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New roles for nurses as approved mental health professionals in England and Wales: A discussion paper

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Abstract:

This paper critically discusses the challenges mental health nurses face in trying to achieve a balance between fulfilling biomedical and social roles. We suggest that dilemmas exist for nurses in attempting to combine both approaches in their practice. We present a specific example of these as occasioned by the advent of the approved mental health professional role in England and Wales. This statutory role requires the adoption of an independent social perspective as a counterbalance to the biomedical perspective brought by psychiatrists. Using the idea of occupational jurisdictions we discuss how nurses embarking on this new role are effectively crossing into territories previously occupied by the profession of social work. We also reveal the tensions for nurses who fulfil the approved mental health professional role whilst simultaneously carrying out work in other areas which demands a more overtly biomedical approach. We review critical accounts of the validity of bio-psycho-social models and concerns about maintaining positive therapeutic alliances alongside making applications for compulsory detention, assessment and treatment. We argue that the new role may become part of the professional project of mental health nursing, but also present challenges in helping redefine nursing's identity and practice.

What is already known about the topic?

- The Mental Health Act 1983, as amended in 2007, provides the statutory framework in England and Wales for the detention, assessment and treatment of people with mental disorder

- Amendments made in 2007 have given nurses and other health professionals new roles during the operation of the Act

- One of these new roles is that of approved mental health professional

What this paper adds

- There are challenges for nurses fulfilling the approved mental health professional role in incorporating an independent social perspective into the decision-making process

- Extensions to nursing work exemplified by the appearance of the approved mental health professional role continue established processes of change in inter-occupational divisions of labour, but also trigger disruption in systems of work

INTRODUCTION

The amendment of the Mental Health Act 1983 in England and Wales in 2007 provided the opportunity for mental health nurses to engage in the functions of the Act as approved mental health professionals. Approved mental health professionals have responsibilities in connection with the statutory detention of people with mental disorder, and the 2007 amendments allow mental health and learning disability nurses, along with social workers, occupational therapists and clinical psychologists, to take on this role following a period of additional training (NIMHE 2008). Until this change in the law only approved social workers were able to do this. These amendments therefore extend the legal powers of nurses and are part of a widening of nursing work occurring internationally. Recent evidence from Australia, for example, points to the informal expansion of mental health nursing roles (Elsom et al 2009), whilst a review of what is known about compulsory mental health treatment highlights the part nurses play in many parts of the world (O'Brien et al 2009). In the UK, the recent extensions to the work of mental health nurses which we address in this paper continue processes of change in interprofessional divisions of labour which stretch back many decades (Hannigan and Allen 2006). Where different professional groups jostle for space in a system of work each will defend, and try to advance, what Abbott (1988) calls its 'jurisdiction'. This refers to the control over work which professions claim on the basis of their access to necessary underpinning knowledge. Securing the right in law to undertake particular types of work is a powerful way for any occupational group to cement its position, and in opening up the approved mental health professional role to multiple groups the UK government's intervention has the potential to trigger significant change in the content and division of professional work.

The legal framework for the compulsory detention, assessment and treatment of people with mental disorder in England and Wales and for and the rights of patients for representation and to appeal was established in the 1983 Act. In addition to replacing the approved social worker role with the role of the approved mental health professional, amendments introduced in 2007 include community treatment orders and the introduction of the approved clinician in place of the responsible medical officer. Mental health nurses working as approved mental health professionals are now able (among a range of other responsibilities) to make applications for compulsory detention, thus carrying out work which until recently only social workers were able to do. Each approved mental health professional must do this by taking a social perspective, coming to an independent decision and considering the least restrictive option for the person. The imperative to adopt a social perspective is seen as a necessary counterbalance to the bio-medical approach in decisions related to mental ill health, its treatment and the liberty of the patient, and as such is written into current national codes of practice (Department of Health 2008, Welsh Assembly Government 2008). For occupational groups seeking to advance their jurisdictional authority to fulfil the approved mental health professional role, having access to a 'social perspective' thus becomes an important part of their claim to possess a requisite underpinning knowledge base.

The origin of the social perspective stems from much earlier in the development of the National Health Service psychiatric system (and can be traced back further to Tuke and others at the York Retreat) when it was widely acknowledged that social causes were partly implicated in the development of mental distress and as such

service responses should reflect this. Jones (1960) noted that the Royal Commission on Lunacy and Mental Disorder 1924-1926 recognised the importance of social elements in mental ill health and urged Local Authorities to provide services for social aftercare. The first psychiatric social workers were also trained in 1926 when psychiatric treatment was known for its attempts at biomedical mimicry of other branches of medicine. The advent of the social work profession's claim to social perspectives in mental ill health was in part a counterbalance to the psychiatric focus on biomedical causes. We speculate that prior to recent changes in mental health law in England and Wales the 'social perspective' was assumed to be part of the background knowledge possessed by social workers. Once it became clear that social workers would be required to share the 'approved' role with other occupational groups it became necessary to state that the social perspective was required from all approved mental health professionals. In this way the social perspective itself becomes a jurisdictional claim of the social work profession and one which must be met by other professions wishing to encroach on this area of work.

Central to the profession of mental health nursing is the notion of forming and sustaining long term therapeutic relationships with patients that enable values-based practice (Department of Health 2006a). The professional imperative is ostensibly to engender trust, honesty and collaborative decision-making. As approved mental health professionals, however, nurses are required to take very difficult decisions in the best interests of the person but which the patient may dispute and firmly resent. Fulfilling this new role therefore presents a significant challenge in sustaining therapeutic engagement in the face of nurses' possession of new and potentially coercive powers. In addition nurses acting as approved mental health professionals

are entering new disciplinary territory, crossing a boundary into an area previously colonised by a social work profession having a long history of jurisdiction and claimed underpinning knowledge in this area. This raises significant questions about how welcome nurses are and the challenges they face in trying to integrate the approved mental health professional role. Against this background in this paper we outline the context to these developments, highlight the main requirements of the nurse acting as approved mental health professional and explore the evidence to date on these changes. We then consider the implications of our analysis for mental health nursing, and review whether the approved mental health professional role is an appropriate one for members of an occupational group largely steeped in biomedical practices. We argue that one outcome of introducing these fundamental changes in the area of mental health policy and practice is the potential for a wave of unintended consequences for the system of work, the provision of mental health care and specifically for the discipline of mental health nursing (Hannigan and Coffey 2011).

POLICY, STATUTORY MENTAL HEALTH WORK AND PROFESSIONAL KNOWLEDGE

It has long been recognised that mental ill health brings with it significant discrimination and exclusion (Thornicroft et al, 2009), and the potential of further oppression in denial of liberty and compulsory interventions. Reflecting this, mental health legislative frameworks internationally are expected to be informed by a human rights perspective (Kelly 2011). As in many other countries, in the UK a predominantly medical model of psychiatry has determined that civil commitment of those diagnosed with mental disorder is primarily a matter for psychiatrists, reflected

in the weight given to medical evidence in the statutory process. Specific mental health law in England and Wales provides the basis for the formal assessment, detention and treatment of people judged to have mental disorder of a degree or nature that warrants treatment and who are representing a significant risk to themselves or others. The law has, however, also consistently recognised that non-medical matters should be considered in civil commitment. The incorporation of a social perspective, for example, may inform decisions to pursue alternatives to hospital as being more appropriate in circumstances where someone is mentally distressed.

Until the recent changes to the Act it was social workers alone who brought this non-medical perspective to bear during formal proceedings, their role supported by educational experiences and an occupational socialisation presumed to sensitise them to the social situation of the person and the views of their nearest relatives. The independence of mental health social workers was a further important factor in informing whether civil commitment best met the needs of those being assessed. Since the amendments to the 1983 Act in 2007 it is approved mental health professionals who now have specific, legal, responsibilities in these circumstances. When consideration is being given to the use of compulsory powers (for example, when mental health professionals are considering admitting an 'at risk' person with mental disorder to hospital for treatment against his or her will) approved mental health professionals have the job of coordinating assessment processes and making independent decisions on whether to apply for detention and the possibility of compulsory treatment to begin (Department of Health 2008, Welsh Assembly Government 2008). The extension of 'approved' work of this type to nurses, clinical

psychologists and occupational therapists in addition to social workers has important implications for practitioners, for interprofessional role relations, and for service users.

The introduction of approved mental health professionals was one outcome of the UK government's focus on what it saw as inflexible working patterns (Department of Health 2007). In addition to signalling a shift towards greater flexibility in roles, the appearance of approved mental health professionals reflected specific concerns which had surrounded the former approved social work workforce. Approved social workers had been found to be increasingly in short supply (Huxley et al. 2005), and were also known to be an ageing group unevenly distributed throughout the regions of England and Wales (Newland 2006). Although data on their specific numbers had not been available since the last of a series of national surveys completed in 1996 (Brooker and White 1997), community mental health nurses by comparison were known to be more numerous and increasing their presence in multiple settings. However, the extension of 'approved' status to health workers was strongly contested. Some social workers, for example, argued that the perspective they brought to bear when decisions surrounding compulsory treatment were being made was occupationally distinct, and served as an important counter to the medical perspective associated most clearly with psychiatrists (Hatfield et al. 1997). As such this claim to a particular, social, perspective in the operation of the law has been an important part of the social work profession's historic jurisdictional appeal to occupy space in the system of mental health work. This has been so notwithstanding the observation that the close association between social work and statutory responsibilities has risked eclipsing the many other contributions social workers are

able to make in the mental health field. What is known is that, in the run-up to changes in the Act, survey research found that few social workers were happy with planned changes to their professional role and only a small minority were positive about their place in modern mental health services (Huxley et al. 2003).

The approved mental health professional role as Rapaport and Manthorpe (2008a) argue is a complex one requiring workers to adopt a parallel position as public authorities for the purposes of the Human Rights Act 1998 alongside their disciplinary role. Approved mental health professionals have overall responsibility for coordinating the process of assessment and its implementation should they decide to make an application when assessing for possible admission under the Mental Health Act 1983 (as amended 2007). Approved mental health professionals must manage legal, administrative and psychological intervention functions alongside clear social control imperatives that balance the risk to and from the individual with attempts to empower and promote the person's recovery. These are significant and extra-jurisdictional roles for mental health nurses creating implicit challenges for how they practice and also their understandings of associated underpinning theory and evidence.

At an early stage of the development of the role of the approved mental health professional Rapaport and Manthorpe (2008b), recognising that little evidence existed for nurses' views of the role, speculated that concerns about the therapeutic relationship and allegiance to the biomedical model may cause conflict for some nurses. They argued too that some nurses may see the approved mental health professional role as a chance to break away from this model and establish a more

independent stance from medicine. There is as yet no evidence on whether either of these outcomes has happened but we suggest that, at the very least, a strong divergence is possible in the role of the mental health nurse which appears to have been largely ignored until now. As we examine in detail below, competing forces are pulling mental health nurses in opposite directions: towards a social model of mental health and illness on one hand, and on the other towards a biomedical model of care and treatment. There may be, at the midpoint, a position often referred to as 'bio-psycho-social' but we caution against nurses making uncritical claims to this approach. We also question whether nurses, however comprehensively prepared, can ever be all things to all people (Happell and Cutcliffe 2011).

THE EVIDENCE SO FAR

The first evidence to emerge on the new role of the approved mental health professional was provided by Hewitt-Moran and Jackson's (2009) early implementer site report. This was a survey and follow-up interview study with individuals in sites where the new roles of approved mental health professional and approved clinician were being implemented. Hewitt-Moran and Jackson (2009) found at this early stage that 49 non-social work professionals (all nurses) had or were due to commence training as approved mental health professionals. The majority of these nurses were in adult community mental health teams though some were in child and adolescent mental health, older people and learning disability services. The incentive to extend the role of approved mental health professional to non-social workers appeared in part to relate to concerns about reduced numbers of available approved staff. When individual practitioners were interviewed however, there was a mismatch in terms of enthusiasm for the changes. Mental health nurses were generally positive and social

workers somewhat less positive about extending the role beyond their professional group. Social workers in this study were concerned about disparities in pay between them and mental health nurses but also more pointedly they raised concerns that nurses may not have the values-base, social perspective or the ability to arrive at decisions independent of their medical colleagues. There was a sense too that mental health nurses might not fully comprehend what was involved in the approved mental health professional role as evidenced by an open day which attracted 90 nurse participants but resulted in only six applications for training (Hewitt-Moran and Jackson, 2009).

The extension of nursing into this field may also be limited by structural challenges such as the lack of integration between health and social care organisations. In England and Wales the usual arrangement of services means than health workers are employed for the most part by NHS organisations providing hospital and community health care. Social care workers on the other hand are employed by local authorities who have a wide remit to provide a range of services including support to populations where 'health' is not the primary need. There is significant overlap between these organisations but also distinct differences in philosophies and structures. Suitably qualified mental health professionals gain their 'approved' status by means of being formally warranted by local authorities. As such, under previous legislation local authorities supported and trained their own employees (social workers) to become approved. The new arrangements however present novel challenges. For instance a national survey of approved mental health professional local authority leaders by Bogg (2011) found that 72% of local authorities had not extended their recruitment of approved mental health professionals to non-social

workers. This perhaps bespeaks an ongoing reticence to engage health workers in this role but also the lack of formal partnership agreements between local authorities and NHS organisations. Where nurses do successfully access the approved mental health professional training programme it has been found that most are directly employed by local authorities rather than by health service organisations (Parker 2010). The usual arrangement is that local authorities nominate potential candidates for courses as these organisations provide the required placements and practice supervision. Post-qualification these organisations are also responsible for legally warranting the approved mental health professional. At a time of financial constraint it may also be that local authorities are inclined to invest in developing their own (social care) staff only. NHS organisations may similarly be seeking to conserve their human resources, rather than supporting their staff to carry out additional tasks and functions which local authorities have the responsibility to provide. It may also be the case that the supposed shortfall in social workers to fulfil this role which was the impetus for these changes to the Mental Health Act 1983 may not yet apply in specific local settings. Bogg (2011) identified that 67 nurses were practising as approved mental health professionals and 31 were at that time in training suggesting limited national take-up of the new role among nurses. Although the evidence remains thin, this does nonetheless show that nurses in some parts of England and Wales are commencing approved mental health professional training and working in the role thereafter.

The training of approved mental health professionals has presented a number of teething problems. For example, Parker (2010) noted that the move of training to postgraduate level had had an impact on completion and attrition rates more

generally. In addition students tended not to see the link between practice competence and studying at a higher level and complained of courses being too focused on academic skills (Parker 2010). The concern here is in distinguishing between the needs of the workers and the needs of the governing bodies (which from the start of August 2012 are the Health and Care Professions Council in England and the Care Council for Wales) who stipulate that approved mental health professional preparation must be at masters level. Parker (2010) suggests that there is a tension between what was traditionally seen as 'training' and what is now positioned as 'education' for a complex and demanding role. This raises a concern about the level of understanding of the role among potential new approved mental health professional trainees. Bressington et al (2011) examined social workers' and mental health nurses' understanding of the role of the approved mental health professional using a concept mapping exercise. They found that social workers had greater understanding of the role prior to commencing educational preparation but that there were similar levels of understanding between groups on completion of the programme of study. Bressington et al (2011) suggest that this finding challenges notions that nurses are inherently disadvantaged by their professional background. The study suggests that alignment to the medical model does not prevent understanding of the concepts required to practise as an approved mental health professional. It remains unclear, however, whether this understanding transfers to practice settings and helps nurses to overcome the challenges, such as making decisions independent from those of medical practitioners.

There are further concerns in relation to the training of approved mental health professionals and the effects upon them of functioning in a role that often involves

highly charged situations where conflict and distress are everyday features. Gregor (2010) observes that these aspects of carrying out 'approved' work place unacknowledged and unrewarded emotional demands on practitioners. She reports from a qualitative study into the views and experiences of social workers in this area, highlighting the stressful nature of statutory mental health work and the importance of support for practitioners from employers. Drawing on data generated from interviews conducted with 25 professionals, Gregor (2010) writes of the 'containment' work that approved practitioners do in managing the stress and trauma experienced by individuals and families, and the emotional labour which this involves. More recently Hudson and Webber (2012) have found in a national survey of approved mental health professionals in England high levels of occupational stress with 43% reaching the threshold for common mental disorders such as anxiety and depression.

TENSIONS FOR NURSES IN ADOPTING NEW ROLES AND ADAPTING

Extensions to the work of mental health nurses bring challenges as they move into new and unfamiliar occupational terrain, and place pressure on taken-for-granted interprofessional relationships. Mental health nursing as an occupation emerged during a period in which the profession of psychiatry became dominant (Nolan 1992). Despite the opportunities for greater professional autonomy for other groups afforded by the move towards community care, psychiatry retains its position of power to this day. Indeed, in the face of threats to their collective authority some psychiatrists have moved to reassert their central role in UK mental health services (Craddock et al, 2008). Nursing's continued alignment to psychiatry is reflected in the present by mental health nurses being supported to fulfil new biomedical roles at a time when

they are also being encouraged, as approved mental health professionals, to demonstrate an independent grasp of social perspectives in Mental Health Act assessments. For instance, part of the wider drive to challenge inflexible professional structures has seen the extension of medication prescribing powers to nurses (Department of Health 2006b) reflecting international developments in the profession (Kroezen et al, 2012). There has also been recent renewed focus upon physical health problems in those with mental ill health and a demand that mental health nurses address this (Hardy and Thomas 2012). These are reasonable extensions of the role of the mental health nurse and their importance in improving services is not to be denied. Indeed it can be argued that their 'fit' with established nursing roles is better than extensions which have taken nurses into the mental health legislative arena, in the sense that medication prescribing and promoting physical health are closely aligned with the established biomedical focus for nursing. It is also unclear whether the role and legislative power of approved mental health professionals will enable nurses to assert themselves more readily with medical colleagues or if the influence of psychiatry is such that the previous independence of those fulfilling approved roles will diminish.

The proliferation of new roles for mental health nurses raises questions about how these are both practically accommodated and philosophically reconciled. The concept of a 'social model' of mental health care, so important in underpinning the jurisdictional authority of any occupational group to undertake approved mental health professional work, is itself problematic with Beresford (2002) acknowledging that there is still much to be done to work out what this is. Rather than delineate a social model *per se* Tew (2005) instead argues for a social perspectives approach

which requires more emphasis on the social processes that play a significant part in the manifestation and maintenance of what has become known as mental illness. It is unclear how far mental health nurses who are largely schooled in biomedicine will be able to provide care informed by this kind of thinking. At the very least, realising a 'social perspective' is likely to be far more complex than might be first imagined and, for nurses, is not an insignificant undertaking.

It is now widely claimed that mental health workers, nurses included, generally adopt what are termed psychosocial, or even bio-psycho-social, approaches (for a discussion and critique of this, see: Pilgrim 2002 and Pilgrim et al 2008). The phrase 'bio-psycho-social' can readily be found in contemporary nursing curricula and in textbooks, but alongside claims that mental health nursing practice is 'holistic' should be treated with extreme caution (Clarke, 1999). Pilgrim et al (2008) have argued that the bio-psycho-social approach has largely been sidelined by the reductionist tendencies of bio-determinism. As Johnstone (1993) noted, even the most ardent promoters of psychosocial interventions persisted with the notion of medication compliance (Leff and Vaughn, 1994). This is a distinctly biomedical response, leading to the suggestion that bio-psycho-social should be written as,

$$\text{`}\textbf{bio}\text{-psycho-}_{\text{social}}\text{'}$$

to illustrate the relative emphasis placed on biological elements and the subsidiary role accorded to psychological and social factors (Tew 2011). Biomedical approaches to mental ill health offer only partial explanations, are likely to be reductionist and remain contested (Pilgrim, 2002). McLaren (2007) has argued cogently that claims to the existence of a truly bio-psycho-social model are

unfounded and impossible to substantiate. For an occupational group such as mental health nursing, however, the bio-psycho-social concept serves an additional purpose as an effective rhetorical device to underpin new jurisdictional claims. The claim is in effect a means to an end and there is little attempt to interrogate the substance or application of the concept. Bressington et al (2011) have shown that suitably trained mental health nurses may be able to 'pass' as purveyors of a social perspective, but Nathan and Webber (2010) have highlighted how social workers themselves struggle to impose a social perspective in mental health settings leading us to conclude that great care should be exercised by mental health nurses in claiming any degree of competence in this area.

There is a view that participation in statutory Mental Health Act work risks damaging therapeutic relationships (Burns et al. 1995, Eastman 1995, Holmes, 2002), though more recent evidence from research involving approved social workers suggests this need not be so (Hurley and Linsley 2006). It has previously been found that community mental health nurses are aware of the impact of compulsory orders on their relationships with service users, and have confidence in their ability to maintain positive relations in the face of tensions (Jenkins and Coffey 2002). Nurses working as approved mental health professionals might do well to learn from their social work colleagues, for whom therapeutic relationships with service users are equally important and who have, collectively, managed to meet the challenge of maintaining these alongside the possession of statutory powers. Noting this, there are still likely to be subtle changes in the ways in which mental health nurses initiate and sustain relationships with service users (Coffey and Jenkins 2002). For instance, it has been shown that service users value the interactions they have with community mental

health nurses compared with those they have with inpatient nurses (Bee et al. 2008) who can be seen as more coercive (Beech and Norman 1995). The implication of this is that community mental health nurses with the legal power to be more coercive in their interactions may lose the support and co-operation of service users. One consequence of new roles could see the historically high satisfaction with community mental health nursing services (Care Quality Commission 2011) decline. Perhaps more important, however, is that therapeutic alliances as the very basis for achieving improved outcomes (Hewitt and Coffey 2005) associated with recovery in serious mental illness (McCabe et al, 2007) may be damaged. It would be naïve to think that therapeutic relationships are not subject to the same flux as other everyday interactions involving people. Mental health nurses may be concerned about the effect of statutory powers on their alliances with service users but there already exist numerous other informal avenues wherein nurses bring to bear their influence. For example, service users are aware that mental health nurses function as an effective conduit for the transmitting of information to psychiatrists (Coffey et al, 2004), including information leading to assessment for compulsory treatment. Mental health nurses are sometimes required to participate in verbal challenges, physical restraint and medication of people with mental health problems and despite this claim to be able to pursue therapeutic alliances (Schafer and Peternelj-Taylor 2003). Bee et al (2008:448) however found that despite nurses' stated interest in the therapeutic relationship many service users complained of insufficient time to talk with their named nurse so that "many experienced only a passing relationship with this person". The challenge for mental health nurses is then to apply formal powers in a sensitive and compassionate way that is informed by the needs and experiences of those using services.

The experience of users of health and social care is an important source of evaluative evidence (Sullivan 2003) and will be significant to the work of approved mental health professionals. The decisions made by approved mental health professionals can lead to compulsory care and treatment, in both hospitals or in the community. There may be considerable and enduring negative outcomes for people who receive services from nurses doing approved mental health professional work. For example, compulsory care may reduce social networks, jeopardize employment prospects and damage self-efficacy (Coffey 2012). In addition to being a valuable source of evidence in its own right, knowledge of service users' experiences of contact with approved mental health professionals fulfilling statutory responsibilities can also contribute to an understanding of practice and procedures at 'street-level' (Lipsky 1980). Service users can provide clear, valid and objective evidence of the services they receive (Coffey and Hewitt 2008), and their views of care and treatment are a relevant indicator of prognosis following involuntary commitment (Priebe et al. 2009). Social, and now increasingly biomedical, approaches claim imperatives to involve and collaborate with users of services, as do contemporary policy drivers. Nurses in their attempts to encroach and colonise the jurisdictions of both social and biomedical professionals must also find ways to form partnerships with service users. The addition of new powers inherent in the role of the approved mental health professional presents significant challenges in reconciling the rhetoric of partnership with enforced compulsory treatment. One example of this relates to how community mental health nurses might encourage shared decision making and the exercise of individual patient autonomy in planning of health care (Charles et al, 1997). Increasingly autonomy, empowerment and involvement in care decisions

have been shown to promote recovery (Adams and Drake, 2006). Set against this community mental health nurses working as approved mental health professionals may also be responsible for removing choice, involvement and autonomy when making decisions to apply for compulsory detention and treatment. These are significant extensions to the role of workers who ostensibly are providers of health care and should not be underestimated especially in light of evidence of the emotional burden that such work entails (Evans et al 2005; Hannigan et al 2000). Cross-professional learning from colleagues in social work may prove a useful avenue to pursue for nurses wishing to understand how the tension between the use of statutory powers and maintaining relationships and involvement with service users can be managed.

CONCLUSION: JURISDICTION AND THE PROFESSIONAL PROJECT OF MENTAL HEALTH NURSING

We have suggested that, for the profession of nursing, the new role of approved mental health professional presents a significant departure from existing modes of practice, and extends the responsibilities of nurses into new and uncharted areas previously the preserve of social workers. These developments are happening as additional (and not necessarily compatible) changes are taking place in other areas of mental health nurses' work. The cumulative effects these shifts are having on nurses' collective understandings of their role are entirely unknown. Equally unknown are the effects these role and responsibility changes are having on the views that others (including service users and members of different professional groups) have about the work and character of mental health nurses. In our view, in the specific case of the 'approved' role, the idea that mental health nurses have

22

unproblematic access to an independent social perspective to inform their decision-making when the use of compulsory powers is being considered looks hopeful at best.

Godin (1996) reviewed the history and development of the early decades of community mental health nursing, arguing that nurses have engaged in a partially successful attempt at professionalisation. This 'professional project' has involved different strategies at different times (such as securing closer alignment with colleagues in primary care) to lever occupational advantage. Any attempt to achieve professionalisation by any group of workers must, according to Freidson (1970), do so by securing autonomy over a particular aspect of work. Psychiatrists largely have sole authority over the diagnosis and treatment of the mentally ill. They also have powers to detain and compulsorily treat their patients. Community mental health nursing has traditionally been subordinate to the powers of psychiatry. New roles in the delivery of mental health care have the potential to challenge this position. Routinely community mental health nurses now conduct independent symptom, health need and risk assessments. Some have limited medication prescribing powers (Nolan et al 2004) and increasing numbers of practitioners demonstrate advanced psychotherapeutic treatment skills (Gournay 2000). The advent of the new role of approved mental health professional may be another step towards advancing the independent professional project of community mental health nursing. As yet we do not know, however, how the profession as a whole will respond to this development. Mental health nursing is a large and internally 'segmented' (Bucher and Strauss 1961) group, and some of its members may come to be defined by statutory approved mental health professional work rather than seeing this as

another element of the larger role. Processes of this type may happen whilst other members pursue other opportunities, such as medication prescribing. However for those using services it remains imperative that nurses place the person at the centre of care. This will require nurses to demonstrate clear independence and the ability to provide a strong counterbalance to what will otherwise be the hegemonic provision of psychiatric care.

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