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# **Responsibility as professional leadership and decision making: Interviews with non-medical Responsible Clinicians**

**Jennifer Oates, Carole Burrell, Selma Ebrahim, John Taylor, Paul Veitch, Toby Brandon**

## **Abstract**

**Background:** Responsible Clinicians are professionals who are primarily accountable for the care and treatment of patients detained under the Mental Health Act 1983 in England and Wales . The role has only been taken up by under 100 nurses and psychologists since 2007. The aim of this study was to explore the experiences of non-medical Responsible Clinicians, to inform our understanding of interprofessional dynamics and professional identity in contemporary mental healthcare.

**Methods:** A qualitative study comprising thematic analysis of interviews with twelve non-medical Responsible Clinicians.

**Results:** A major theme of 'Interpretations of responsibility' emerged, with two sub themes: 'Responsibility as leadership' and 'Responsibility as decision making'. Taking on the role had implications beyond the care of specific patients. Participants saw themselves as having the power to shape their team and service whilst exercising their authority to make difficult decisions about risk and restrictions.

**Conclusions:** More widespread adoption of the non-medical Responsible Clinician role should not be seen solely as a solution to workforce shortages or lack of opportunities for professional advancement. Consultant nurses and psychologists who take on this role are seizing the opportunity to steer service developments more widely, influencing team dynamics and perceptions of accountability.

200 words

## **Keywords**

Mental health services; Risk; Shared decision making; Professionalism

## **1. Introduction**

Most countries have some form of mental health legislation that permits the compulsory detention and treatment of people deemed to be suffering from mental disorder. In England and Wales that legislation is the Mental Health Act 1983 (amended 2007). The criteria for detention under the Mental Health Act are not specific disease classifications, rather they comprise '*any disorder or disability of the mind*' (section 1 (2)) the '*nature or degree*'

of which warrant a person's detention *'in the interests of their own health or safety or with a view to the protection of others'* (section 2 (2) and section 3 (2)). As a safeguard against the potential abuse of power by agents of the state, primarily medical professionals, mental health legislation requires a number of parties to be involved in decisions to detain people (Rogers and Pilgrim, 2014). The Mental Health Act describes the roles whose primary purpose is to vouchsafe clinical decision making about mental disorder, namely the Second Opinion Appointed Doctor (SOAD) (under sections 57 and 58), the Independent Mental Health Advocate (IMHA) (section 130), and the Approved Mental Health Professional (AMHP) (section 114). Once detained, each patient will have a named Responsible Clinician (RC), who is legally accountable for their care and treatment. Prior to the 2007 amendments to the Mental Health Act the equivalent role was that of Responsible Medical Officer. Post 2007 the redefinition of the role as Responsible Clinician meant that other professionals than medics (usually psychologists and nurses) could become Approved Clinicians (AC), making them eligible to have *'overall responsibility'* (section 34 (1)) for specific patients if they possessed *'the most appropriate expertise to meet the patient's main assessment and treatment needs.'* (Department of Health, 2015, para 36.3).

The role has not been widely taken up by non-medics. In 2018 there were fewer than 60 non-medical RCs compared to over 6,000 medical RCs (Oates et al, 2018). Seventy per cent of non-medical RCs completed an online survey in 2017, revealing their majority (64.9%) to be psychologists, 24.3% to be nurses, 1 social worker and 1 occupational therapist. This is in the context of there being around 43,000 registered mental health or learning disability nurses, 13,300 psychologists or psychological therapists and 7,700 psychiatrists in consultant, staff grade or and speciality grade posts in England and Wales in January 2019 (NHS Digital, 2019, StatsWales 2020). The spread of non-medical RCs has not been even across the nations, with the majority being employed in two neighbouring trusts in the North of England. One of these trusts had been a 'field test' site for the development of the role, meaning that an educational programme and peer support network had evolved in that area of the country.

In this paper we present qualitative findings from the first national study of non-medical mental health service professionals who have taken on the RC role. There has been one previous localised study (Ebrahim, 2018). The aim of our study was to explore the experiences of non-medical ACs, to inform our understanding of inter professional dynamics and

professional identity in contemporary mental healthcare, extending the study's relevance beyond England and Wales.

## 1.1 Background

An analysis of how new professional roles have been interpreted in practice is timely, given the multiple pressures that currently face mental health services and affect future mental health workforce planning. Health services in England have been functioning in an era of austerity, with increased local accountability for financial decision making being matched by pressure from central government to decommission services (Harlock et al, 2018). The impact of austerity on areas of social life, such as housing, benefits and job insecurity seems to have a particular impact on mental health (Knapp, 2012; Stuckler et al, 2017; Cummins, 2018), escalating demand for services. The number of detentions under the Mental Health Act has been increasing in recent years (Care Quality Commission, 2019), rising higher in England than elsewhere in Europe (Wessely et al, 2018), although there has been a reduction in the number of available psychiatric hospital beds (Wessely et al, 2018).

A further major pressure on the health service is the shortage of mental health clinical professionals, including nurses, psychologists and psychiatrists (Durcan et al, 2017). The National Health Service (NHS) Long Term Plan (NHS England, 2019) committed to supporting clinicians to expand their scope of clinical practice (2019, p86), not least to address the workforce shortage. The interim NHS 'People Plan' (Harding, 2019) published in June 2019, called for transformation of roles with 'richer skill mix' (Harding, 2019, p32). Increasing the number of non-medical RCs could be one way of addressing skill mix and shortages, giving senior nurses and psychologists the opportunity to act as senior clinicians.

Mental health service development in the past half century has always been driven by a combination of financial pressures to reducing the cost of services alongside a moral imperative to move away from perceived psychiatric paternalism (Chow et al, 2018). The recent Independent Review of the Mental Health Act (Wessely et al, 2018), recommended that a statutory principle of choice and autonomy be included in a revised Mental Health Act, giving enhanced weight to the patient voice (2018). Although not expressly stated, in the context of inpatient care and treatment this would arguably extend to respecting patient preference over their RC. It is within this context that individual clinicians, service pro-

viders and professional bodies must examine the implications of a wider uptake of the non-medical RC role.

## **2. Material and methods**

We conducted a qualitative study using an inductive thematic analysis of interview data (Braun and Clark, 2006). Such a methodological approach is suitable when little is known about the lived experience of a specific social group (Holloway and Wheeler, 2012). Rather than imposing a theoretical framework on findings, inductive analysis was used to identify the emergent preoccupations and shared experiences of the group. The study is reported here with reference to the COnsolidated criteria for REporting Qualitative research (CoREQ) (Tong et al, 2007). Ethical approval was gained from the lead author's university Research Ethics Committee. Research was undertaken according to the British Psychological Society (2014) Code of Human Research Ethics.

### **2.1 Data collection**

We interviewed 12 non-medical RCs. Inclusion criteria were that they were a practicing RC with a caseload. Data collection took place between January 2018 and January 2019. Participants were recruited via a national survey of non-medical ACs, which was responded to by 70% (n39) of all English and Welsh ACs (Oates et al, 2018). Of these, 31 offered to take part in an interview. Interviewees were purposively selected to represent a balance of nurses and psychologists, as well as a range of mental health service provider organisations (of whom 10 of the 63 mental health trusts in England and Wales were represented). We approached 13 people for interview. We had one non-response.

The majority of non-medical ACs in England and Wales are employed by two neighbouring organisations, many of whom were colleagues of members of the project team. We chose to include three employees from these organisations as participants. They were interviewed by a member of the team who did not know them. Transcripts were anonymised before sharing with the wider research team. All interviews were conducted via telephone, which was most convenient given the geographical spread of participants and research team. Three researchers did the interviews. The interviews were semi-structured, using a topic guide, which covered: the challenges and opportunities of the role, supervision and developmental needs, changes in perspective since taking on the role. Interviews were audio recorded and transcribed.

### **2.2 Data analysis**

Data analysis of interview transcripts followed a phased emergent thematic analysis approach as described by Braun & Clarke (2006). In the first phase, five researchers independently read transcripts to identify emergent themes and gain a general understanding of the data with open coding the texts. A map of emergent themes was developed by the lead researcher. Then three researchers undertook a shared coding exercise for two of the 12 transcripts, as an iterative, consensus-building process to finalise the coding scheme. The lead author transferred all transcripts to NVivo 12 and recoded all data according to the coding scheme and developed a narrative summary of the data, which was reviewed and agreed by all authors.

### **3. Results**

Participants were all practicing RCs. Five were female. Seven were male. Seven were consultant psychologists. Five were consultant nurses. Six worked in a forensic setting. Three worked in acute adult psychiatry. One worked in a rehabilitation setting. One worked in a dementia setting. Due to the limited number of RCs, and concerns raised by them about preserving their anonymity, we have only identified respondents by pseudonym (conferring gender) and profession here.

This paper focuses on one of two major themes inductively derived in our analysis: 'Interpretations of responsibility.' The second major theme of 'Becoming an RC' will be explored in a further publication. There were two sub themes: first, 'Responsibility as leadership', whereby participants saw themselves as professional leaders and team members, having power to shape their team and service; second, 'Responsibility as decision making', exercising authority by making difficult decisions about risk and restrictions.

#### **3.1 Responsibility as leadership**

Participants described how they had used their power in the RC role to foster a certain ethos in their service. Commonly the desired ethos was one of inclusiveness and collaboration (both with service users and with fellow multidisciplinary team members), so even though the RC was in an authoritative role, they used this position to promote a flattening of hierarchy and team accountability. When taking on the role or as they became more comfortable in it, participants had instigated changes in team practice, such as changing when and how case meetings took place and when and how patients were seen for reviews, aiming to suit patients' wishes as much as possible. An inclusive approach to decision making was seen as important for both patient outcomes and the engagement of

team members. Frank, a nurse, described how his team were looking at 'how we can more actively involve the patients in the MDT' using pre meeting preparation and a 'Recovery Star' approach (a tool for individual service users to set goals for recovery). For some RCs the team move towards a more 'flattened hierarchy' was as the result of external review feedback, in Frank's case, the feedback led his team to decide that:

*'we decided well actually we need to have something which isn't hierarchy driven, the MDT, where decisions can be made openly by the RC, but everybody should have an equal means of contributing towards that discussion.'*

Another RC, John (psychologist) described how he contextualised his RC accountability in terms of team accountability:

*'I always try to ensure that patients understand fully that while I might be the person that has to sign the papers for those patients I'm the Responsible Clinician for, that everything is done within the context of the team, that it is not about me but it's about the team which includes the patient and their family.'*

An example of how hierarchy was being challenged was how Edward (psychologist) brought in a 'Devil's Advocate' role to team meetings in order to empower team members to speak up and voice varied opinions, to avoid 'Groupthink' (Janis, 1982). Collaborative decision making was central to participants' confidence in their role, as voiced by Neil (nurse):

*'There's a lot of power there and I suppose that can be a bit frightening at times, but that's why I think that you have to remind yourself that you don't, despite being a person who is ultimately responsible, you don't work in isolation and you don't make decisions without getting as much information and opinions from everybody; from the patient, from the OT, from the psychologist, from the doctor.'*

Whereas all participants saw their RC role as an opportunity to influence team dynamics, Gina (psychologist) was a participant who explicitly aligned her RC role with team leadership. She found that the role empowered her to influence aspects of her service much more than when she was a team psychologist:

*'I think the main things that I enjoy is that it enables you to have much more of an overall co-ordination and more of a lead on the overall sort of getting things together, and the culture of how you do things'*

She had recently been on a leadership development course and talked about having a 'vision' for her service. Her way of promoting that vision had evolved, from 'blue sky thinking' (which had been resisted by some colleagues) to brokering relationships with colleagues to influence change. Olivia (nurse) was another RC who talked about a 'vision' for her service, in this case to become 'nurse-led'. Becoming an RC was central to realising that vision:

*'...we were developing a new ward and I wanted to make changes within it, and I spoke to the Medical Director at the time and I said I'd like to make this nurse-led, and he basically said "what are you talking about?", and I explained my vision to him and he supported me in that and developed my practice, so through non-medical prescribing, he did a lot of mentorship with me around diagnosis and then took me forward for the ACRC when I was able to do that.'*

It is worth noting here that whilst becoming an RC had conferred on Olivia sufficient power to realise her vision, this depended on approval and assent from her medical director. This suggests that medics still held the ultimate authority over how services were developed.

As well as RC status conferring authority and power as leaders within a service, being an RC meant taking a leadership role within the profession, certainly for the psychologist RCs. They saw themselves as leading the way for colleagues, and 'stepping up' as senior clinicians, an expected aspect of being a Consultant. Being an RC and having 'Consultant' in the job title, denoted that participants were leaders who had a clinical, patient focus rather than a managerial focus. For Martin and Neil, who were nurses, however, the RC role confounded established thinking (by nurses and psychiatrists) about nurses' roles within a team, because it was a clinical lead role rather than being part of the formal management hierarchy (for example as ward manager or matron). Martin described how that understanding had to develop through colleagues seeing directly how he worked in practice:

*'this is mainly down to the nursing management structure, it's very rigid and hierarchical ... so you understand what a Band 5<sup>1</sup> and Band 6 and a Band 7 and Band 8A does. They have management responsibilities so when you send in a Band 8A and they are not a manager you are trying to explain the Advanced Practice role because they just don't get it. They see it as a management role. It's only when they see it in practice that they start to understand. I found it very difficult to explain to a large group of psychiatrists as well, what I do. It's just those that have worked with me who understand the role and it is very difficult to translate that across to others.'*

### **3.2 Responsibility as decision making**

The second sub theme of Responsibility was about being the ultimate decision maker, making difficult decisions about risk. As RCs participants had the ultimate say on decisions about leave and discharge, decisions that could impact on public safety and the safety and wellbeing of service users. Commonly participants had times when they had felt the 'gravity', 'privilege' and 'weight' of their responsibility. For Diana (psychologist) this was due to being '*thrust into quite tricky ethical positions*' around restrictions of liberty and coercion. This was summed up by Martin:

*'It's the responsibility. It's people's lives. I decide that you get locked up for six months. I decide whether you get to go home. I decide that you are going to be forced to take some horrible medication that is going to give you side effects that you don't like. These are pretty horrible things to do to people but I think you have got to retain that sense of perspective in that in humanity we do things that are pretty awful to people in psychiatry. We do it with the best intentions and with a good evidence base but they are unpleasant things to do. I think if you lose perspective on that you probably should get out of the profession.'*

The RC's unease with their responsibility could be countered by establishing a network of peers and establishing collaborative relationships with patients and colleagues. As described in the 'leadership' theme, there may be other reasons why participants advocated

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<sup>1</sup> The numerical Bands are the professional salary grades used in the English National Health Service

for a more 'shared' approach. The weight of the role became more manageable over time, as summed up by Olivia:

*'I'm probably making decisions now that I'd have been absolutely terrified to make a few years ago, but I feel a lot more confident in my knowledge and what I'm doing now to be able to make that.'*

Similarly, Helen (psychologist) said that over time

*'I think I've lost some of the naivety that I had.'*

Participants had previously been involved in team decision making about treatment, and in the nurses' case they may have been enacting RC's decisions about particular treatments given under coercion, such as medication being given under restraint. A key concern that was voiced about the effect of the RC role was that being accountable for decisions around treatment would damage the therapeutic relationship that nurses and psychologists have with their patients. The 'naivety' Helen had lost was regarding how she thought she would be able to avoid situations in which patients may be recalled to hospital, through having a more psychologically-informed therapeutic relationship with her patients compared to previous RCs. She thought that she would be able to do her job so skilfully that she might not need to recall patients. Now, with experience, she was more accepting that dealing with unpredictability and making unpopular decisions to avoid harm may be inevitable in the role.

Although Helen described how over time she had become more comfortable with taking decisions such as recalling patients, several RCs described how their perception of risk could differ from their colleagues. Just as they framed their approach to leadership and decision making as being more collaborative than RCs in their previous experience, they perceived themselves to be less risk averse and less restrictive than other members of the team. This could cause friction, when members of the nursing team, for example, had to enact decisions such as escorting patients on leave. In such circumstances the RC's role might be *'to hold the team's anxiety'* (Gina) or to listen to opinions and yet making a different decision.

Difficult decisions all centred on management of risk, which could mean placing restrictions on that individual patient and in some cases could lead to the use of restraint to administer treatment. Such circumstances were ones in which participants questioned the appropriateness of their decision making. The key to being confident about decisions seemed to be being able to articulate them well to both patients and colleagues and to be able to set them in the context of an overall aim of working towards discharge. 'Being present' when other staff had to enact their RC decisions, such as restraint or medical treatment without consent was a way of demonstrating authenticity and demonstrating to colleagues that they took responsibility for decisions. Again, this was seen as different to previous RCs in their experience, who may have authorised treatment on a ward but not stayed on the ward to deal with the consequences. Prior experience of having to enact decisions that directly affronted patients' autonomy, such as restraint, were seen by some RCs as a mark of credibility when being accountable for such decisions in the RC role. As Neil said:

*'I understand, I've worked in their roles, I've been in the situations that they describe and how we deal with those situations, how it affects us ...I've been involved when patients have been very aggressive or they've been very distressed. I've seen it, I've spoken to patients at the time and I've been a nurse in that situation, so I suppose I've got a better understanding.'*

Edward (now a psychologist), also drew on his previous experiences to determine his behaviour as an RC:

*'If someone is going to be given medication against their will I would like to, even though I'm not actually present with him, giving the injection, I want to be there, I want to be around, just to support the team as much as anyone, the patient might not want to talk to me, but I want the team to know that I'm available. So I'll be a physical presence, because I understand, as I said, earlier in my career, being a healthcare assistant, I know how hard that can be for the nursing teams, the healthcare assistants, even though I didn't like it, but again the psychiatrist just wasn't around, didn't seem to have any understanding of what was being asked of the team, so as much as possible I try and counter that.'*

#### **4. Discussion**

The findings of this study add to our understanding of professional identity within mental health services, particularly in relation to inter professional collaboration and notions of risk and shared accountability. Non-medical ACs have a unique perspective on professional working with detained patients because they have stepped beyond the traditional bounds of their professional roles, taking on additional responsibility which they see as giving them the authority to influence colleagues and teams. Their increased accountability for individual detained patients is a way into having wider influence, including shaping the identity of their profession. There were two major aspects here: taking on increased authority within clinical multidisciplinary teams meant they could shape team dynamics and influence perceptions of their profession, whether nursing or psychology, and second, participants viewed their primary responsibility in relation to patients to be about decision making on risk, and taking responsibility for the consequences of those decisions. There was strong commonality between participants in their attitudes to the 'responsible' aspects of their roles. They saw themselves as agents for a more democratic and less hierarchical approach to mental health professional practice than they had previously experienced. They saw becoming an RC as an opportunity to promote shared decision making within a team as well as with patients and their families. They associated this with 'being present', a closeness to 'the coal face' of mental health practice compared to the RCs with whom they had previously worked. The organisational context was a vital aspect of the perceived 'success' of the RC's approach, particularly for those RCs like Martin and Olivia who had a 'vision' for their services which becoming an RC had given them the authority within their organisation to promote and develop. Importantly, organisational support for the RC and having the power to influence service development were not conferred on the RC immediately on taking on the role, rather they were as a result of them being in the role and seeming to be effective in it.

This study develops notions of mental health professionalism and leadership that have been proposed in other recent qualitative studies. Thematic analysis of interviews is exactly the right form of research to be undertaken when we seek to understand the lived experience of clinicians making complex decisions and negotiating a contested professional landscape. Taking on a new role within mental health services can feel isolating (Procter et al 2016), however this sense of isolation and the 'weight' of responsibility' of becoming an RC may be because of the nature of the role itself, rather than because the role is new or was previously held by someone from another profession. Coffey and Hannigan (2012), discussing another role created by the 2007 amendments (the move from Approved Social

Worker (ASW) to Approved Mental Health Professional (AMHP), opening the role up to nurses, psychologists and other colleagues), talk about crossing occupational jurisdictions. They argue that tensions may arise for nurses between their traditional alliance with med- ics and also the threat to the ‘therapeutic’ nature of their relationship with patients if they have a more active role in initial decisions to detain. The same concerns could be levelled at the non-medical RC role, who whilst not making initial detention decisions may decide to renew detention.

Our finding that participants saw the RC role as an opportunity to shape professional identity and assert professional influence accords with the notion of ‘professionalism’ in mental health services as a ‘dynamic’ and ‘situated’ social contract, as described in Aylott et al’s(2018) recent rapid review. Chow et al (2019) have identified that the main drivers of change in mental health services in England, Germany and Italy since 1990 as: distancing from deinstitutionalisation as a moral imperative, reducing the costs of care, addressing the limitations of community care and an emphasis on the containment of risk. Certainly, financial pressures and a step away from a ‘medical’ model seem to be important drivers for organisational uptake of the non-medical RC role, and risk containment was a major concern for the participants in this study. The impetus to create the non-medical RC role at the time of the last major review of the Act may have been in part to reduce psychiatrists’ workload (Proctor et al, 2016), and organisations adopting the role may be driven by pressures to reduce cost and address medical workforce shortages, as well as distributing responsibility and offering patients the ‘most appropriate’ person to direct their care, but this vanguard group of non-medical RCs seem to be using the role as a way of influencing the ethos of their mental health services towards a ‘democratic’ stance. The findings accord with those of Stuen et al’s (2018) interview study of eight Norwegian RCs (psychiatrists and psychologists) concerning decisions they made about community treatment orders in their assertive community teams. They found that tension and challenge regarding professional judgement were emphatically a feature of their decision making, and that ‘shared responsibility’ within the team was an important feature in RCs being confident in their decisions. Findings here also accord with those from Ebrahim’s (2018) initial interview study of non-medical ACs, that this group seek to promote ‘distributed leadership’, whereby they ‘brokered’ rather than imposed decisions. Similarly, the interview findings here build on the findings of the national survey (Oates et al, 2018), that motivation to become a non-medical RC was at least in part due to a desire to effect service change and enhance the status of their profession. We do not have accounts of medical RC decision making with

which to compare the findings of this study, so the extent to which non-medical RCs take a more distributed, shared approach over other clinical leaders has not been tested.

## **5. Limitations**

Our study reflects the experiences of one group of people at one point in the history of mental health services. Aspects of the non-medical RC role are unique to English and Welsh mental health legislation, however, the insights provided here have importance beyond the specific settings we describe, because they reflect the professional preoccupations of the mental health workforce, namely how professional power is negotiated and how responsibility for risk is perceived. Of particular interest is how a role that seems to be centred on individual clinical responsibility for individual patients is being interpreted in such a way as to have much more influence within teams, services and professions.

A limitation is that this is a small-scale qualitative interpretative study, albeit with a national reach, significant coverage and methodological rigour. We are presenting an analysis of individual clinicians' perceptions of their roles and influence. The extent to which non-medical RCs have genuinely reduced hierarchy, promoted shared decision making and influenced attitudes to risk cannot solely be measured through one-off interviews. A further limitation is that we did not interview psychiatrist RCs and there was no prior research on service user or psychiatrist views of the RC role with which to compare our findings. The research team included members with nursing, psychology and legal backgrounds but neither psychiatrists or mental health service users. A longitudinal study, involving service users, perhaps of an ethnographic nature would be required in order to map the cultural shifts and inter professional dynamics that claims are made for here.

## **6. Conclusion**

The participants in this study were in the vanguard. Some were the sole non-medical RC in their organisation. As such, some of their insights may not be reflective of the non-medical RC experience if the role was to be adopted more widely. This seems likely given two parallel policy drivers within the National Health Service right now: the call for health professionals to expand their remit and work in a less medically-dominated way, not least due to a shortage of psychiatrists, and the increase in importance of patient voice, choice and autonomy, as called for in the recent review of the Act (Wessely et al, 2018). Organisational adoption of the non-medical RC role should not be seen solely as a neat solution to workforce shortages within a service or lack of opportunities for professional advancement

by individual clinicians. Our findings suggest that consultant nurses and psychologists who take on this role may well seize an opportunity to influence service developments more widely.

The study demonstrates that when nurses and psychologists are afforded the opportunity to lead inter professional clinical teams they may use their position of power to influence team dynamics and perceptions of their profession as well as being accountable for specific clinical cases. The findings of this study should inform decisions regarding expansion of the non-medical RC role made by mental health services provider organisations. It seems that having senior nurses and psychologists in leadership roles that are primarily clinical over managerial will likely affect the ethos of a service towards a more flattened hierarchy and could mean that decision makers are more 'present' in the clinical setting. The findings should also inform individual clinicians who may be considering taking up the non-medical RC role. They may see this study as evidence for a route towards greater influence beyond and within their profession.

5076 words

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