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Implications for mental health workforce strategy, professional training and supervision of more widespread adoption of the multi-professional Responsible Clinician role: Results of a qualitative inquiry

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Abstract

Within mental health legislation in England and Wales the Responsible Clinician for specific patients should be the Approved Clinician with the most appropriate expertise to meet their primary assessment and treatment needs. The study aimed to explore nurse and psychologist perspectives on becoming a Responsible Clinician in the context of their limited uptake of the role and calls for an increase in advanced practice roles within mental health. It comprised a qualitative inquiry in the form of a thematic analysis of 12 semi-structured interviews. Four sub-themes emerged under the theme of 'becoming a Responsible Clinician'. They were: (i) the Responsible Clinician amongst other roles; (ii) developing in the role; (iii) working with psychiatrist colleagues; and (iv) organisational context. Responsible Clinicians were juggling the role with other senior clinical responsibilities, often without a coherent programme of ongoing educational development or organisational support structures. If mental health service provider organisations adopt this extended role more widely then role-specific support and supervision arrangements should be in place as part of a coherent workforce strategy. This is particularly important given the legal and ethical responsibilities of the Responsible Clinician.

(188 words)

Keywords: responsible clinician, mental health, advanced practice, mental health law, professional roles

1. Introduction

The 2007 amendments to the Mental Health Act 1983 in England and Wales created new statutory roles for mental health professionals. The previous responsible medical officer (RMO) became Responsible Clinician (RC). Nurses, social workers, occupational therapists, psychiatrists and psychologists became eligible to be RCs. RCs are responsible for the overall care and treatment of specific patients detained in hospital or subject to compulsion in the community under mental health legislation. RCs must be deemed competent as an approved clinician (AC) by an approvals panel with the delegated authority of the Secretary of State for Health and Social Care, based on a portfolio of evidence of their professional competence (Department of Health, 2017). The RC has specific legal responsibilities in relation to their patients (for example, granting leave of absence, discharging from or extending detention) which are predicated on the RC having demonstrated competence in a range of skills including: the identification and assessment of mental disorder; assessment of risk and capacity; knowledge of a range of treatments; and skills in leadership, care planning and communication (Department of Health, 2017).

The Mental Health Act 1983 Code of Practice provides statutory guidance for the operation of the Act. It states that a patient's RC should be the '*the available approved clinician with the most appropriate expertise to meet the patient's main assessment and treatment needs.*' (Department of Health, 2015, para 36.3). A psychologist, mental health nurse, social worker or occupational therapist could be the available approved clinician in possession of the expertise required by a particular patient or patient group, for example, in a specific psychological approach to their care and treatment. However to date uptake of the RC role by eligible multi-professional staff has been limited. Only around 0.1% percent of RCs in England are not psychiatrists (Health Education England, 2020). It may be that for some non-medical healthcare professionals, being responsible for decisions to detain or discharge patients is anathema to their perception of the core purpose of their professions. It has been suggested, however, that clinical care in any setting in which patients have been or could be legally detained is provided under a 'coercive shadow' (Szmukler et al, 2014).

The presented study is timely because in January 2021 the English government published a White Paper consultation on reforms to the Mental Health Act, following an independent review (Wessely et al, 2018), which proposed increased accountability of RCs for care and treatment plans, community orders and lengths of admission. Furthermore, in late 2020 Health Education England published an Implementation Guide for NHS organisations and partner agencies seeking to expand the multi-professional RC workforce (Health Education England, 2020a). It reflects a commitment in the NHS People Plan (the statement of national healthcare workforce strategy) to increase RC

numbers within the year 2021 (NHS, 2020). Workforce pressures within the English healthcare system have led health service providers and policy makers to seek out innovative and cost-effective ways of deploying the limited resource of senior mental health professionals to meet population demands. This includes a revision of roles and tasks that were previously the domain of medical staff (Harding et al, 2019), hence a surge in interest in multi-professional RCs. This study is of wider interest because it mirrors calls for re-evaluations of professional domains to address gaps in provision within mental health services worldwide (Delaney, 2017; Delaney & Vanderhoef, 2019; Kakuma et al, 2011). Similar multi-professional roles exist in New Zealand, for example, but again, the proportion of non-medics is small and research into the experience of this workforce is minimal (McKenna et al, 2006).

This study is also of interest to service providers and educators seeking to offer senior clinicians, for example nurse consultants, appropriate clinically-focused roles commensurate with 'advanced practitioner' status. Lack of opportunities for continuous professional development have been cited as a common reason for experienced staff leaving the National Health Service in its Long Term Plan (Department of Health, 2019). Directors of nursing have reported that senior clinical nursing roles often lack clarity in relation to post-holders' responsibilities, competencies (Brimblecombe et al, 2019) and post-qualification career pathways (Rafferty et al, 2015). Where training programmes exist to assist clinicians to progress to becoming advanced practitioners, there has been a lack of consensus regarding what that training should involve and what an advanced practice career pathway might entail (Dover et al, 2019). There has been limited focus on continuous professional development for mental health clinicians who are in consultant-grade roles in the later stages of their careers, and whilst strategic frameworks for introducing advanced nursing practice roles do exist (e.g. Boyko et al, 2016), they have not been used in mental health services. The recently published Career Framework for Mental Health Nursing and Advanced Practice Curriculum Framework for Mental Health, both published by Health Education England (2020b; 2020c) refer to the mental health RC role as an option for senior nurses but the role is not discussed in detail, except that it reflects *'the highest level of expertise (usually) in one particular clinical specialty within mental health, and the expectation to clinically lead and influence for the highest standards in practice.'* (2020b, p24).

The aim of the current study was to explore the experiences of nurse and psychologist AC/RCs with the goal of informing educators and employers on how to best support wider adoption of these roles in mental health services. It focuses on the experiences of a group of nurses and psychologists who were early adopters of the extended AC/RC role. The numbers of occupational therapists and social workers who had taken on the role when the study was undertaken was negligible (Oates et al, 2018), thus the focus of the study was on these two professions. The paper builds on

the findings of the first national survey (Oates et al., 2017) and Ebrahim's (2018) interview study of a geographically specific group of multi-professional RCs which explored their views on the leadership aspect of the role. Qualitative studies such as these are often most appropriate when there is little known about a particular group of 'social actors' (Holloway & Wheeler, 2012).

2. Material and Methods

Three researchers conducted twelve 60 minutes semi-structured telephone interviews between them using a topic guide (see Appendix 1) from January 2018 to January 2019.. Interview participants were purposively selected from respondents to a national online survey of multi-professional ACs (Oates et al, 2018) to represent a range of clinical settings and of mental health service provider organisations. All study participants were practicing RCs. Seven were male, five female. Five were nurse consultants and seven were consultant clinical psychologists. They worked in acute mental health, dementia, rehabilitation, children and young people's, and forensic mental health services.

Audio recordings of the interviews were transcribed and thematically analysed following Braun and Clark's (2006) six-phase approach. In the 'familiarisation' phase one researcher listened to the audio recordings and read the transcripts multiple times. Next 'initial codes' were generated through line-by-line annotations of the transcripts, followed by the organisation of data into thematic nodes using *NVivo* software. Then nodes were sorted and mapped into a thematic tree comprising higher order, middle order and sub-themes. The validity of the analysis was enhanced through a comparative coding exercise, in which three researchers compared codes for two of the transcripts and agreed codes and themes. Next themes were reviewed in order to form a coherent pattern, at which point higher order themes were identified. In the 'defining and naming' phase, the lead researcher produced descriptions of each theme, with illustrative quotes. These were shared and agreed with the wider research team. In the final 'producing a report' phase, a comprehensive account of the themes was written by the lead author then discussed and agreed with by the research team. This paper presents an analysis derived from the higher order theme of 'becoming a Responsible Clinician'. Another higher order theme ('responsibility and power') has been discussed in a previous publication (Oates et al, 2020).

The study protocol, topic guides, participant information and consent procedures were approved by XXX Research Ethics Committee (REF XXX:). Pseudonyms were used throughout the analysis and in the reporting of the study. Limited information about participants has been presented here in order to preserve the anonymity of study participants who gave consent to take part in the study.

3. Results

'Becoming a Responsible Clinician' was the higher order theme, with sub-themes of: (i) the Responsible Clinician role amongst other roles; (ii) developing in the role; (iii) working with psychiatrist colleagues and (iv) organisational context. The overarching and sub-themes encapsulated how study participants had been supported to develop and how their AC/RC roles fitted into the existing health service delivery structures of their employing organisation.

3.1 The RC role amongst other roles

Participants reported having extensive clinical experience and expertise in working with patients in specific settings. They were the RC for particular patients based on having the best skills and experience to meet that patient's main care and treatment needs. Allocation of an appropriate caseload was agreed in different ways. Some RCs were the lead clinician for a specific ward, for example a nurse-led specialist unit. For others, caseloads were divided on their units between themselves and a medical colleague according to an assessment of whether the patient would best suit a psychologically-led approach or a medically-led one. Of note, some RCs were also lead clinicians for non-compulsorily detained (voluntary) patients because being an RC had resulted in them becoming the lead clinician for a particular ward. Two participants said that they took 'their share' (an agreed quota) of most acutely unwell patients. For John this was about not having the 'luxury' of declining cases, which he had had in his psychologist role; and for Frank it was about proving that psychiatrist colleagues are not the only people who could manage 'acute' patients.

For most participants, being an RC was one of several roles they held within their organisation. Lloyd and Edward made a distinction though, between their roles as psychologists and their roles as RCs. Lloyd said:

'Well, I'm not being a psychologist to the patients I'm RC-ing; I've made that decision so it's a therapeutic relationship but it's not a psychologist-patient relationship because we're lucky enough to have psychologists on the ward that I'm delivering to and so yeah, there's no need. I'll be treading on toes if I was to start trying to be a psychologist as well as an RC.'

Commonly, study participants said that they had been concerned that being an RC may adversely affect their therapeutic work with patients. For example, Lloyd said:

'... my perception of the role before I became approved was that it would be incompatible with a therapeutic relationship with the patients that I was RC-ing. It just felt like some coercive power-based role with a patient would preclude any possibility that you could have any sort of therapeutic relationship with them.'

There was a difference between the nurses and psychologists here, with the nurses seeing RC responsibilities as fitting well with the other aspects of being a nurse consultant, including prescribing, supervision and research. The psychologists saw some potential conflict between being a consultant clinical psychologist and being an RC due to the coercive power and authority inherent in the role potentially conflicting with their therapeutic identity and relationships.

3.2 Developing in the role

Participants described how they took on RC responsibilities following periods of shadowing and working alongside other (usually medical) RCs. They gradually took on a caseload whilst gathering evidence for their approval portfolio. Compiling the evidence for the portfolio was seen as arduous, with Keith (a psychologist) saying that:

'... they [the approvals panel] needed case records and example risk assessments, details of all my training and all that sort of stuff. They were of the view that that still wasn't enough and I, sort of, thought, well, I have a hell of a lot more training than a psychiatrist who automatically gets this so, you know.'

Participants talked about growing in confidence in the role over time. They became more confident in making treatment decisions but also in addressing tribunal panels and completing legal paperwork. This was seen as typical of how confidence grows in any new (and relatively uncommon) role, but there were particular challenges to face, as summed up by Lloyd:

'I think you could probably divide the challenges into the ordinary confidence-building challenge that comes with any new senior role, and distinct to that, the political challenge of working alongside medical colleagues, and other professional colleagues actually from other disciplines, who are less enthusiastic about the idea of me being an RC than I am. I think that's putting it diplomatically.'

Important aspects of developing as a RC were support from peers and clinical caseload supervision, both from other multi-professional RCs and from medical colleagues who were their peers in the sense of sharing caseload decisions within their service. Participants' developmental needs were primarily related to making difficult clinical decisions and management of their caseload. For Gina (a psychologist) and Olivia (a nurse), who conceptualised their roles as RCs as being 'clinical leaders', their developmental needs related to establishing leadership skills and promoting certain models of care, as well as dealing with particular cases. Several participants described how they

supported and supervised other members of their team. For Olivia this was part of her vision for the service to remain 'nurse-led' when she retired.

Study participants described a range of experiences regarding supervision and support. Diana (a psychologist) described a 'really good relationship' with her medical colleague, whereby they supported each other to balance caseloads:

'He might say to me 'Oh, you've got five or six really challenging people with kind of quite challenging personalities and who are self-harming a lot on the ward, are you all right with all of those five or six people? Do you want me to take someone, or reallocate people?' and we'll just kind of ... we allocate people for a period of time and, you know, I would offer the same in terms of, you know, do we need to think about this in a different way.'

Similarly, Neil's primary support was his consultant psychiatrist colleague, although the relationship was described as more supervisory than the peer-to-peer support described by Diana:

'I have supervision with the consultant who works on the ward, so we have supervision about, he was my supervisor I suppose when I was going through the approval process. So we have ongoing supervision now, so if I'm struggling with a patient or if I've had a new experience or something like that, we meet each week and we can discuss those things.'
(Neil, a nurse)

Other (psychologists) participants described how they accessed a peer support network via the British Psychological Society and as members of the learning set from a local university RC preparation course. Through networking with other RCs, participants were aware of different support and supervision arrangements in other organisations. As members of a small group of multi-professional RCs, participants had to define and seek out support and supervision arrangements that suited them. John, for example, held a director role in his organisation as well as being an RC. He described how his organisation had expanded their RC learning sets as the roles had developed over time. Helen did not have the same amount of organisational sway:

'I have not had another AC to go to, to go and have those conversations and I think that's a huge miss really. I sort my own training out myself so we're looking at further training related to keeping, you know, maintaining that role whether it be through BPS or other forums, so I go and research that myself and just book myself on. But yeah, there's nothing coming through from our Trust in terms of developing the role or supporting the role.'

There was frustration voiced by some participants at not being able to access the same training and developmental opportunities as medical colleagues, whereas others were able to access relevant training and supervision along with AMHP and medical colleagues.

3.3 Working with psychiatrist colleagues

There were three types of relationship described: psychiatrists as mentors and supervisors; psychiatrists as peers; and psychiatrists in positions of influence over the role. There were positive and negative experiences of each. Some of the RCs had been mentored by psychiatrists during their pre-approval preparation and for some this had led to an ongoing supervisory relationship, either for regular case supervision or on an ad hoc basis to advise on treatment plans. Participants described how the dynamic between them and psychiatrist colleagues became more peer-like once they obtained AC approval or proved themselves as competent in the role. This change in dynamic was particularly felt by the nurse RCs, as exemplified by Olivia:

'...Because previously I was a nurse, and I know this sounds silly, but the Consultant psychiatrists now see me as one of them, which is nice because they invite me to everything, it's like a peer-to-peer.'

Encounters with psychiatrists in powerful roles included trust medical directors and medical members of tribunal panels. Participants described how their medical directors had championed their role and their autonomy, for example, Olivia's vision for a nurse-led unit. This was the case particularly when the RC roles were embedded in trust workforce strategies. Being 'tested' by medics was an experience described by several participants, for example when they discussed cases with their mentor and peer RC medics.

Psychiatrists who sat on tribunal panels ranged from being encouraging to testing and patronising the RC, as described by Keith:

'So, I've had some tribunal doctors ask me exceptionally basic questions that, what do they keep asking me this for? And it's obvious that they're testing me, do you know what I mean? Do you know, asking me about basic symptoms of, I don't know, psychosis or something. And while I appreciate it, you know, I think, "You've seen my report, why are you asking me about it?" You know, it almost feels like I'm being tested, whereas other ones have been fine.'

It is important to acknowledge that where most participants reported that colleagues had accepted them in their role, three participants described hostility and friction between themselves and medical and nursing colleagues. Lloyd described his difficulties getting access to relevant experience from his assigned RC psychiatrist mentor. He termed this as *'described enthusiasm but enacted reluctance'*. Even in services where there were multiple non-medical RCs, study participants were in a minority and found themselves educating fellow mental health professionals about what the role entailed, and importantly, the clinical ethos that they, in a leadership role, wanted to create.

Most participants gave accounts of positive feedback they had received from ward-based colleagues, including psychiatrists, about their role, typically that they were 'more present', 'more flexible' than other or previous RCs. They did, however, describe collegiate resistance relating either to their change in status (from fellow nurse or psychologist to clinical decision maker) or to changes in their attitude to risk on becoming RC, particularly if they (as the RC) was seen as a 'risk-taker'. This was summed up by Gina:

'...But I think the nursing team, what they struggled with, was if I challenged the medical model quite a lot, not overtly particularly but just being but just in terms of approach being so different and things around less restrictive practice.'

3.4 Organisational context

This theme encapsulated how study participants viewed their role in the wider context of the strategy and policies of their employing organisation and the National Health Service. Recent governmental austerity policies were seen as having had a pervasive influence. Several participants described the impact of workforce shortages and *'lack of investment in services, the loss of staff, the lack of investment in nursing posts'* (Keith) as impacting on their work. Whereas Keith saw that national mental health policy was leading to shortages of senior nursing roles and limiting nurses' opportunities to progress in their careers, Lloyd, from a psychologist point of view, argued that psychologists should take on key roles such as RC in order to seem less 'disposable' when cuts were imminent.

Problems with medical recruitment were seen as a reason why some organisations were becoming more interested in the multi-professional RC role, with Helen and Frank describing a lack of psychiatrist cover in their areas. Diana described how the replacement of medics with multi-professional RCs was not always a popular move with medical colleagues as they saw it as impacting negatively on their 'on call rota', to which non-medical staff could not contribute, resulting in medics being on call more frequently. Edward described that developing multi-professional RCs could be

seen as a threatening encroachment on 'the preserve of the medically trained professional'. He said:

'... there's a fear among the medical directors, from some of my psychiatry colleagues, that if they allow non-medics to do this role there'll be a reduction in psychiatry posts.'

The development of the multi-professional RC role was, for some participants, part of their employing organisation's strategy to develop and diversify the workforce, alongside other developments such as non-medical prescribers (pharmacists and nurses) and advanced clinical practitioners. All participants were in consultant-grade posts, but appropriate remuneration and salary grading for the RC role were contentious issues. The RC role was seen primarily as a senior clinical post, but for the nurses it represented a '*huge jump*' (Martin) from a nursing advanced practitioner role. Martin took on the RC role as a means of testing how it might fit in a developmental structure for advanced nursing practice for his organisation. As vanguard multi-professional RCs, several participants were involved in writing local policies about how the role would work. Edward (a psychologist) said:

'I had to also write a policy around how I should be deployed, who would manage me, I guess how conflicts would be managed if the primary treatment need changes, for example, became much more medicalised in nature.'

The ceiling for nurses within NHS clinical structures is nurse consultant, a post held by all five nurses interviewed. Olivia, who had been an RC for several years said there was nowhere up for her to go professionally (in terms of salary and job grade) unless she became a director of nursing. Grading and salary were also concerns for psychologist participants. When John described the discussions about grading and remuneration in his trust he said that there was a lack of motivation amongst some senior psychologists to take on the role in addition to their other responsibilities. Keith considered that there was a low uptake of the RC role because of a lack of clear financial incentives in terms of re-grading or salary increase. He had been involved in discussions about a re-grading and salary top-up but such a significant change would have knock-on effects elsewhere in his organisation because:

'... there's no new money, so we'd have to take it from existing funds, which would mean a reduction in psychiatry time.'

Participants described how their employers were beginning to incorporate expectations of being an RC or willingness to train to be RCs as part of job descriptions for nurse consultant and consultant psychologist posts. Martin, who held a strategic lead role, said that:

'We're working on a development structure to allow people to become approved clinicians and allow them to be compensated appropriately as well for that. We've got to be clear about how that works in different roles because working as a Responsible Clinician in a very busy acute ward is a very different experience to working in, say a learning disabilities unit with a small number of beds and a very static group of clients, or in an older adult ward.'

Diana saw the perception of multi-professional RCs in her trust as moving from an experiment, to a viable means of addressing mental health workforce shortages to: *'I think we are starting to move towards a place where people recognise it's a positive skill mix,'* whereby there could be clinical advantages to having multi-professional RCs. For her, shifting the organisational perspective to one of active recruitment of multi-professional RCs was about building up the evidence that it worked in practice

4. Discussion

The findings of this study offer a novel insight into the complexities of the multi-professional RC role. Despite the role being in existence for over a decade, it is still in its infancy. Organisational uptake has been often 'experimental' rather than part of a coherent workforce plan. There was a consensus about the importance of support and supervision tailored to this specialised role, but this was implemented differently in the different organisations involved. Gaining the trust and respect of colleagues could be frustrating and the process of gaining statutory approval to be an RC was seen as arduous. It was apparent that this vanguard group and their employers had been working out how to define the role, how the role should be supported and developed, and how it might be governed and incorporated into a workforce strategy. Sometimes there was lack of adequate peer support within employing organisations. Relationships with psychiatrist colleagues ranged from collegiate and supportive to hostile, not least because professional territory encroachment could have implications for psychiatrists' workloads and career prospects. Organisational promotion of the multi-professional RC role was in its early stages but was being adopted in an increasingly strategic way in some organisations, as evidenced by its inclusion in workforce strategies, however there was no consistency between organisations about remuneration and grading and organisational buy-in was not always matched by enthusiasm from psychiatry colleagues affected by non-medical staff taking on senior clinical roles. As one of the first studies of the experi-

ences of this inter-professional group, there are few other groups with whom to make a direct comparison and there has been no research on psychiatrists' perspectives on the multi-professional RC role. The tensions described by study participants mirror those reported by newly-appointed AMHPs, particularly in relation to tensions between therapy and coercion (Coffey and Hannigan, 2013). British Psychological Society guidance dealt with the issue when it recommended that psychologist RCs *'must remain aware of and give full consideration to any potential competing duties of care between the RC and psychological therapist roles when providing psychological treatments to patients over whom they have compulsory powers'* (Taylor et al, 2009; p. 10)

There are parallels also with survey findings on mental health nurse prescribers (Dobel-Ober & Brimblecombe, 2017), particularly the observation that it may take many years for new roles to be taken on in large enough numbers to have a significant impact on service delivery models. The themes reflected here are similar to those described by Casey et al (2019) in their study of the barriers and enablers to advanced practice roles in nursing and midwifery which found that such roles must be championed by senior colleagues, inter-professional peers and must be part of a strategic workforce approach.

The stimulus for a more widespread adoption of the role has arrived with Health Education England's call to increase numbers of clinicians working *'at the top of their licence'* (Harding, 2019) and the recent publication of Implementation Guidance for NHS and partner organisations on developing multi-professional RC roles (Health Education England, 2020). The findings of the current study suggest that there must be coherent governance and support structures in place given the legal weight of the clinical decisions that RCs are required to make on behalf of detaining authorities.

5. Limitations

This study has a number of limitations. It reflects the experiences of a small group of clinicians at one point in time working within one country's legislative framework. It lacks the service-user viewpoint and a longitudinal perspective. However, considering the implications of the implementation of the role in the context of advanced practice, new ways of working, workforce diversity and demographic issues, the study findings potentially have a broad reach, particularly in relation to national workforce strategy in England.

6. Conclusion

The study findings have implications for mental health service provider organisations if there is to be widespread adoption of the RC role by non-medical staff. Becoming an RC appears to be a viable and rewarding career development opportunity for senior psychologists and nurses who have the most appropriate expertise and skills to lead on the care of particular groups of patients. These

extended roles could involve multi-professional RCs becoming clinical leads for entire services in order to achieve cultural change and transformation of traditional models of care. Individual clinicians must consider how taking on these statutory roles will affect their therapeutic relationships with patients, given they will be directly responsible for decisions to restrict their liberty. The balance of the RC workload and other responsibilities must be subject to ongoing review and should be the focus of the mentorship, support and supervision that such a role demands. Addressing the practical implications of incorporating multi-professional RCs into a sustainable workforce strategy and plan that is applied consistently may help to reduce inter- and intra-professional tensions - as would clarity about career development pathways, grading and remuneration.

(4,846 words)

Acknowledgments:

XXX

Declaration of interest statement:

XXX;

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Tables

None

Figure legends

n/a

Appendix 1

Interview topic guide