the next three years.

Implementation of the IAPT agenda

The GWs' and GMHWs' roles have been defined further, the former as high-intensity low-volume workers,[8] whilst the latter become low-intensity high-volume workers.[9] There is expectation that the training for these front-line primary care mental health workers complies with the national curriculum.[8,9] An important component of the training is rooted in evidence-based practice, in particular, delivering cognitive-behavioural therapy (CBT) to people suffering from common MH problems, which include depression and anxiety disorders.[10–12]

Recruitment of high- and low-intensity workers places emphasis on attributes and skills of the individuals rather than possessing a professional qualification. The main role of these workers involves being able to deliver CBT at a level identified in the stepped care model,[13] with different workload volumes. Therefore, a professional qualification is not deemed essential.

High-intensity workers now succeed the GWs who have tended to be community mental health nurses working closely with primary care teams. As a result, their practice falls under the professional conduct of the Nursing and Midwifery Council's jurisdiction.[14] However, GMHWs have tended to have an academic degree in psychology without a professional background, and they are now functioning as low-intensity workers. Their role is similar to that of a support worker except that they deliver low-intensity psychological interventions under the supervision of a qualified professional competent in delivering psychological therapies in primary care. Retention of these workers has been a concern,[15] as they enter the role with the intention of pursuing a future in clinical psychology. As a result of the concern about retention, some employers are considering recruiting people without an academic degree but who are matured with life skills and have the potential to deliver low-intensity psychological interventions following training.

Is there a need for professional regulation for non-professionals in primary care mental health?

High- and low-intensity workers do not necessarily have to have a professional qualification, provided that they have the appropriate training to deliver psychological interventions. Professional regulation currently does not apply to non-professionals and there is no code of professional conduct to which they have to adhere. However, there are organisations that these workers may join and become members of, e.g. the British Association of Behavioural and Cognitive Psychotherapists (BABCP). The BABCP determines its own standards of training and practice before accrediting an individual as a proficient cognitive-behavioural therapist.[16] This is a self-regulating organisation aiming to promote good practice in CBT. Being accepted as an accredited therapist reflects that the worker has undergone appropriate training and reached a proficient level of practice. In this case, the worker can refer to a standard of self-regulation imposed by the BABCP. There are, however, obligations with which these workers would need to comply, e.g. the employing authority's policy on confidentiality and work practices. There is an argument that the Mental Health Act (1983), which was amended in 2007, would not have any bearing on the work of PCMH workers as it relates to people who are entering secondary care services. However, the code of practice that accompanies the Act (a new one is to be published later in 2008) contains a set of guiding principles for MH practice. This is relevant to all MH practitioners regardless of roles.

In a legal judgement *R* v. *Mersey Care NHS Trust* in 2003, on the status of the code, Lord Bingham concluded that the code should be followed unless there is a good reason for departure relating to an individual patient or groups of individuals sharing particularly well-defined characteristics. This implies that non-compliance with the code has legal ramifications and that compliance is mandatory.

There are other legislations such as the Human Rights Act (1998), the Equality Act (2006), the Disability Discrimination Act (2005) and the Mental Incapacity Act (2005) which impose acceptable working practices that are relevant to people suffering from common MH problems. For example, under Article 14: Freedom from Expression of the Human Rights Act, discrimination is prohibited on the grounds of sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status. These prohibitions reflect the values of the Equality Act (2006). PCMH workers should be able to work effectively with clients from a diverse range of backgrounds, with considerable variation in ethnicity, educational history, employment, social status and political orientation; and provide equal opportunities for appropriate interventions. Article 8 of the Human Rights Act includes the right to have information about an individual kept private and confidential, this implies the expectation that MH workers are aware of their role in the storage and sharing of client information.

Under the Mental Incapacity Act (2005), a central principle is that every individual has the right to self-determination. Although PCMH workers are not expected to work with people who are mentally incapacitated, it is, however, important to consider that everyone has the right to make decisions about their care, i.e. choice of treatment, and also they should be active participants in their recovery. MH workers are therefore expected to share the decision-making process with the client, with respect to the nature and type of the chosen therapy based on the client's recognition of the problem and right to determine the outcome of the intervention.

The Disability Discrimination Act (2005) makes it unlawful to discriminate against people in respect of their disabilities in relation to employment, the provision of goods and services, education and transport. It defines a person as having a disability where they have a physical or mental impairment that has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. Common MH problems could affect an individual's ability to perform daily activities and treatment is required. The Act places duties on service providers and requires 'reasonable adjustments' to be made when providing access to goods, facilities, services and premises. 'Reasonable adjustment' is an active approach that requires employers or service providers to take steps to remove barriers from disabled people's participation. PCMH workers need to consider the venue where they offer the intervention. Their clients would need to be able to access the services offered, e.g. lifts should be available for those unable to climb the stairs. The pressure for these workers to have high-volume caseload might result in discrimination against clients who are not able to attend appointments. Instead, these clients may need to be visited at home, in particular, clients with a phobia of going out. The information presented may imply discrimination if it was not understood, e.g. in a language that prevent services users from accessing services and exercising the choices they may have.

The various legislations and code of practice impact on MH provision, as these regulations determine good practice from which judgements are made on the quality of the service. As a result, the quality of the service offered by the practice of PCMH workers is governed by regulations imposed by legislation and the code of practice. Additionally, guidance issued by official organisations such as the Department of Health and the National Institute for Health and Clinical Excellence also impose the acceptable level of practice. Therefore, the quality of PCMH is assured despite the absence of professional regulation.

The Ten Essential Shared Capabilities framework provides the basic principles that underpin positive mental health practice.[17] It also underlines the essential elements for training. Competency and skills are well structured in the Knowledge and Skills Framework for career progression in health and social care and rely less on professional qualifications. In addition, the Mental Health National Occupational Standards also set out requirements for practice. Coupled with the national curriculum for PCMH workers,[8,9] the quality of training offered to the workers and the requirements for practice are guaranteed.

The protection of the public

Workers in health and social care are required to undergo Criminal Records Bureau (CRB) checks as part of the recruitment process. CRB checks aim to protect the public through the CRB's disclosure service, and enable organisations to make safer recruitment decisions by identifying individuals who may be unsuitable to work with vulnerable people or children. PCMH workers are subject to this scrutiny. Unsuitable individuals would be identified during the recruitment process, hence offering a level of protection to the public.

Additionally, protection of the public can be facilitated through safe practice by clinical supervision. There are a number of definitions for the term 'clinical supervision', with different emphasis.[18–21] The common factor in the definitions is that it is a reflective process during which critical discussion takes place between the supervisor and supervisee with the aim of enhancing practice. Clinical supervision in PCMH is essential to ensure a good level of service is offered.

The national curriculum for training of low- and high-intensity workers requires supervisors to be identified. Further, these workers are expected to be trained in evidence-based practice, i.e. the delivery of CBT interventions to clients suffering from common MH problems within the stepped-care model.

Is there a need for professional regulation for primary care mental health workers?

The high-intensity workers who are registrants of a professional body will have to comply with the regulations imposed. However, this is not a requirement in PCMH workers within the IAPT agenda. Their main role is to deliver CBT interventions proficiently to people suffering from common MH problems. The training for PCMH workers is expected to be delivered at master's level, which implies that these workers are expected to function at this level.

There is also an expectation that PCMH workers have regular clinical supervision to ensure safe and acceptable practice. The process of supervision is supported by the guiding principles of the legislation and the guidance in the Mental Health Act (1983) Code of Practice. Further, the workers will have undergone CRB checks to ensure that they are suitable to work with vulnerable people. There seem to be adequate safeguards which provide a framework for PCMH workers to practise safely and effectively regardless of their non-professional background.

Conclusion

The development of PCMH provides an example of utilising a well-educated and trained but non-professional staff in delivering evidence-based interventions. Together, a number of essential, equally important factors provide the framework for quality of services that offer protection to the public. These factors formulate the standards for practice and are as follows:

- the legislation and the guiding principles
- education and training to the required standards
- clinical supervision
- stringent recruitment procedures
- good practice guidance and the codes of practice
- employing evidence-based practice.

Although professional regulation provides a mechanism to protect the public and to improve quality of care for the registrants, its influence is dependent on other factors that underpin its effectiveness. An adequate framework assuring quality of care and offering protection of the public in PCMH can be just as effective as professional regulation.

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CONFLICTS OF INTEREST

None.

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