JOANNA ADEBAYO BSc (Hons)

CLINICAL PSYCHOLOGIST RESPONSIBLE CLINICIANS: EXPLORING EXPERIENCES AND FACTORS INFLUENCING UPTAKE OF THE ROLE

Section A: Multi-professional Approved Clinicians: What are the Factors that Influence Uptake of the Role? A Systematic Review

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Summary of the Major Research Project

Section A presents a systematic literature review of the empirical research of the factors (barriers and facilitators) influencing uptake of the Multi-Professional Approved Clinician role by mental health professionals, other than psychiatrists. Seven studies were identified from the systematic search. Barriers and facilitators were categorised into internal and external factors. Internal factors included: attitudes, and knowledge and skills. External factors included: organisational structures, resources and peer support. A critical evaluation of the studies is discussed, and the practical and research implications are considered.

Section B presents a qualitative study exploring the experiences of clinical psychologists in the role of Responsible Clinician. Eight clinical psychologists who had been working as responsible clinicians were interviewed, and interviews were analysed using interpretative phenomenological analysis. Five superordinate themes and accompanying subthemes capturing the experiences of the participants were identified. The superordinate themes are: "From psychologist to approved clinician psychologist", "The psychological effects of responsibility", "The system makes or breaks", "Relationships shift in the face of power", and "Making our mark: From paralysis to influence". Findings are discussed in the context of existing literature. Clinical implications, as well as limitations and directions for future research, are also considered.

Table of Contents

List of Tables and Figures

Tables

Section A

Section B

Figures

Section A

Section C: Appendices

SECTION A

Multi-professional approved clinicians: What are the factors that influence uptake of the role?

A systematic review

Word count: 7083 (+123)

Abstract

Uptake of the Multi-Professional Approved Clinician role by mental health professionals, other than psychiatry, has been low, following amendments to the Mental Health Act (1983) in 2007. This review aimed to systematically review and appraise the literature pertaining to factors (barriers and facilitators) that influence the uptake of the multi-professional Approved Clinician role. Systematic searches were conducted using online databases ASSIA, PsychINFO, Medline and CINAHL. Grey literature was also searched. Seven papers met the inclusion criteria. Barriers and facilitators identified in this review were presented and categorised into internal and external factors. Internal factors included: attitudes towards the expansion of the role, and knowledge and skills required for the role. External factors included: organisational structures, resources and peer support. There is a need for organisations to consider the barriers and facilitators, to identify how to reduce or eliminate the barriers, and to reinforce the facilitators identified. Given the small body of available literature, future research is warranted to confirm these findings.

Keywords: Approved Clinician; Mental Health Act; Mental Health

Introduction

Definition and terminology

The Mental Health Act 1983 (as amended by the Mental Health Act 2007), in England and Wales, is the mental health legislation referred to in this review, and short titled as 'the Mental Health Act' throughout. The review's main concern is the introduction of the reconfigured roles of the Approved Clinician (AC) and Responsible Clinician (RC), resulting from amendments to the Mental Health Act. These amendments were implemented in November 2008. An AC is defined as a person that has been deemed competent by the Secretary of State (in England) or Welsh Ministers (in Wales) to act as an AC for the purposes of the Mental Health Act. An RC is the AC who has been granted overall responsibility for the care of a patient under the Mental Health Act. The RC role was once exclusively held by medical practitioners, which was known as the Responsible Medical Officer (RMO). These roles can now be undertaken by clinical psychologists, mental health and learning disability nurses, social workers and occupational therapists.

Different terminology has been used to refer to the roles of AC and RC. Before the Mental Health Act was amended, the RC was previously referred to as the 'Clinical Supervisor'. Following the amendment of the Mental Health Act, the terms 'Non-Medical AC and RC' were frequently used; however, it has been argued that this term implies that the role differs from the role held by medical practitioners (Barker, 2019, p.5). Throughout this review, the role will be referred to as the 'Multi-Professional AC' as this is considered to be the most appropriate terminology. However, references will be made to earlier terms, 'Non-Medical AC' and 'Clinical Supervisor', when referring to the terms used in specific papers.

The main responsibilities of a Multi-Professional AC and RC are described in Table 1. However, some aspects of responsibility are limited when the RC is not a medical practitioner. Initial detention and conversion of Section 2 to Section 3 can only be initiated by medical practitioners. Also, Multi-Professional ACs and RCs are only able to make decisions within the competencies of their profession. Therefore, if a clinical psychologist is the RC for a patient's care, a medical AC will hold responsibility for decisions surrounding aspects of care relating to psychotropic medication.

Table 1

Main responsibilities of Approved Clinicians and Responsible Clinicians

Approved Clinician (when not acting as Responsible Clinician)	Responsible Clinician
May be permitted to make decisions pertaining to the treatment or detention of patients in hospital.	Approve Section 17 leave
May be permitted to visit and assess patients in private.	Review detentions and Community Treatment Orders (CTOs)
	Renew detentions and Community Treatment Orders (CTOs)
	Discharge from detention and Community Treatment Orders (CTOs)
	Power to recall Community Treatment Orders (CTOs)
	Section 5(2) holding power to detain patients up to 72 hours

Multi-Professional ACs are required to meet the competencies outlined in the 'Approved Clinician (General) Directions' in order to become 'approved', meaning it is a statutory role (National Institute for Mental Health in England, 2008). These include competencies in assessment, treatment, care planning, leadership and multi-disciplinary team

working, equality and cultural diversity, communication and knowledge of the role. The level of competencies required to undertake the role indicates that the role is only suitable for mental health professionals in senior or consultant posts (Department of Health, 2008). Mental health professionals are required to present a portfolio, demonstrating evidence of meeting these competencies to delegated approval panels. They are also required to attend an approved two-day AC induction training course to enhance their knowledge and skills (Hall & Ali, 2009).

The Multi-Professional AC and RC roles have also been introduced outside of England and Wales, following similar amendments to mental health legislation. In New Zealand, under the amended Mental Health Act 1992, the RC holds similar responsibilities to those held in England and Wales. However, it is recommended that the role is only undertaken by nurses, clinical psychologists and medical practitioners (Ministry of Health, 2002). The acronym, RC, will be used interchangeably to refer to the Responsible Clinician role in England and Wales and internationally.

Historical context

The evolution of the Mental Health Act in England and Wales has undergone a gradual shift from a dominant medicalised approach to mental health towards a multi-disciplinary approach, setting the tone for the formation of the Multi-Professional AC and RC roles. Historically, the Mental Health Act 1959 repealed the Mental Treatment Act 1930 and the Lunacy Act 1890, and placed decisions around patient care and treatment in the hands of medical practitioners without them needing to seek judicial authority (Hamilton, 1983). Mental health disorders were defined as illnesses that required medical attention, which positioned the medical profession as the most appropriate group to attend to mental health (Bean, 1975). During the 1960s and 1970s, scepticism emerged around the domination of the

medical model. The Royal College of Psychiatrists advocated that the RMO should make the final decision regarding patient treatment and that medical second opinions should be considered advisory rather than definitive (Eastman, 2006). However, professionals from other disciplines argued that it was not always appropriate for doctors to make decisions about the practice of particular treatments, particularly those that are contentious (Fennell, 2002). The White Paper 'A review of the Mental Health Act' (Department of Health and Social Security, 1978) was published, which made a proposal for second opinions to be acquired from multi-disciplinary panels (including laypeople, lawyers, social workers and psychiatrists), particularly in regards to treatment that was considered to be hazardous and irreversible i.e., electroconvulsive therapy (Hamilton, 1983). This led to the development of a new Act, the Mental Health Act 1983, which incorporated a multi-disciplinary perspective. Under this amended Act, the Approved Social Worker role (ASW) was also introduced, which enabled social workers to perform a social assessment of a patient's circumstances to determine whether other services could appropriately meet their needs to avoid hospital admission, challenging the dominant medical model (Rapaport, 2005).

A further shift towards a multi-disciplinary model in mental health care began to occur in the 1990s, which contributed to the blurring of sharp distinctions between professional roles. Services were mandated to include multi-disciplinary teams, such as community mental health teams and early intervention teams (Department of Health, 1999). The 'New Ways of Working' Programme initiated by the National Institute of Mental Health in England advocated for all professional groups to collectively share responsibility for providing mental health care (Department of Health, 2007). Concurrently, a Mental Health Bill was published in 2007, which aimed to underpin the multi-disciplinary model adopted in mental health care by offering the legal framework to relax existing professional boundaries. The intention was for there to be a shift towards a 'competency-based approach' where staff

with the relevant experience and skills could undertake specific roles regardless of their professional background (Crichton & Darjee, 2007). The Mental Health Bill led to another amendment of the Mental Health Act.

The amended Mental Health Act broadened the professional groups able to fulfil specific functions under the Mental Health Act. Firstly, the Multi-Professional AC and RC roles were reconfigured, replacing the RMO, and could be undertaken by medical practitioners, psychologists, nurses, social workers and occupational therapists. A Multi-Professional RC was the AC that had been granted the power to oversee treatment for patients and make decisions about discharge and extending detention. The second role to be reconfigured was the Approved Mental Health Professional (AMHP), which replaced the existing ASW role. In comparison to the Multi-Professional AC role, the AMHP has statutory powers to apply for the detention of an individual in hospital under the agreement of a medical practitioner. Like the Multi-Professional AC role, the AMHP role can be undertaken by social workers, nurses, occupational therapists and psychologists; however, it cannot be undertaken by medical practitioners. The definition of "medical treatment" was also broadened under the Mental Health Act to incorporate psychological, nursing and specialist mental health care, reflecting the range of professional groups eligible to undertake new roles under the Mental Health Act (Department of Health, 2015).

Debates regarding the multi-professional AC and RC roles

The broadening of professional groups eligible to become AC has prompted some debate within professions, providing some insight into how different professional groups perceive their professional identity. Within the clinical psychology profession, concern has been expressed about the potential for the profession to become redefined by the acquisition of new statutory powers. Holmes (2002) argued that there is the potential for clinical

psychologists to become grouped together with psychiatrists and social workers, who traditionally hold statutory powers, negatively impacting their conventionally collaborative relationships with clients. On the other hand, Gillmer and Taylor (2011) suggested that granting clinical psychologists the opportunity to achieve AC status can lead to improvements in care for service users, where their treatment needs are can be more appropriately met by psychological approaches. Similarly, within the nursing profession, concern has been expressed about the impact of undertaking new statutory roles on therapeutic nurse-patient relationships and further difficulties with balancing care and coercion. However, it has been argued that the role provides the opportunity for a stronger nursing focus in patient care (Veitch & Oates, 2017). The differing arguments suggest that whether mental health professionals should become ACs is still an ongoing debate.

Theoretical considerations

Theoretical perspectives can offer some insight into the conflict within professional groups about the reconfiguration of the Multi-Professional AC and RC roles. Professional identity can be defined as the enduring collection of beliefs, motives, qualities, values and experiences in which individuals define themselves in their professions (Ibarra, 1999). Professional identity is rooted in social identity theory and enables distinctions to be made between members of different professional groups (Low et al., 2012). Social identity theorists argue that a part of a person's self-concept comes from the groups they are members of. Therefore, social identification is the perception of belongingness to a group (Turner & Tajfel, 1986). Professional identity is thus developed within specific professional communities of practice, where professional rules and practices are communicated and shared (Wenger, 1998). This can create a psychological bond between a person and a particular profession. However, professional identities can evolve in response to self-

perception and/or changes in circumstances (Sutherland & Markauskaite, 2012). This can pose challenges to professionals who may experience change as a dilution of their professional identity or a diversion from what is expected from their particular profession (Pate et al., 2010). This may be applicable to the roles of AC and RC where professionals have to contend with competing duties of care e.g., the duty to detain as an RC and the duty to work collaboratively with service users as a clinical psychologist (Taylor et al., 2009).

Rationale for this review

From its inception in November 2008 to present, uptake of the Multi-Professional AC role by mental health professionals, other than psychiatry, has remained low. As of July 2019, there were only 63 Multi-Professional Approved Clinicians in England (36 clinical psychologists, 23 nurses, 1 occupational therapist and 3 social workers (Health Education England, 2020a). Although there has been some commentary amongst professional groups about the role, to date, no systematic reviews have identified the facilitators and barriers to the uptake of the Multi-Professional AC role. This review aims to synthesise and appraise the available literature regarding the uptake of the Multi-Professional AC role. The frame of barriers and facilitators was taken to the review, as understanding the facilitators and barriers to the uptake of the Multi-Professional AC role would support organisations to implement and develop strategies to support the appointment of mental health professionals from other disciplines in the role. This means that the discourse surrounding whether mental health professionals should be encouraged to take on the role is less captured; however, this review's focus is on the factors influencing uptake.

This is particularly pertinent, given that an Independent Review of the Mental Health Act was completed, which identified that rates of detention under the Mental Health Act have risen, alongside an increase in staff vacancies, particularly consultant psychiatrists (Wessely

et al., 2018). In response, a White Paper was published in January 2021 by the government in England for reforming the Mental Health Act. It sets out increased responsibilities for RC pertaining to reviewing patient detention, CTOs and care and treatment plans. Moreover, an implementation guide was published by Health Education England to support NHS organisations to implement multi-professional AC and RC roles (Health Education England, 2020a). This is congruent with the recent release of additional funding to be granted for the development of the AC role (Health Education England, 2020b). It is hoped that this review may contribute to identifying ways of improving standards of care in mental health through wider implementation of the Multi-Professional AC role.

Method

Search strategy

A systematic literature search was conducted in October 2020 to identify relevant papers. Firstly, an electronic search was conducted to identify peer-reviewed literature in online databases, which included: ASSIA, PsychINFO, Medline and CINAHL. Secondly, given the expected paucity of research in this area, grey literature was searched using EThOS, Google and Google Scholar. This was intended to widen the scope of the search and produce an inclusive synthesis, reducing the likelihood of publication bias. Lastly, reference lists of relevant papers were manually searched to identify additional relevant papers. Key search terms were used in various combinations using 'OR' and 'AND' Boolean terms, as seen in Table 2.

Table 2

Key search terms

Role	Mental Health Professionals
Responsible clinician*	Psycholog*

Approved clinician*	Occupational therap*
Clinical supervisor*	Social work*
	Nursing*
	Nurse*
	Mental health professional*
	Mental health practitioner*
	Multi-professional*
	Multi-disciplin*

Note. Search terms using truncation to allow for variations of search terms to be obtained

Inclusion and exclusion criteria

Broad eligibility criteria for studies in the review were set due to the paucity of research in this area. Studies based in England and Wales were prioritised, based on the focus of the review; however, studies based in other countries that had developed similar roles to the Multi-Professional AC were included to provide further insight into the possible barriers and facilitators to implementing the role. The eligibility criteria for studies to be included in the review are presented in Table 3.

Table 3

Eligibility criteria

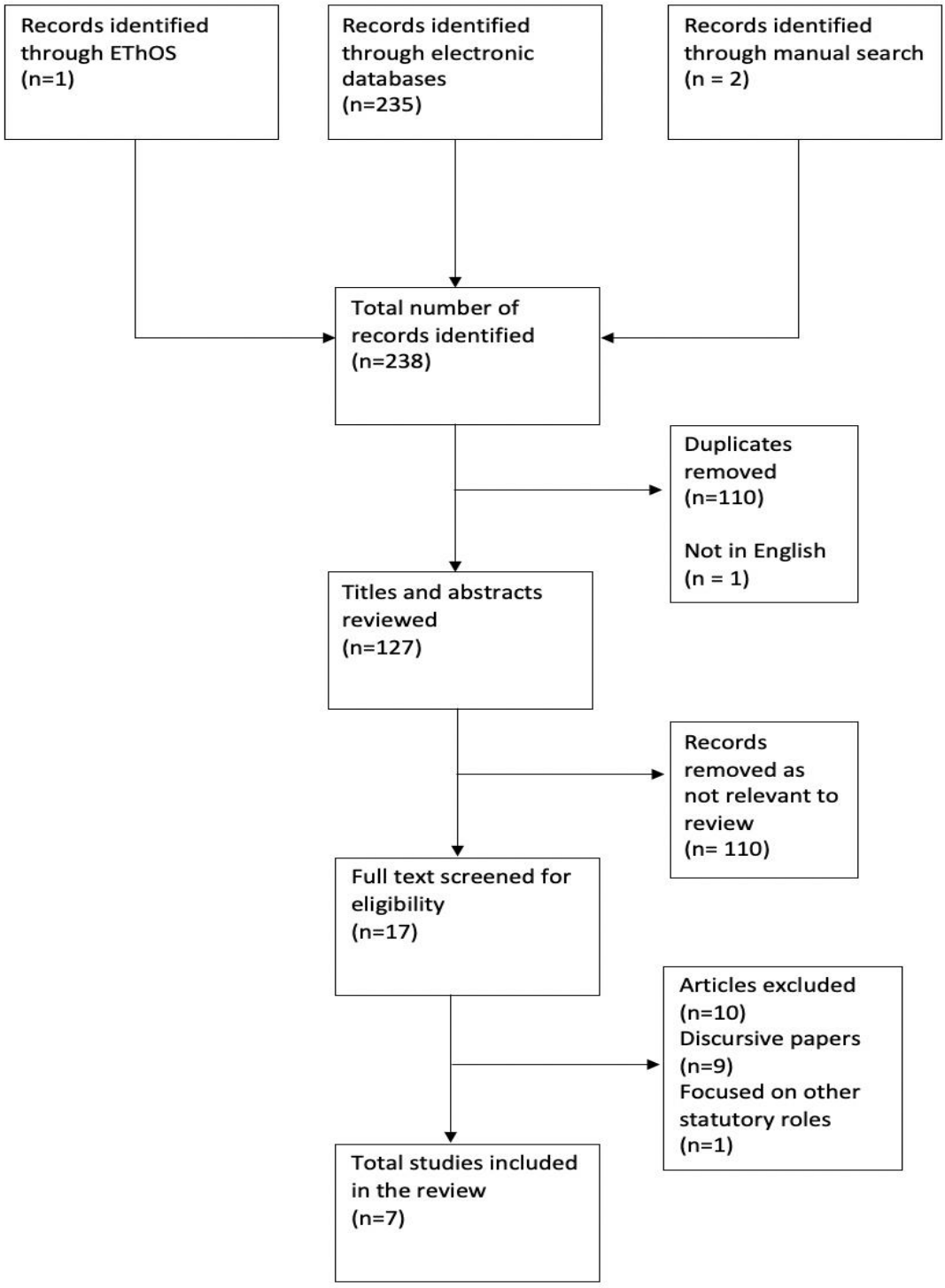
Inclusion criteria	Exclusion criteria
Studies focusing on attitudes, understandings and perspectives regarding the barriers and facilitators to the implementation/uptake of the role of Multi-Professional AC/RC.	Studies not written in the English language.
Studies, where the main focus was not on the roles of AC and RC, were included if separate analyses were provided on perspectives on the roles of AC and RC.	Studies focusing solely on other statutory roles under the Mental Health Act (i.e., AMHPs).
	Nonempirical papers (e.g., letters, opinion pieces, and discursive papers).

Note. AC = Approved Clinician; RC = Responsible Clinician; AMHP = Approved Mental Health Professional.

An outline of the search strategy is presented in Figure 1. Duplicated articles and articles that were not written in English were removed from results obtained from the initial search. Titles and abstracts were reviewed for relevance to the review. Full texts of articles were assessed for eligibility to be included in the review. A total of seven papers were identified as fitting the inclusion criteria for this review.

Figure 1

PRISMA flow-diagram of literature search



Structure of this review

An overview of the seven identified studies will be presented. A critical evaluation of the methodology of the studies will be provided. The main findings of these studies will then be summarised, and key themes drawn from the research relating to the barriers and facilitators to uptake of the Multi-Professional AC role will be discussed. The findings are considered in the context of existing literature. The practical and research implications will also be considered.

Results

Overview of the studies

The studies included in this review are summarised in Table 4. Of the seven papers included in the review, six were carried out in England and Wales, and one was carried out in New Zealand. Three papers were identified from grey literature, which are included in the summaries in Table 4 (Gray et al., 2020; Miller & Dickens, 2007; Hewitt-Moran & Jackson, 2009). The studies varied in the participants that were included in their sample. Two studies only included psychologists in their samples, and one study only included nurses in their sample. One study did not specify who the participants were in their sample but stated they were pilot leads in four NHS Trusts. One study included patients and members of a staff team; however, their disciplines were not specified. One study included psychiatrists and nurses and psychologists who were Multi-Professional ACs or in the process of gaining approval. One study included psychologists, nurses, social workers and an occupational therapist who were Multi-Professional ACs. Sample sizes varied across studies, with five studies including less than 40 participants and two studies including more than 100 participants.

Based on the topic of focus, all of the studies included in the review employed interview and/or questionnaire designs. Three studies used a qualitative design, and four employed a mixed-methods design. The mixed-methods studies and most of the qualitative studies used questionnaires (either purely qualitative or a combination of qualitative and quantitative components) to reach a wider audience. Some studies combined this with focus groups or interviews to provide richer data. However, one qualitative study only used interviews. There was some consistency in the themes identified across the studies, despite there being variation in the specific measures and questions asked.

Table 4

Overview of studies characteristics

Author, year	Aims	Sample	Design and analysis	Measures	Key findings
Ebrahim (2018)	To explore the barriers and facilitators to implementing the roles of AC in practice	Questionnaire: 7 nurses and 16 clinical psychologists. m=9; f=14. 56% gained approval as AC, 44% working towards approval as AC. Interview: 3 CP ACs, 3 MHN ACs and 3 psychiatrist ACs.	Survey data, descriptive statistics. Interviews, thematic analysis	Self-developed questionnaire	Barriers: Limited time to develop portfolios, difficulties accessing appropriate cases, difficulties backfilling posts to enable AC duties. Facilitators: biopsychosocial approach to mental health, organisational support, networking opportunities and CPD.
Oates et al. (2018)	To illustrate the attributes and concerns of non-medical ACs	39 non-medical approved clinicians m=20; f=19 64.86% psychologists, 24.32% nurses, 8.11% social workers, 2.7% occupational therapist, 5% no profession given.	Survey data, descriptive statistics and thematic analysis	Self-developed questionnaire	Barriers: lack of organisational support, attitudes of psychiatrists, lengthy and difficult approval process, knowledge/skills. Facilitators: mentorship and support, motivation to improve service user care, organisational expectation, knowledge/skills.

Gray et al. (2020)	To examine the hopes and fears of staff and patients in having a Multi-Professional Responsible Clinician on a forensic mental health ward	8 members of staff, 8 patients	Survey data, semi-structured interviews, thematic analysis	Self-developed questionnaire	Barriers: staff and patient concerns about knowledge/skills of multi-professional RC. Facilitators: patients hope that multi-professional RCs will adopt a less risk-averse approach, staff hopes that multi-professional RC will be more inclusive of a range of opinions.
Miller and Dickens (2007)	To examine the preparedness of clinical psychologists to undertake the role of clinical supervisor	32 members of the psychology staff working for a mental health service provider (6 consultant clinical psychologists, 5 clinical psychologists, 21 assistant/trainee psychologists).	Survey data, descriptive statistics	Self-developed questionnaire	Barriers: beliefs that the role will impact therapeutic alliance, worries that uptake of role would impact the provision of psychological treatment.
McKenna et al. (2006)	To describe the enablers and facilitators to nurses undertaking the role of RC.	107 nurses 66% female N=11 RC	Survey data (descriptive analysis of data; content analysis of open-ended questions)	Self-developed questionnaire	Barriers: limited knowledge/skills, concerns that new duties would change the nursing role, limited time to take on new roles. Facilitators: interested in the role and viewed it as a legitimate career path

Hewitt-Moran and Jackson (2009)	To monitor the progress of early implementer sites in NHS trusts actively aiming to extend the role of AC to non-medical professionals	Pilot leads from four NHS trusts	Interviews; analysis not documented	N/A	Barriers: staff attitudes, difficulty backfilling posts, lack of organisational structures, knowledge and skills. Facilitators: organisational structures, peer support, difficulty recruiting psychiatrists.
Parsloe (2012)	To explore clinical psychologists' beliefs about new statutory roles in order understand their beliefs about the profession	292 clinical psychologists from Cooke et al. (2002) study. Six clinical psychologists in focus group	Survey data and focus group interviews; grounded theory	Self-developed questionnaire	Underlying beliefs identified: clinical psychologists can transform services through obtaining statutory powers. clinical psychologists must fight against assimilation through preserving distinct spaces for working collectively.

Note. AC = Approved Clinician; RC = Responsible Clinician; CP = Clinical Psychologist; MHN = Mental Health Nurse; CPD = Continuing Professional Development; N/A = Not Applicable.

Critical appraisal

The Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018) was used to assess the methodological quality of the studies. The MMAT was devised for systematic reviews that include quantitative, qualitative and mixed-method studies. The MMAT allows for the concomitant appraisal of various types of research using one tool. Five criteria for each methodology are used to assess the quality of the studies. A summary of the MMAT appraisal for each study in the review is presented in Table 5 and 6. Overall quality score ratings are discouraged, and so this information is presented qualitatively. In general, quality appraisal using the MMAT indicated that the studies included in the review were of medium to high quality. However, one study was of low quality (Miller & Dickens, 2007), and so findings should be interpreted with caution.

In this section, the appraisal of the studies in the review is presented in more detail under the headings: qualitative and mixed methods, as these were the methodological approaches adopted by the studies in the review.

Table 5

MMAT appraisal for qualitative studies

	Gray et al. (2020)	Parsloe (2012)	Hewitt-Moran and Jackson (2009)
Study design	Qualitative	Qualitative	Qualitative
1.1 Qualitative approach applicable to the research aims?	Yes	Yes	Yes
1.2 Qualitative methods of data collection acceptable to address the research aims?	Yes	Yes	Yes
1.3 Findings adequately obtained from the data?	Yes	Yes	No
1.4 Are results interpretations adequately supported by the data?	Yes	Yes	Yes
1.5 Are links between the source of data, collection, analysis and interpretation clear?	Yes	Yes	No

Table 6

MMAT appraisal for mixed-methods studies

	Oates et al. (2018)	Ebrahim et al. (2018)	Miller and Dickens (2007)	McKenna et al. (2002)
Study design	Mixed-methods	Mixed-methods	Mixed-methods	Mixed-methods
1.1 Qualitative approach applicable to the research aims?	Yes	Yes	Yes	Yes
1.2 Qualitative methods of data collection acceptable to address the research aims?	Yes	Yes	Yes	Yes
1.3 Findings adequately obtained from the data?	Yes	Yes	No	Yes
1.4 Are results interpretations adequately supported by the data?	Yes	No	No	No
1.5 Are links between the source of data, collection, analysis and interpretation clear?	Yes	Yes	No	No
4.1 Sampling method relevant to research aim?	Yes	Yes	Yes	Yes
4.2 Representative sample?	Yes	Yes	Yes	Yes
4.3 Appropriate measurements?	Yes	Yes	Yes	Yes
4.4 Low risk of non-response bias?	Yes	Yes	Yes	Yes
4.5 Appropriate statistical analysis	Yes	Yes	Yes	Yes
5.1 Adequate rationale for mixed-method design?	Yes	Yes	Yes	Yes
5.2 Study components integrated effectively?	Yes	Yes	Yes	Yes
5.3 Adequate interpretations of study components?	Yes	Yes	Yes	Yes
5.4 inconsistencies between components sufficiently addressed?	Yes	Yes	Yes	Yes
5.5. qualitative and quantitative components adhere to individual quality criteria?	Yes	No	No	No

Qualitative

Three qualitative studies were included in the review (Gray et al., 2020; Parsloe, 2012; Hewitt-Moran & Jackson, 2009). Given the scarceness of research into the Multi-Professional AC and RC roles, the exploratory nature of a qualitative approach was deemed to be a valuable contribution to the review. All of the studies clearly stated the aims of the research, which could be appropriately answered through qualitative investigation. However, the explicitness of the theoretical and methodological orientations of the studies varied. One study used Grounded Theory (Parsloe, 2012), one was described as exploratory (Gray et al., 2020), and one did not describe the qualitative approach (Hewitt-Moran & Jackson, 2009).

The studies varied in the methods used for data collection. One study employed qualitative surveys and a focus group (Parsloe, 2012), one used interviews (Hewitt-Moran & Jackson, 2009) and one employed qualitative surveys and interviews (Gray et al., 2020). All the adopted methods of data collection were appropriate for the research questions of the studies; however, clear limitations could also be identified.

Hewitt-Moran and Jackson (2009) did not clearly state that the interviews had been audio-recorded in their study. Therefore, it is difficult to ensure the rigour and validity of the research (Seale & Silverman, 1997). Also, Parsloe (2012) drew on the qualitative component of a questionnaire used in a previous study (Cooke et al., 2002). This can be criticised on epistemological grounds as the researcher was not personally involved in collecting this data which may have impacted his interpretations of the findings (Blommaert, 2001). Additionally, Gray et al. (2020) obtained a low response rate from staff on their survey (8 out 35 members of staff), impacting the representativeness of the sample and saturation of the data as a sample size of 15-20 participants for qualitative surveys is recommended (Braun & Clarke, 2006). Furthermore, studies that primarily use qualitative surveys are limited by the

extent to which data can be generated due to the nature of open-ended questions; however, qualitative surveys were also supplemented with interviews and focus groups in these studies. Also, given that this area of research is under-researched, using qualitative questionnaires as a primary method of data collection may have enabled researchers to reach out to a larger number of participants (Braun et al., 2020).

Two of the three studies clearly stated the data analysis methods used. One study indicated that thematic analysis was used (Gray et al., 2020), and one study indicated that the constant comparative method derived from Grounded Theory was used (Parsloe, 2012). Conversely, one study (Hewitt-Moran & Jackson, 2009) did not describe the data analysis method used, in addition to the lack of clarity around data collection. However, all studies clearly evidenced their findings using quotes derived from the data. This enabled differentiation between the subjectively described experiences of the participants and the interpretations of the authors. Two studies explicitly stated that coding had been reviewed by all authors or further analysts (Parsloe, 2012; Gray et al., 2020). Only one study discussed reflexivity (Parsloe, 2012). The author reported that a reflective diary and memos were kept, which documented the research process. The lack of accounts of reflexivity in the other two studies made it difficult to decipher the author's relationship to the research and any potential bias (Mays & Pope, 2000).

Overall, two studies were of high quality (Gray et al., 2020; Parsloe, 2012), and one study was of medium quality (Hewitt-Moran & Jackson, 2009). The latter study lacked clarity about the data collection and method of analysis.

Mixed-methods

For the appraisal of mixed-methods studies, the qualitative criteria, the appropriate quantitative criteria and the mixed-methods criteria within the MMAT were used. Only one mixed-method study in the review met all of the criteria (Oates et al., 2018). The overall quality rating of the studies using this tool is judged against the weakest methodological component of the study.

Four mixed-method studies were included in the review (Oates et al., 2018; Ebrahim, 2018; Miller & Dickens, 2007; McKenna et al., 2006). Three studies used a convergent design (Oates et al., 2018; Miller & Dickens, 2007; McKenna et al., 2006), and one study used a sequential explanatory design (Ebrahim, 2018), meaning that results from the questionnaire guided the development of the interview schedule.

The rationale for employing a mixed-methods design was clearly outlined in all studies; however, there was variation in how well this design was executed. Oates et al. (2018) employed questionnaires that included a range of open and closed questions, and participants responses were analysed using descriptive statistics and thematic analysis. They separately presented the results from the qualitative and quantitative components, and these were clearly outlined. They also provided numerous quotes to support the qualitative findings, which reflected the perspectives of various professional groups. In the discussion section, both components were drawn together effectively.

On the other hand, Ebrahim (2018) used a mixed-method design to enable further exploration of the findings obtained in questionnaires which included closed and open questions. Qualitative data from the interviews were substantiated with numerous quotes; however, quotes obtained from the open-ended questions in the questionnaire were not presented, limiting the ability to justify the themes derived from this sample. Moreover, McKenna et al. (2006) largely presented findings from the quantitative component, whereas

findings from the qualitative component were weakly expressed. Very few quotes were presented, providing insufficient support for the themes identified. In Miller and Dicken's (2007) study, the qualitative component of this study was an open-ended comment section at the end of the questionnaire. The authors reported that only 38% of the sample included additional comments, reflecting conventionally low response rates (Denscombe, 2009). The optional nature of the open-ended comments leaves the study subject to responses bias. Additionally, information was not provided about how comments were analysed, and the data obtained from the qualitative component was 'thin' with no direct quotes included.

Overall, two studies were of high quality (Oates et al., 2018; Ebrahim, 2018), one study was of medium quality (McKenna et al., 2006), and one was of low quality (Miller & Dickens, 2007). The low and medium quality ratings were due to the lack of transparency surrounding the qualitative elements of the studies.

Summary of findings

In this section, findings from the identified studies regarding barriers and facilitators to the uptake of the Multi-Professional AC role by mental health professionals, other than psychiatry, are presented and categorised into internal and external factors. Internal factors consist of: attitudes, and knowledge and skills. External factors consist of: organisational structures, resources and peer support.

Internal factors

Attitudes. The most commonly reported internal barrier and facilitator to uptake of the Multi-Professional AC role by mental health professionals, other than psychiatry, were attitudes towards the role. Oates et al. (2018) reported that 'non-medical ACs' generally displayed positive attitudes towards the role of Multi-Professional AC. 'Non-medical ACs'

expressed hopes that becoming ACs would enable them to improve the standard of care of patients. They expressed desires to adopt a more recovery-focused and person-centred approach through actively involving patients in decisions around their own care, such as offering the choice of RC according to their specific treatment needs, which may be more psychologically centred than medical. Patients also expressed hope that having a 'non-medical AC' would offer them more freedom and a quicker pathway through service (Gray et al., 2020). Additionally, Hewitt-Moran and Jackson (2009) reported that pilot leads hoped that by extending the AC role, mental health professionals that were appropriately qualified and already involved in the care of particular patients could take on responsibility for their treatment, ensuring continuity of care. Moreover, Parsloe (2012) reported that many clinical psychologists had expressed beliefs that obtaining AC status would reduce medical dominance in mental health services and enable them to obtain greater power and influence in services regarding how mental illness is constructed and consequent treatment. Similar sentiments were shared by mental health professionals that were working towards or had obtained AC status who believed that being in the role would support a biopsychosocial approach to mental health (Ebrahim, 2018).

Alternatively, studies reported contrasting views, indicating negative attitudes towards mental health professionals, other than psychiatrists, taking up the role of AC. Miller and Dickens (2007) found that 60% of clinical psychologists held an opposing or neutral stance to the introduction of the role of 'Clinical Supervisor', indicating that the majority would not want to take on the role. Notably, consultant clinical psychologists demonstrated the least support for the role, despite them being the target group for the role given their level of experience. Responses from clinical psychologists indicated that they felt that undertaking the role would impact their therapeutic alliance with clients and that the traditionally therapeutic aspects of the profession would be replaced with decision making and risk

assessing. Additionally, Parsloe (2012) reported that clinical psychologists were concerned about the impact the role of AC would have on their professional identity. They expressed concerns that it would become difficult to distinguish clinical psychology from psychiatry if they were perceived to be colluding with coercive practices. Relatedly, nurses in New Zealand expressed ambivalence about undertaking the role of RC due to concerns that it was informed by the medical model and that it would potentially create role confusion (McKenna et al., 2006).

Psychiatrist attitudes towards mental health professionals from other disciplines undertaking the role of AC were also identified as barriers and facilitators to uptake of the role. Hewitt-Moran and Jackson (2009) reported that psychiatrist attitudes towards the extension of the role were mixed. Some psychiatrists in an NHS Trust had been reported to be hostile following plans to extend the role due to beliefs that there was no value in it and concerns about losing power. However, some psychiatrists welcomed it and were pleased to be able to pass on responsibility to other mental health professionals who were more suited to oversee care for certain clients. Relatedly, Oates et al. (2018) reported that some 'non-medical ACs' felt that psychiatrists were dismissive and felt that they were undermining their domain. However, some 'non-medical ACs' felt psychiatrists had expressed positive attitudes, which were viewed as enabling the implementation of their role.

Knowledge and skills. The ability to undertake the role due to perceived knowledge and skills was considered to be a facilitator for uptake of the role. McKenna et al. (2006) reported that all of the nurses acting as RC had an awareness of the relevant competencies for the role, and the majority of nurses not currently in the role expressed similar awareness. Additionally, nurses in the study felt that they possessed the necessary skills to meet supervisory and cultural competencies to undertake the role. This seemed to reflect the length

of work experience of the nurses as 84% had more than 10 years of experience and worked in settings where there was extensive use of the Mental Health Act. Moreover, in Oates et al's (2018) study, the majority of 'non-medical ACs' had extensive work experience prior to undertaking the role. On average, professionals had been qualified for 21.5 years, and the majority were in consultant posts. Consequently, they viewed their clinical experience as adequate preparation to pursue the role as the next step in their professional development.

Despite extensive clinical experience, deficits in knowledge and skills were also perceived to be a barrier to uptake of the role of multi-professional AC. McKenna et al. (2006) found that the majority of nurses reported skill deficits relating to clinical assessment, particularly with reference to disability and competency assessment skills. Relatedly, nurses felt that they had not received adequate training to undertake the role and were relying on pre-existing skills acquired from prior clinical experience. Also, Oates et al. (2018) reported that one participant expressed concerns about their ability and capacity to take on a potentially difficult addition to their present clinical role. Other staff members and patients have also expressed concerns about Multi-Professional AC's potentially lacking knowledge concerning medication and being unable to prescribe medication. Concern was expressed about them becoming reliant on medical practitioners to undertake certain tasks (Gray et al., 2020).

External factors

Organisational structures. The most commonly reported external barrier and facilitator to uptake of the Multi-Professional AC role was organisational structures. 'Non-medical AC's' were more motivated and permitted to undertake the role if their organisation had been involved in setting up pilot schemes to extend the role or if the role was already established (Oates et al., 2018). Also, organisational agreement surrounding cover and

support for medication-related aspects of the role and strategies for encouraging deployment, including additional remuneration for added responsibilities were found to be facilitators to implementing the role (Ebrahim, 2018). Additionally, organisational adoption of 'New Ways of Working' initiatives involving sharing responsibility amongst professionals was found to enable implementation of the Multi-Professional AC role (Hewitt-Moran & Jackson, 2009).

On the other hand, the lack of local systems and protocols for extending the multi-professional AC role at any organisational level was found to be a major barrier (Hewitt-Moran & Jackson, 2009). However, these findings were obtained prior to the publishing of guidance on the role and competencies required for the Multi-Professional AC role in November 2008. Regardless, similar confusion surrounding the process to become a Multi-Professional AC within organisations was expressed by 'non-medical AC's' long after the national guidance had been published (Oates et al., 2018). This was consistent with the lack of buy-in to implementing the role from many organisations at the time.

Resources. Availability of resources, particularly relating to time, staffing and funding, were found to be frequent external barriers and facilitators to the uptake of the multi-professional AC role. 'Non-medical AC's' cited limited time to develop their portfolios, which they described as extensive and burdensome. They also cited limited clinical time to develop their skills and implement the roles due to existing responsibilities and having to balance the workload (Ebrahim, 2018; Oates et al., 2018). Two studies also cited the lack of additional remuneration as a barrier to uptake of the Multi-Professional AC role (McKenna et al., 2006; Ebrahim, 2018). Staffing difficulties were also linked to the availability of time. Psychologists highlighted that mental health services are under-resourced and psychological treatment provision is limited, impacting psychologists' ability to undertake new roles (Miller & Dickens, 2007). Similarly, organisations indicated that

difficulties backfilling posts impacted extension and implementation of the role (Ebrahim, 2018). However, initiatives and extra funding to employ lesser qualified professionals to backfill posts, such as psychology associates, were found to facilitate the extension of the role in some NHS Trusts. Difficulties recruiting psychiatrists in some NHS Trusts was also seen as an opportunity to support staff from other disciplines to undertake the role (Hewitt-Moran & Jackson, 2009).

Peer support. Peer support was an external factor that generated barriers and facilitators to uptake of the multi-professional AC role. 'Non-medical ACs' cited being in 'action learning sets', with peers who were also going through the approval process and completing their portfolios, as an integral component in enabling them to gain AC status (Oates et al., 2018; Hewitt-Moran & Jackson, 2009). Additionally, opportunities to network and be mentored by psychiatrists and existing 'non-medical ACs' helped to prepare them to navigate the AC approval process (Hewitt-Moran & Jackson, 2009; Ebrahim, 2018; Oates et al., 2018). This involved being provided with opportunities to shadow them in practice. Whereas, lack of support from psychiatrists was found to be a barrier, reflective of negative attitudes that may be held by some members of the profession towards the extension of the role (Oates et al., 2018).

Discussion of findings

This review aimed to identify the barriers and facilitators to uptake of the Multi-Professional AC role, following re-configuration of the role under the Mental Health Act (2007). The studies included in the review were assessed to be of low to high methodological rigour highlighting the varying quality. Studies were sourced from peer-reviewed journals and grey literature; however, there was little variation between the methodological quality of the peer-reviewed and grey literature research. Given the varying quality and the small

number of studies in the review, caution should be applied when interpreting the results. However, it is also important to acknowledge the infancy of this area of research and that the studies included in the review are the first to investigate this area.

In this review, attitudes, and knowledge and skills were identified as being both internal barriers and facilitators to uptake of the Multi-Professional AC role. Also, organisational structures, resources and peer support were identified as playing a role in generating external barriers and facilitators to uptake of the role. The findings demonstrate that barriers and facilitators to uptake of the Multi-Professional AC role occur at individual, team and organisational levels.

The most highlighted internal barrier and facilitator was attitudes. Conflicting attitudes were identified towards the extension of the Multi-Professional AC role, where on one spectrum the role was viewed as a deviation from professional norms and assimilation with psychiatry, and on the other spectrum, it was viewed as an opportunity to transform services and patient care. This relates closely to previous debates and commentaries about the Multi-Professional AC role and concerns about its impact on professional identity (Holmes, 2002; Veitch & Oates, 2017). According to social identity theory, some professionals perceive change as a threat to their identity, particularly if they identify strongly with their existing professional identities (Pate et al., 2010). It was noteworthy that positive attitudes towards the role were more strongly endorsed by professionals who were already Multi-Professional ACs or in the process of gaining approval. This may be reflective of an evolving professional identity allowing this group of people to embrace new roles (Sutherland & Markauskaite, 2012).

Regarding knowledge and skills, some professionals felt that they possessed the necessary knowledge and skills to carry out the role while others questioned their

competency to become an AC/RC. It is significant that professionals who were Multi-Professional ACs or in the process of seeking approval more commonly expressed having the knowledge and skills for the role and had a lot of clinical experience. This is consistent with recommendations that the AC is appropriate for professionals in senior or consultant roles (Department of Health, 2008). This suggests that the duration of clinical experience may offer one explanation for differences in perspectives. Additionally, it is probable that the AC role is still widely understood as a medical role, and so the knowledge and skill base of mental health professionals from other disciplines are questioned.

Organisational structures were the most commonly identified external and internal barriers to uptake of the AC role. In some organisations, there appeared to be clear organisational strategies for the extension of the AC role, whereas in other organisations, these appeared to be absent. This may account for skewed and limited uptake of the role more widely. Although there has been an evolution of the Mental Health Act, the organisational structures in place were not compatible with this shift. Similarly, this was reflected in the availability of resources, where the presence or absence of funding, adequate staffing and clinical time influenced uptake. The uptake of this role in organisations may be slow due to conflicts with existing organisational norms and expectations, leading to absent structures and resources.

Also, the presence or absence of peer support was found to influence uptake of the role. It appeared that those who were able to access support from those on a similar journey to approval or received endorsement from psychiatrists felt enabled to pursue the role. On the other hand, those unable to garner support from other ACs and psychiatrists experienced this as a hindrance. The findings suggest that peer support may foster a mutual sense of identification for those on the journey to seeking approval (Tajfel & Turner, 1986).

Limitations of this review

Several limitations are apparent in this review which are important to consider. Firstly, as this is an initial research review, a small number of studies were included in the review. Studies based within England and Wales were sparse, and so one study based in another country with similar roles was drawn upon. Although some commonalities could be identified between the studies based in England and Wales and internationally, firm conclusions cannot be drawn as the findings may not be generalisable to the UK NHS context. Also, studies in the review adopted a range of different methods for gathering data, and the barriers and facilitators reported in studies that employed survey questionnaires often lacked depth, impeding understanding of the factors that influence uptake of the Multi-Professional AC role.

Moreover, the studies in this review were conducted at different times relative to the introduction of the functions of Multi-Professional ACs and RCs. Studies included were conducted before, during and after the introduction of the Multi-Professional AC and RC roles. Inclusion of studies from different time points was considered to be important in providing a comprehensive understanding of the barriers and facilitators to uptake of the multi-professional AC and RC role, and exclusion of these studies would have also reduced the number of studies in the review. However, over time, there have been changes in societal context, service configuration and language used around the role (e.g., the clinical supervisor is now termed the AC and RC), which may have resulted in differences in perceptions and understanding of the role. Therefore, the findings may not present an accurate or conclusive picture of current barriers and facilitators to uptake.

Practical implications

Given the small body of literature into this area, it is not unexpected that there has been little investment from organisations into the implementation of this role, and vice versa. However, this review highlights the need for organisations to consider the barriers and facilitators identified when implementing this role. This could support organisations to reduce or eliminate the barriers, and reinforce the facilitators identified.

The findings suggest that many professionals have not received adequate support to undertake the role due to unclear or absent organisational structures and limited resources. As reported in the 'New Ways of Working for Everyone' document, strategies for new ways of working are difficult to successfully implement if they are not clearly demarcated or they are inadequately resourced (Department of Health, 2007). Therefore, organisations need to implement strategic plans with clearer definitions and objectives for the development of Multi-Professional ACs within organisations, as proposed by Health Education England (2020a). It would also be important for organisations to identify ways to free up staff time to fulfil AC functions. This can be achieved through backfilling posts and the additional funding that has been promised (Health Education England, 2020b). The implementation of the AC and RC roles require a larger organisational change than was previously appreciated.

Internal barriers and facilitators were also identified, highlighting conflicting attitudes and perceptions of the role itself, as well as concerns about self-competence. Mental health professionals and service users expressed some ambivalence about the impact of the role being extended to other professionals on standards of care, relationships with patients and professional role identity. This may be reflective of limited insight into what the role looks like in practice. Consequently, there is a need to emphasise and endorse the value and the importance of mental health professionals from other disciplines taking on the AC role. This can be facilitated by demonstrating the effectiveness of Multi-Professional ACs to increase

motivation. Additionally, a thorough assessment of needs is required to ensure that mental health professionals who are considering seeking approval to become an AC have access to the appropriate channels of support to develop the skills and knowledge required to fulfil the role.

Research implications

While this review provides an initial synthesis of the barriers and facilitators to uptake of the role, this area is still under-researched. Further high-quality research is warranted to strengthen the evidence base. The number of Multi-Professional ACs gradually rises year-on-year as more professionals go through the approval process. Therefore, follow-up studies should be conducted when numbers have significantly risen.

Additionally, future studies should adopt qualitative methods that will enable a more in-depth exploration of barriers and facilitators to uptake of the role, such as interviews and focus groups. This may capture barriers and facilitators that may not have been identified in this review. Furthermore, it would be beneficial for future research to explore whether there are unique barriers and facilitators inherent within specific settings and organisations. This is important given that the Multi-Professional AC role has been implemented more widely in the North of England where the majority of Multi-Professional ACs are located, and resources and funding differ across the country. However, the recent release of additional funding intends to correct this.

Moreover, future research to explore barriers and facilitators faced when carrying out the functions of Multi-Professional AC and RC in practice is needed as this isn’t adequately captured in the current evidence base. Further research should also examine the experiences of specific mental health professionals, other than psychiatry, in undertaking the role of

Multi-Professional RC. This would be important in capturing the nuanced experiences of specific professional groups in the role (e.g., clinical psychologists).

No quantitative studies were identified in the review; although, this is expected given that the research in this area is in its infancy. Future research could examine the impact of mental health professionals from other disciplines undertaking the Multi-professional AC role on service and patient outcomes. This could be achieved through the use of quantitative outcome measures to help justify the need for wider implementation of these roles.

Conclusion

This review explored the barriers and facilitators to uptake of the AC role, following the amendment to the Mental Health Act. Internal and external barriers and facilitators to the uptake of the AC role were identified. Attitudes, knowledge and skills were pinpointed as internal barriers and facilitators, while organisational structures, resources and peer support were pinpointed as external barriers and facilitators. This review highlights the need for organisations to proactively seek ways to emphasise the facilitators and reduce the barriers in order to increase uptake, as well as to continually investigate possible future barriers and facilitators.

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SECTION B

Clinical psychologists' experiences of being Responsible Clinicians: An interpretative phenomenological analysis

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Abstract

Background: There is a lack of attention to the specific experiences of distinct professions in the Responsible Clinician role. There has been growing commentary about this role within the clinical psychology profession pertaining to whether clinical psychologists should take on this role; however, research has been limited.

Aim: This study aimed to explore the experiences of clinical psychologists in the Responsible Clinician role.

Method: Semi-structured interviews were conducted with 8 clinical psychologist Responsible Clinicians. Interviews were transcribed and analysed using interpretative phenomenological Analysis.

Results: Five superordinate themes and seventeen subthemes were derived from the analysis. The superordinate themes are: “From psychologist to Approved Clinician psychologist”, “The psychological effects of responsibility”, “The system makes or breaks”, “Relationships shift in the face of power”, and “Making our mark: From paralysis to influence”. The findings highlight the complexity of clinical psychologists’ experiences in the Responsible Clinician role.

Discussion: Findings are discussed in the context of existing literature. Clinical implications include the need for ongoing peer support and mentorship for clinical psychologist Responsible Clinicians. The study limitations and directions for future research are also considered.

Key words: Clinical psychologists, Responsible Clinicians, mental health

Introduction

The Mental Health Act 2007: Approved Clinicians and Responsible Clinicians

The Mental Health Act (MHA) 1983 offers the legal framework for the assessment and treatment of people with mental health disorders. Partly in response to a movement towards a multidisciplinary model of care and competency-based approach, the MHA 1983 was amended in 2007. One of the main amendments to the MHA was the introduction of two new roles: Approved Clinician (AC) and Responsible Clinician (RC). The AC is a person that has been deemed competent by the Secretary of State (in England) or Welsh Ministers (in Wales) to act as an AC for the purposes of the MHA. Mental health professionals are expected to successfully demonstrate the 8 AC competencies to be approved (Table 1).

Table 1

Approved Clinician competencies

Competency	**Examples of competency**
Role	Understanding of role, key functions and legal responsibilities
Legal and policy framework	Knowledge of Mental Health Act, Human Rights Act, Mental Capacity Act
Assessment	Identify the occurrence and severity of a mental health disorder
Treatment	Understanding of mental health interventions e.g., physical, social and psychological
Care planning	Care plans which combine social services, health and further resources
Leadership and multi-disciplinary framework	Leading a multi-disciplinary team effectively
Equality and cultural diversity	Need to promote equality and diversity in a sensitive and active way

Communication	Presenting evidence at tribunals and court

The RC is the AC who has overall responsibility for the treatment and care of an individual detained under the MHA. The main responsibilities of ACs and RCs are presented in Table 2. However, notably, initial detention and conversion of Section 2 to Section 3 can only be initiated by medical practitioners, presenting some limits to other professions in the role.

Table 2

Main responsibilities of Approved Clinicians and Responsible Clinicians

Approved Clinician (when not acting as Responsible Clinician)	Responsible Clinician
May be permitted to make decisions pertaining to the treatment or detention of patients in hospital.	Approve Section 17 leave
May be permitted to visit and assess patients in private.	Review detentions and Community Treatment Orders (CTOs)
	Renew detentions and Community Treatment Orders (CTOs)
	Discharge from detention and Community Treatment Orders (CTOs)
	Power to recall Community Treatment Orders (CTOs)
	Section 5(2) holding power to detain patients up to 72 hours

More professions became eligible to become RCs, consisting of psychiatrists, psychologists, mental health and learning disability nurses, occupational therapists and social workers. The RC role, which was known as the Responsible Medical Officer (under the MHA 1983), had previously been the sole domain of medical practitioners. The 2007

amendment to the MHA challenged the distribution of responsibility that had inherently been placed within consultant psychiatrists (Kennedy & Griffiths, 2002). Under the MHA 2007, the definition of 'medical treatment' also encompasses psychological, nursing and specialist mental healthcare, providing more treatment options to patients with varying needs. It was specified in the Code of Practice (Department of Health, 2015a) that a patient's RC should be the clinician with the most appropriate skill set to meet their needs.

In 2019 there were only 63 ACs from non-medical professions (36 clinical psychologists, 23 nurses, 1 occupational therapist and 3 social workers) (Health Education England, 2020a). The AC and RC roles have been identified as opportunities for clinical psychologists (CPs) to have increased clinical leadership (British Psychological Society, 2010). However, despite steps taken to encourage clinical leadership within the profession, the roles have been taken up by a small number of CPs.

Debates within the clinical psychology profession

CPs have remained split about whether to take on the AC and RC roles. Some have argued that the roles enable CPs to hold greater power in the process of decision-making with regards to patient care (Kinderman, 2002; Roberts, 2005). Additionally, some have argued that the roles may elevate the status of clinical psychology (Diamond, 2002; Pilgrim, 2003). Pilgrim (2003) suggested that CPs adopting formal roles under the MHA could contribute to making the profession indispensable. Alternatively, some have argued that CPs may be viewed as participating in coercive practices rather than being collaborative and compassionate, leading to possible estrangement from patients (Holmes, 2002; Marriott et al., 2001). Similarly, the roles may have less appeal because it jars with the professions' ethical compass (Holmes, 2002). For example, the duty to detain as an RC and the duty to seek consent and to work with service users collaboratively as a CP (Taylor et al., 2009). This

argument may be rooted in the social identity theory, which posits that deviation from the norms of a professional group may be experienced as threatening (Pate et al., 2010).

In regards to structural issues, Gillmer and Taylor (2011) suggested that limited uptake of these roles was due to the MHA 2007 (which introduced these roles) being an amendment of the MHA 1983. Therefore, there was no additional funding available at the time to implement the roles. This placed the onus on oneself to prepare for the role in the absence of clear structures, processes and guidance. However, additional funding has now been released to develop these roles (Health Education England, 2020b).

Empirical research investigating uptake of the roles

The AC and RC roles have attracted some research interest. Most of the research has been concerned with the barriers and facilitators to uptake of the roles by mental health professionals.

Factors that facilitated uptake included positive attitudes to improve patient care, to develop a quicker pathway through the service for patients and to reduce medical dominance (Gray et al., 2020; Hewitt-Moran & Jackson, 2009). Also, mental health professionals' belief that they had the knowledge and skills to be RC facilitated uptake (Oates et al., 2018). Mental health professionals reported that organisations with the appropriate structures in place such as clear roll-out plans and protocols improved uptake (Hewitt-Moran & Jackson, 2009). Also, allocated time, adequate staffing, organisational funding and peer support were found to facilitate uptake (Oates et al., 2018; Hewitt-Moran & Jackson, 2009).

Barriers to taking up the role included negative attitudes about the impact on therapeutic relationships with patients, fear of assimilation with psychiatry and potential for role confusion (Miller & Dickens, 2007; McKenna et al., 2006). Also, mental health

professionals' belief that they lacked the knowledge and skills to be an RC was a barrier (McKenna et al., 2006). Additionally, unclear organisation protocols and roll-out plans in place inhibited uptake (Oates et al., 2018; Ebrahim, 2018; Hewitt-Moran & Jackson, 2009). Limited time, lack of job backfill, inadequate funding and limited peer support were also found to inhibit uptake of the role (Ebrahim, 2018; Oates et al., 2018; Hewitt-Moran & Jackson, 2009). However, these studies had a number of limitations. Some studies adopted survey designs so findings often lacked detail or were weakly expressed. This limited the richness of the information gathered.

Limited research has focused on experiences in practice as RC, likely reflecting the slow uptake of the role. Only two studies have explored multi-professional ACs experiences in practice as RCs (Ebrahim, 2018; Oates et al., 2020). Oates et al. (2020) found that RCs viewed themselves as possessing the power to transform their services and teams, alongside using their power to make challenging decisions about risk. Additionally, Ebrahim (2018) explored how multi-professional RCs (within one organisation) can enable clinical leadership in mental health and found that it was achieved through promoting distributed leadership and ensuring patients have the appropriate clinician to meet their needs.

Rationale

The dearth of research provides limited evidence about the experiences of multi-professional ACs as RCs. Moreover, research has not investigated the experiences of distinct professions in this role. Previous research has grouped professions, despite cultural (such as professional status and stereotypes) and structural (such as lines of accountability) differences between professions (Nolan & Badger, 2002). Similarly, professions are also governed by varying philosophical approaches, which may impact how they approach clinical leadership roles. For example, the medical model is often endorsed by nurses and medical practitioners,

while the psychological model is often endorsed by CPs (Carlyle et al., 2012; Woodbridge & Fulford, 2003). Therefore, a fuller understanding of how the RC role is experienced by different professions is required. Given the growing commentary about this role, it would be of importance to capture the unique experiences of CPs in this role. Particularly as CPs are often further removed from practices of control compared to other professions.

Aims of the research

This study aims to address this gap in the literature by exploring the experiences of CP ACs in the role of RC. This study aims to provide an in-depth, descriptive and interpretative account of their experiences. It is hoped that this research will help to aid the profession and organisations to identify how CPs can be better supported in the role.

Research questions

This study aimed to address the following research questions:

How do CPs experience the role of RC?
How do CPs make sense of how they carry out the role of RC?
How do CPs perceive themselves in the role of RC?

Method

Research Design

Qualitative design

The study adopted a qualitative design, employing semi-structured, one-to-one interviews. A qualitative approach was chosen to elucidate in-depth descriptions of phenomena and lived experience and to uncover complex processes (Barker et al., 2002).

This was deemed appropriate given the exploratory nature of this research. Additionally, semi-structured interviews enabled a richer account of participants' experiences while also affording the researcher the flexibility to explore issues raised by the participants (Smith et al., 2009).

Interpretative Phenomenological Analysis

Interpretative phenomenological analysis (IPA) (Smith et al., 2009) was selected as the qualitative method for this study. IPA is primarily concerned with participants' sense-making of their experiences and the meanings specific experiences hold for them (Smith, 1996). The researcher endeavours to achieve an 'insider perspective' into the participant's inner world; however, IPA recognises that gaining this perspective is not directly attainable, and so the researcher must play an interpretative role. Therefore, the researcher engages in a 'double-hermeneutic process', whereby the researcher attempts to make sense of the participants attempting to make sense of their lived experience (Smith & Osborn, 2003). The inevitability of researchers' assumptions and conceptions influencing interpretative activity is also acknowledged, requiring a process of reflexibility (Larkin et al., 2006).

IPA was selected as the methodological aims of IPA are consistent with the study's aims. It also enables the researcher to draw nearer to understanding the participants' lived experiences through committing to engage with the meaning-making process. Also, IPA is idiographic and emphasises the importance of examining the experiences of a small number of participants in greater detail rather than making more general claims (Reid et al., 2005). This felt applicable to this study given the under-researched nature of this topic. Grounded theory was also previously considered as a potential methodology; however, grounded theory is concerned with developing a theory to explain psychological phenomena rather than highlighting lived personal experiences (Willig, 2001).

Recruitment

Participants were recruited from the British Psychological Society (BPS) AC Forum. The Forum was thought to be an appropriate source for recruitment given the second supervisor's membership of the Forum and the ability to access CP ACs. The researcher introduced the research during one of the Forum's events and approached CPs in these roles. Research posters were left at the event for potential participants to make contact (Appendix A). Due to some difficulties in recruiting participants, participants were asked to suggest others, with the required characteristics, who may be willing to participate. Participants who expressed an interest in taking part in the study were contacted and sent an information sheet (Appendix B) about the study and were informed that they could ask questions. Those still willing to participate were given time to consider their participation before consent was sought and the interview was scheduled.

Participants

Eight participants were recruited for this study, in accordance with the recommended sample size for an IPA study (Smith et al., 2009).

To ensure the sample was homogenous, the following inclusion criteria were applied:

- Qualified CPs.
- Granted AC approval.
- Acted as RC for a period of at least 6 months.

The criteria for acting as RC for at least 6 months was applied as this was considered to be sufficient time to be able to reflect on experiences in the role. Five of the participants were female, and three were male. They worked in learning disability, child and adolescent,

and rehabilitation settings. All of the participants were Consultant CPs working in the NHS (representative of six NHS Trusts in England and Wales). Based on the small number of CP ACs in England and Wales, further information about the participants is not disclosed to preserve anonymity.

Data Collection Process

Interview schedule

The interview schedule (Appendix C) was developed in conjunction with the researcher supervisors who are experienced in the chosen methodology and research area. The interview schedule was also informed by relevant literature and the research questions. Based on the inductive nature of IPA, the interview schedule comprised of broad questions followed by prompts.

Procedure

Interviews were conducted via telephone or Zoom and Microsoft Teams due to the COVID-19 pandemic and participants being geographically spread. Consent forms (Appendix D) and informed consent were obtained from all participants via email prior to the interview. Before the interview, the purpose of the study was explained, and participants were reminded of their right to withdraw from the study at any time. The interview schedule was used to guide the interview process. Questions were asked flexibly, dependent on the flow of the interview, and to enable further probing of areas that arose during the interview.

Interviews lasted between 40 and 71 minutes. Interviews were conducted over 9 months. Interviews were recorded using a Dictaphone and uploaded onto an encrypted

memory stick. Interviews were then transcribed verbatim by the main researcher. To maintain anonymity, all identifiable information on the transcripts were removed.

Data analysis

Data analysis was guided by the six steps suggested by Smith et al. (2009) for IPA:

Stage 1: Transcripts were read and re-read to enable the researcher to immerse herself in the data. Recordings were listened to while reading the transcript for the first time to decipher any additional meaning behind the data.

Stage 2: Through line-by-line analysis, initial notes were made on the transcripts, focusing on linguistic, descriptive and conceptual comments based on what struck the researcher's interest.

Stage 3: Emergent themes were developed from analysing exploratory comments. This moved the analysis from descriptive to interpretative.

Stage 4: Once a set of themes were established within each transcript, connections across the emergent themes were examined. A list of the emergent themes was typed, printed and cut so that the themes were on individual pieces of paper. This allowed the researcher to move the themes around spatially to establish connections. The approaches used to find connections between the emergent themes were abstraction (similar themes are brought together), subsumption (an emergent theme obtains a super-ordinate status), numeration (recording theme frequency to indicate importance) and polarization (opposing themes are brought together). Themes were organised into a table for each transcript.

Stage 5: Stages 1 to 4 were repeated for the other transcripts while bracketing emergent ideas from the previous transcript when analysing the next transcript to allow new themes to occur.

Stage 6: Patterns across the transcripts were searched for. Initially, patterns were examined across the first five transcripts, and their superordinate and subthemes were clustered together. Then, themes from the first five transcripts were drawn on to orientate to the themes identified from the remaining three transcripts. Themes were newly introduced or reconfigured and relabelled through identifying convergence and divergence between transcripts.

Quality assurance and reflexivity

The four principles defined by Yardley (2000) were adhered to, to ensure the quality of qualitative research throughout the research process.

To demonstrate 'sensitivity to context', the researcher became situated with existing literature related to the area of investigation and theoretical underpinnings of the research. The researcher also had conversations with the second supervisor, who is a CP AC, about his role and he highlighted his personal difficulties in navigating the system to gain approval, particularly due to lack of additional funding. The researcher also met with service users who have had experiences of being detained under the MHA. These conversations revealed that that service users were not aware that the AC/RC role had been extended to CPs but were hopeful that CPs may be able to improve care for people who are detained.

To demonstrate 'commitment and rigour', each stage of the data collection and analysis was described. The researcher also adhered to the IPA guidance of Smith et al. (2009), as a novice researcher in IPA. Emergent themes and codes were also shared and checked by the main supervisor to assess credibility.

To demonstrate ‘transparency and coherence’, a detailed account of the research process was provided throughout. Also, a reflexive stance was maintained. Before interviews, the researcher conducted a bracketing interview (Appendix E) with another trainee CP to bring to awareness any biases that could potentially impact the research. For example, an assumption was held that CPs in this role leaned more towards the medical model. A reflective diary (Appendix F) was also kept throughout the research process to preserve a self-reflective stance throughout the research. The diary also highlights the researcher’s shift in her position regarding whether CPs should be encouraged to take on this role, from uncertainty towards a belief that there is a role for CPs to change the system from within.

The present study will provide novel insight into the experiences of CP ACs as RC and hopefully help the profession and organisations to support them in their role, leading to improvements in patient care, consistent with NHS values (Department of Health, 2015b). This demonstrates the study’s ‘impact and importance’. Also, findings from the research will be disseminated to participants and wider clinical forums.

Ethical considerations

Ethical approval for this study was obtained from the Salomons Ethics Panel (Appendix G) and the Health Research Authority (HRA) (Appendix H).

Informed consent

Informed consent for participation in the study was guaranteed by providing participants with an information sheet, which provided key information about the study and confidentiality. Participants were asked to complete a consent form via email. Also, participants were informed of their right to withdraw from the study at any stage.

Potential for breaching codes of conduct

The potential for codes of professional conduct to be breached was carefully considered while judged unlikely. If such breaches were disclosed, the researcher would seek support from the main supervisor to decide on the best course of action, on a case-by-case basis. The main supervisor is an experienced clinician and was previously a member of the BPS disciplinary panels, so would be able to provide appropriate guidance.

Potential distress

The possibility of participants finding talking about their experiences distressing was considered. Participants were informed prior to the interview that they could pause or terminate the interview. Participants were also given the opportunity to reflect on their experience of the interview process and to ask questions after the interview. The researcher's main supervisor was also available for further debriefing with the participants if needed.

Results

From the analysis, five superordinate themes and seventeen subthemes emerged, as displayed in Table 3.

Table 3

Superordinate themes and subthemes

Superordinate theme	**Subtheme**	**Number of participants contributing to subtheme**
From Psychologist to Approved Clinician Psychologist	Questioning the self	5/8
	Shifting professional self	6/8
	The "responsible" psychologist	5/8
The Psychological Effects of Responsibility	Responsibility as taxing	5/8
	Responsibility as threatening	6/8
	Responsibility as lonely	3/8
The System Makes or Breaks	Unjust medical dominance	5/8
	The organisation is in the driver's seat	8/8
	Finding a window of opportunity	4/8
Relationships Shift in the Face of Power	Relationships with patients' rupture	6/8
	Repairing and reconciling with patients	5/8
	Unchartered territory with colleagues	7/8
	A place of acceptance with colleagues	8/8
Making Our Mark: From Paralysis to Influence	Psychology's inaction and avoidance	6/8
	Stepping up to the plate	5/8
	Improving psychological care	8/8
	Promoting collaborative working	7/8

From Psychologist to Approved Clinician Psychologist

This superordinate theme captures participants' process towards a reconciled identity which integrates being a CP with being an AC/RC.

Questioning the self

Some participants were confronted with an initial sense of self-doubt about becoming an RC and questioned what the role would mean for their sense of self as CPs.

In the early stages, I had a while of thinking, God, am I still a psychologist? What...what...what is that…this kind of odd hybrid? (P3)

The participant's use of a rhetorical question implies a lack of security in her CP identity. She attempts to make sense of what she has become in the role and concludes with *"this kind of odd hybrid*", highlighting that the role initially brought some sense of strangeness to her identity.

This conflict was also highlighted as being triggered by other psychologists' disapproval of the RC role:

For a while, it made me worry, are they right? Have I moved into a role that…that's problematic? That's holding up models that they wouldn't want to hold up? (P2)

Some part of her seemed to have started to internalise others disapproval. Similarly, some participants outwardly expressed initial regret in becoming an RC:

For the first time… I thought, what have I done? (laughs). Why am I doing this? (P7)

Participant 7's laughter denotes some discomfort in expressing this regret, triggering the immediate response of *"why am I doing this?"*. She appears to attempt to reconcile with what led her to this role.

Shifting professional self

Participants described an evolution in their perceptions of self as CPs, informed by career progression, time and experiences, which ultimately prepared them for the RC role.

When you go up the ladder, you are expected to do a whole new range of things. So, that was kind of happening anyway. So, my view of myself as a psychologist had moved a long way (P6)

Participant 6's visualisation of a ladder to denote progression implies he sees being an RC as part of this progression. Therapeutic interventions also seemed to become a less important part of being a CP over time. As Participant 2 said:

Over time anyway, I think I do less and less therapy work. I do far more indirect work or consultation work. I'll do that whether I'm an RC for somebody or not (P2)

Reference to a progressive distancing from the CP profession was also made, suggesting time leads to professional growth:

I've been through an experience and continue to go through experiences that they don't really…a lot of them don't really have an understanding of (P4)

The "responsible" psychologist

For some participants, there was an attempt to reconcile their positions as both "CP" and "RC". This subtheme's title represents the fusion of both roles.

I've also heard people say I've become one of them, as in psychiatrists. I haven't. I honestly haven't, but I think I've got a foot in both camps (P7)

Participant 7's emphasis on the word "*honestly*" implies a need to reassure that she hasn't abandoned being a CP. Her description of having "*a foot in both camps*" implies a neutral compromise in holding both positions. Others navigated the process of defining themselves as CPs in a way that incorporated their RC role.

I didn't see myself as a treating psychologist. Um, so, I was approaching them as a psychologist, but I wasn't delivering treatment. So, the position I had…was different (P6)

Participant 6's description of no longer being a *"treating psychologist"* implies reference to an 'old' view of self. However, he upholds that he still approaches the role *"as a psychologist",* suggesting he is still able to be a CP while being an RC. Similarly, Participant 4 attempts to make sense of what type of psychologist he is, in light of the RC role:

Before as a psychologist…well a straight psychologist before the AC bit (P4)

Participant 4 quickly corrects himself and refers to his 'old' self as a *"straight psychologist"*, implying that being an RC adds something more to his perception of himself as a psychologist.

The Psychological Effects of Responsibility

This superordinate theme describes the psychological impact of holding responsibility on participants. Many participants provided insight into their internal mental states when navigating the RC role.

Responsibility as taxing

This subtheme addresses participants' experiences of the emotional, mental and time-demanding nature of being an RC. Participant 4 recalls the impact of one of his patient's absconding:

I remember that night. I didn't sleep. I phoned the ward at 4:30 in the morning, and he had been picked up. Thank God, but that was awful (P4)

This demonstrates that the emotional toll extends beyond the confines of his workplace. His recollection of the time emphasises the significance and lasting impact of this event. This emotional toll was also described by Participant 6:

I would almost every day check the clinical notes to see if anything has happened with them…the patient. Just to kind of satisfy my own sense of peace of mind (P6)

His responsibilities appeared to impact his ability to keep calm, as highlighted by the need to regularly monitor his patients. Participant 1 described the impact of holding responsibility on her personal life:

The cover arrangements can make it harder to take annual leave as well. Perhaps what I didn't expect because you don't really realise until you're in it (P1).

This suggests it's not just emotionally challenging to separate from the role but also difficult to manage personal and professional boundaries.

Responsibility as threatening

For most participants, being responsible enhanced their concerns about feared potential consequences.

Realising the types of pressures and the level of responsibility because you realise that if this all comes back, it can all come back to bite (laughs) because it's your name (P7)

Participant 7's laughter appeared to contrast with the potential for decisions made to *"come back to bite",* perhaps reflecting some discomfort and anxiety in facing this potential outcome. As Participant 8 says:

Balancing the anxiety about if you take somebody off [CTO] and then something terrible happens (P8)

There is a sense of being stuck with the task of weighing up the risks and benefits. Participant 4 more explicitly named a potential threat posed in the role:

Part of me knows that if I continue to do this role, at some point, a patient will die. Someone from an overdose or something will go wrong. But I'm terrified of that. I still am. (P4)

He describes an impending sense of dread of a patient potentially dying on his watch, emphasised by the uncertainty about when this may happen.

Responsibility as lonely

This subtheme addresses the loneliness and isolation felt by a minority of participants due to being responsible. This experience of feeling alone seemed to sink in early on in the role. As Participant 5 says:

Being let loose into the world of… of you know being a clinician without…without having a mentor around to back me up (P5)

His description paints a picture of him being left to fend for himself. Participant 3 added further meaning to this felt experience:

I think it can be a bit lonely because you are having to carve your own way, but I think when there's more people, then it will be less lonely, and it will become more normal (P3)

She spoke about having to figure out how to navigate this role as a CP without guidance, leading her to hope that the loneliness will be curbed by more people in the role. Participant 2 describes that although she is part of a team, being the person holding responsibility feels isolating:

I'm the one that holds all that at the end of the day, and it feels really…it feels really isolated (P2)

This implies that there is some mental distance between her and the rest of the team in that she is left holding something that others do not understand.

The System Makes or Breaks

This superordinate theme acknowledges the role of the wider system, specifically the organisation and existing medical hierarchies, in predicting the success or failure of CPs being able to undertake the RC role.

Unjust medical dominance

This subtheme addresses the unfairness of a system that is geared towards and favours the medical model. Participants describe this as a hindrance to carrying out the role:

They got another Consultant Psychiatrist in. I didn't realise how political it was. It was very difficult. The consultant bodies in most Trusts are very dominant. I was like, how come these guys are so powerful (P4)

For Participant 4, his attempts to suggest that he was capable of being the sole RC on the ward were met with pushback, which presented sudden realisation of the medical dominance. Participants also discussed the limitations of being unable to prescribe medication and how this meant they fared against other professions.

People thinking that prescribing is a core part of an RC role because we are so used to RCs being medics. So, kind of what I call a deficit model of a multi-professional AC, where people are thinking, 'ok, so what are all the things that you can't do as a psychologist' (P3)

I mean frankly, I think we are at a disadvantage in that we don't prescribe. Nurses who can prescribe, who can also become an Approved Clinician are in a far better position (P6)

The organisation is in the driver's seat

The ability for CPs to become RCs was voiced by participants as being dictated by the organisation. The trajectory taken seemed to vary in participants' organisations.
Some participants reported their organisations' willingness to support CPs stepping into this role.

Right from the start, there was support within the Trust (P8)

Our Trust was very supportive of this. I mean, I think, to be fair, they put themselves out there really by agreeing to do this because nobody had ever done it before (P7)

Paradoxically, initial support from some organisations shortly came to an end:

When I first became an RC…it felt as if organisationally, people might be behind it, and it may become something that the Trust becomes…you know, very in favour of and continues to

expand, and that hasn't happened. There's been nobody since. Um, so it's kind of…I don't know. It just feels like I did it, and then no one else has done it (P2)

Participant 2's hesitation conveys a sense of being puzzled by the organisation initially being *"very in favour"* of the role, yet *"there's been nobody since".*

Finding a window of opportunity

In recognition of the organisation having control, participants commented on the opportunities that presented themselves momentarily in their organisation, granting them access to the role:

…there was no psychiatrist. There weren't that many other options with what the team could do. It was less about having made a good argument for psychology being able to do it and more about that there wasn't psychiatry available (P2)

There weren't enough Psychiatrists to fill the roles. So, I think they thought that this would probably help do that (p5)

These accounts suggest that ordinarily, CPs would not have been the organisations first choice for the role, implying that CPs have to wait their turn. Contrastingly, others played a more active role in seeking out this opportunity:

It seemed to change when I ambushed the medical director in the car park. I mean ambushed in the loosest sense (laughs). Basically, I wore her down. I wore her down over time (P4)

His description presents a sense of hurriedness as if he felt there would be no other opportunity. The extent of his efforts is conveyed in his account that he *"wore her down".*

Relationships Shift in the Face of Power

This superordinate theme highlighted the ways in which participants' relationships with patients and colleagues adapted and changed in the context of holding power.

Relationships with patients' rupture

This subtheme spoke of the relational breakdown with patients from assuming a position of greater power.

I've had patients that were very distressed or very unwell and saying, 'Well, you're not even a proper doctor. Why are you my RC?' (P3)

Participant 3 was confronted by patients challenging her validity as an RC. This alludes to some patients' perception of their status as a profession and a sense that CPs being RCs goes against the normal order. Others spoke of the emerging distrust from patients in having a CP RC:

He just kind of couldn't look me in the eye. It felt really different. He was really kind of shaking…very different to his usual kind of presentation (P2)

In her transcript, Participant 2 reflected on being an RC for a patient she had previously seen for therapy. She describes the patient's marked discomfort observed in their body language, suggesting the role has presented a relational barrier. Participant 4 commented on patients' mistrusting his intent behind wanting to be more connected:

What's this about? Why are you asking me…why are you trying to be…? They struggle with this to attempt to be more personable and to listen. (P4)

This is a striking dichotomy, considering the participant tried to be more *"personable"*, yet this approach was perceived as a *"struggle"* for patients. This suggests that patients struggle to associate this presentation with someone that holds power.

Repairing and reconciling with patients

Some participants described their efforts to repair and reconcile relationships with patients in light of existing power imbalances. For example, Participant 5 described his attempts to negotiate with patients:

Meeting halfway on… on certain things. There are obviously certain things I can't meet halfway on, if it has to be given, it has to be given, but other things like leave, you can compromise with. I'll try and do that as much as possible (P5)

Similarly, Participant 2 described having open conversations with patients about how they want to address her:

I can think with people about what does it mean if you call me Doctor [surname] or what does it mean if you call me [first name]? What feels like it best sums up our relationship? (P2)

There is a sense that openness was encouraged to try and level power differences. Participant 3 places an emphasis on spending time with patients to reconcile relationships:

I will see most of my patients, most days, even if it's just for 5 or 10 minutes if they're really unwell and that's all they can manage. People have to learn to trust me enough to be able to talk about their issues with me. So, I've just got to find whatever ways I can to build the trust (P3)

Participants appeared to recognise the need to make the most of any given opportunity in the absence of being able to build a therapeutic relationship.

Unchartered territory with colleagues

Some participants described feelings of uncertainty or the unknown within their relationships with colleagues due to them becoming the RC.

He thought it was all shrouded in mystery in the past, and now we know what it is… psychiatrists are a little bit threatened by that (P6)

Some psychiatrists are really curious about it. They get threatened by it (P4)

There was a shared experience of the unknown being superseded by threat. There appeared to be some protective element within the *"mystery"* for psychiatrists that was uncovered by more knowledge of what it means for a CP to be an RC. Participant 1's suitability for the role was questioned by her team:

I think a number of people in the team probably didn't see me as a leader…they saw people as leaders as being really forceful and strong, telling people what to do (P1)

She seems to suggest that as a CP, she challenges what is typically understood as constituting power.

A place of acceptance with colleagues

Participants described an eventual sense of progression within their relationships with colleagues where there was an acceptance of them being RC.

An additional level of… of perhaps respect that she gained in… for me in terms of, you know, understanding that I can help her make some of these decisions as well (P5)

It gave my colleagues also a sense of feeling supported and seeing that I was willing to put...kind of stand behind those theories that I'd been talking about (P3)

Participants garnered support from the team and felt that the team had an increased faith in their ability to be RC. Moreover, Participant 7 described establishing trust with the psychiatrist in her team:

She's very psychological, I'm probably more medical than a lot of psychologists that I know. And, um, we each trust each other to make decisions for each other's patients (P7)

The overlap in their styles of thinking enabled Participant 7 to build a bridge of understanding with the psychiatrist.

Making Our Mark: Paralysis to influence

This superordinate theme encapsulates participants movement from inaction to influencing care psychologically as RC.

Psychology's inaction and avoidance

Participants commented on their perception of the profession as being inactive and avoidant in matters that relate to decisions around patient care under the MHA and the RC role.

I see psychologists sometimes sitting in a room. I'm like, ok, you've sat there for an hour, are we any further forward? (P4)

Here, a sense of frustration is highlighted in the lack of progress made when psychologists come together. Participant 2 describes psychologists' deliberate intention to avoid the role of RC:

My psychology colleagues…generally, they don't want to do this. No one else wants to do this (laughs). They'll say quite strong things like it being a betrayal of all the values of being a psychologist (P2)

The use of the word *"betrayal"* suggests that she believes others think she is on the 'wrong side'. Participant 8 further comments on this divide:

I think it's very easy for psychologists to take a 'we are lovely, fluffy psychologists' and 'horrible, horrible psychiatrists' but, yeah, it's an important role. The Mental Health Act is one way of doing that. It's not perfect but, you know (P8)

Participant 8's use of juxtaposition in her description of psychologists and psychiatrists implies an awareness of psychologists' desires to separate themselves from psychiatrists and what they feel they represent within the mental health system.

Stepping up to the plate

Participants described a desire to move away from a position of inaction and avoidance and to accept the challenges that come with being an RC. They also indicated their desire for CPs to take on this role.

And I thought that as a senior clinician, I needed to step up to that responsibility. I shouldn't shirk that any longer and just say, 'well, that patient isn't for me' (P6)

A good way for psychologists being able to have more influence. Also, I suppose taking the pressure off psychiatrists (P5)

Others felt they had reached their breaking point in the system, and the RC was the next logical step:

I felt you either had to shut up about it or do something about it (P4)

Participant 4 presents himself with an ultimatum, suggesting some discomfort with the way things were.

Improving psychological care

All participants talked about their ability to influence patient care in a psychologically informed way through stepping into the RC role.

…being formulation based about everything and using that as a guide. We are all really clear about what is our basis for making decisions (P2)

Participant 2 described a shift in her team towards becoming formulation-led. Similarly, Participant 5 described his ability to steer his team away from a medically dominated approach:

Using my clinical background to inform a less…risk-averse, more psychologically informed approach. Things like how we design a treatment plan that isn't just medically informed. (P5)

Participant 6 described his process of encouraging patients to come to their own understanding, influenced by his background as a CP:

'How do you think you got into this position? how do you think this has happened?'. And always trying to encourage some kind of self-reflection and some kind of psychological thinking (P6)

Promoting collaborative working

Participants described their push, as RC, towards more collaboratively working within their teams:

Other professions like the fact that things have become more collaborative. That there's more dialogue (P3)

My approach to…being probably more collaborative. They said, 'gosh, I've learnt so much'. So, I guess seeing a different way…style of doing things and seeing the outcome of that (P1)

There is a sense that participants felt their contribution of encouraging collaborative working was appreciated by their colleagues. Similarly, Participant 7 speaks about presenting a united front with colleagues to reassure patients that their care is a team effort:

It's not my patients and your patients. the patients know they've got both of us (P7)

Discussion

The study's aim was to explore the experiences of CPs in the role of RC. The findings are considered in the context of the research questions and existing literature.

In trying to make sense of how they view themselves in the RC role, participants described an initial or continued shift in their professional identity. For some, this was sparked by questioning their decision to become an RC, and for some, this was part of a

continued evolution of their view of themselves as CPs. For some participants, it could be postulated that the role ignited an internal conflict in their duty to enforce power as an RC and to seek consent as a CP (Taylor et al., 2009). This resonated with previous research, which found that some CPs were concerned that the RC role would impact their ability to establish therapeutic relationships with clients (Miller & Dickens, 2007). Drawing upon social identity theory, the progression in how some participants viewed themselves as CPs was indicative that professional identities are not fixed and evolve (Sutherland & Markauskaite, 2012). Most participants perception of being a CP was one that was conceptualised as taking on more of a leadership role. This likely enabled them to integrate the RC role with their CP identity with little conflict.

With regards to how CPs experience the role of RC, participants described the psychological effects of being RC. Some participants accounts were emotive in nature, as they expressed fear, heaviness and loneliness in the role. Participants described being fearful of the consequences of holding responsibility. It may be that this feeling is heightened for CPs in that they are often further removed from situations where this level of risk is present. Also, some participants reflected on the emotionally and time-demanding nature of being responsible. This finding mirrors previous research that has highlighted RCs difficulties coping with the weight of responsibility (Oates et., 2020). A minority of participants described feelings of loneliness in being an RC due to being the sole person holding responsibility or not being connected with other CP RCs. Given the small number of CP RCs in England and Wales, it was unsurprising that this feeling was shared by participants, highlighting the importance of supervision and support in the role (Oates et al., 2018).

Moreover, participants described the system as predictive of how easy or challenging it was to navigate the RC role. Some participants described existing hierarchies that favoured

medical practitioners being RCs. This echoes findings from previous research that highlighted staff and patient concern about CPs being unable to prescribe medication (Gray et al., 2020). Despite efforts to enable other professions to become RC, there remains a system at play that associates' medics with the RC role. This presents an additional barrier for CPs in the RC role that may not exist for other professions with prescribing rights, such as nurses. Some participants described their organisation as influential in determining whether CPs can become RCs. This was reminiscent of previous research that lack of organisational support was a hindrance to carrying out the role (Hewitt-Moran & Jackson, 2009). This suggests that whether CPs continue to be offered access to the RC role is not wholly in their control.

Participants also described changes in their relationships with colleagues and patients due to being in a position of power. Some participants found that patients and colleagues questioned their suitability for the role or felt hesitant. This resonates with previous research that has found that RCs have experienced resistance from colleagues before and after becoming RC (Oates et al., 2020; Hewitt-Moran & Jackson, 2009). The findings also confer with assumptions that CPs becoming RC contributes to some estrangement from patients (Marriott et al., 2001). However, some participants described being able to repair relationships with patients and also found that colleagues gradually supported them being in the role. This suggests that over time, CPs are able to encourage individuals in the system to adapt to change.

In regards to how they make sense of how they carry out the RC role, participants described being able to influence care psychologically and through collaborative working. Participants described adopting a formulation led approach to work with patients. This fits with staff beliefs that CPs can support those with psychological needs (Gray et al., 2020). Participants' encouragement for collaborative working highlights that CPs are able to use

practices that are consistent with their core principles in the RC role (Taylor et al., 2009). Participants described feeling it was necessary to assume responsibility in order to influence care psychologically, as mentioned by Kinderman (2002). This appeared to challenge other perspectives in the profession that being an RC may deviate from the core principles of the profession (Holmes, 2002). This suggests that for CP RCs, a desire to influence care overpowers concerns about assimilation to psychiatry.

Limitations

Participants were based in different NHS Trusts and settings, meaning the context in which they carried out the role of RC varied. It is not clear whether context would have made a difference to participants' experiences. However, this was unavoidable given that the sample was drawn from a small and dispersed population.

This study adopted purposive and snowball sampling. This meant that CP RCs that were purposively sampled referred other CP RCs that they knew, excluding other CP RCs in the population. This may have introduced bias as they were not recruited from regional approvals panel registers. For example, participants may have shared views that are more or less likely than what is observed in the general CP RC population. Also, those wanting an outlet to share their experiences may have been more motivated to participate, due to being disgruntled or happier in the role, potentially impacting the data.

Moreover, the majority of the participants in this study were female. Although a breakdown of the number of CP RCs in England and Wales is available, the gender composition of CP RCs is less clear. Therefore, it is not clear whether this sample is typical of the CP RC population.

Lastly, the course of the research was inevitably influenced by the researcher. This included the researcher's development of the interview schedule, pursued lines of inquiry during interviews and the researcher's sense-making of the data. Although quality measures were employed to minimise issues of interpretation, including discussion of themes in supervision and the researcher's engagement in a bracketing interview, the researcher's preconceptions may have affected the findings of this study. It would also have been beneficial for the researcher's views around whether clinical psychologists should take on the role to be embedded more clearly within the research, to co,

Also, the researcher's attitude of openness to the data may have contributed to personal views on whether clinical psychologists should take on the role being too heavily removed from the research. However, this approach was necessary to ensure that participants' experiences in the role were wholly captured, as this is the purpose of the study and is necessary for an IPA study.

Clinical implications

This study brought light to CPs experiences in the role of RC, particularly the challenges faced from holding responsibility. In this study, the psychological impact of being an RC, shifts in relationships and the process of navigating a dual identity were highlighted. CP RCs would gain from attending reflective practice groups dedicated to the experience of being a CP RC, to foster the professional identity formation process and to overcome and reflect on challenges in the role (Mann, 2009). The BPS Approved Clinician Forum may be a space to facilitate this, to improve support for CPs in this role. Similarly, in order for clinical psychologists to be better supported in their role, there may be a need for clearer guidance in BPS practice guidelines regarding tailored supervision for this role, as this is less clear. This is to ensure there is a clearer consensus about how this is implemented in organisations.

Some participants also named the loneliness felt in being an RC. Research highlights that peer support is an important part of the process towards gaining AC approval (Oates et al., 2018). Therefore, it would seem important for there to be ongoing peer support throughout the journey of being an RC. The development of mentoring schemes for new and aspiring CP RCs delivered by more experienced CP RCs could foster skill development specifically tailored to the needs of CPs.

Participants also reflected on the role of the organisation in determining whether CPs can become RCs. There is a need for commitment from senior directors to facilitate the ease of transition from CP to RC. This can be aided through CP RCs working closely with the organisations to discuss CP's needs and supporting organisations to recognise the value of clinical psychology to the role through monitoring service and patient outcomes.

Research implications

There are areas in this study that may warrant further investigation. This study offered some insight into CP RCs relationships with other professions and patients in relation to them holding responsibility. Further research could explore patients and other professions' perceptions of their relationships with CP RCs, to offer a more rounded perspective on the impact of shifted responsibility on relationships.

Participants were based in different settings and therefore worked with different patient populations. Future research could explore the experiences of CP RCs within different settings with different patient populations. This may help to capture the more nuanced understanding of what is involved in being a CP RC. For example, the experiences of CP RCs working in learning disability settings may differ from those working in forensic

settings. Also, future research could examine the impact of CP RCs on length and patterns of sectioning and patient satisfaction.

There was an absence of discussion about race, ethnicity and gender in the interviews; however, this was not the intended focus of the study. Future research could explore the impact of race, ethnicity and gender on the role.

Conclusion

This study provided insight into CPs' experiences of being an RC. The findings suggest that CP RCs engage in a process of reconciling their CP identity with becoming an RC. They were also able to shift from a place of having little influence to being able to influence patient care psychologically. However, the role of the organisation and existing medical hierarchies was apparent for participants in determining the ease or difficulty in navigating the RC role. Further obstacles were also experienced in the role. There was a sense that, at times, being an RC can feel lonely, burdensome and threatening for CPs. Similarly, most participants experienced early shifts in their relationships with patients and colleagues as a result of becoming an RC; however, most were able to reconcile or maintain positive relationships over time. Given the complexity of their experiences in the role, there is a place for reflective spaces and CP-led mentoring schemes to enable them to shape their identity, process their emotions, and to support continuous learning. Future research is needed to explore the more nuanced experiences of being a CP RC in specific settings and to examine the impact of CP RCs on length and patterns of sectioning and patient satisfaction.

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Appendix A. Research poster for potential participants

Canterbury Christ Church University

Version Number: 2
Date: 25/07/19
IRAS ID: [redacted]

The experiences of Clinical Psychologists as 'Approved Clinicians' in the role of 'Responsible Clinician'

There is a dearth of research into the experiences of Clinical Psychologist Approved Clinicians in their role as Responsible Clinician.

We are interested in hearing more about your experiences of obtaining the role and your experiences in practice if you are:

- **A qualified Clinical Psychologist.**
- **Have been granted approval as an Approved Clinician.**
- **Carrying out the role of Responsible Clinician for a period of at least 6 months.**

Contact [redacted] if you are interested in taking part.

Appendix B. Participant information sheet

Canterbury Christ Church University

Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG

www.canterbury.ac.uk/appliedpsychology

Information about the research

Project Title: The experiences of Clinical Psychologists as 'Approved Clinicians' in the role of 'Responsible Clinician'.

We would like to invite you to take part in a research study. This information sheet provides some details about the research, why it is being done and what involvement in the research will consist of. Before you decide whether you would like to take part, [redacted] who is carrying out the research, will go through this information sheet with you and answer any questions you may have.

What is this study about?

The aim of this study is to gain a better insight into the experiences of Clinical Psychologist 'Approved Clinicians' in their role as 'Responsible Clinician', including the process of obtaining the role as well as their experiences in practice. There is little research into the experiences of non-medic Responsible Clinicians and it is hoped that this study will encourage further discourse about the role.

Do I have to take part?

You can stop being part of the study at any time, without giving a reason. Your data will be permanently deleted and will not be included in data analysis, if requested.

What will I be asked to do?

If you agree to take part, the researcher will arrange a mutually convenient time to interview you. You will be asked to sign a consent form to confirm that you have read and understood the information sheet. I will also ask your permission to audio record the interview, which will later be transcribed and analysed. You will be asked to talk about your experiences in the role of Responsible Clinician. The interview will take up to one and a half hours.

Who is carrying out the study?

The study is being carried out by [redacted] Trainee Clinical Psychologist, as part of a Doctoral qualification in Clinical Psychology undertaken at Canterbury Christ Church University. The study is being supervised by [redacted] Consultant Clinical Psychologist at Canterbury Christ Church University and [redacted] Consultant Clinical Psychologist/Approved Clinician.

What are the risks of taking part?

There are no significant risks to taking part. In the unlikely event that you become distressed, the researcher will discuss sources of support with you. You can also stop or pause the interview at any time.

Will information from or about me from taking part in the study be kept confidential?

Yes. The only exception where confidentiality would be breached is if any information is disclosed during the interview that suggests significant concerns about harm to others. In this case, the researcher would have to notify their supervisor.

In this study, you will be asked to complete a consent form if you are willing to participate. You will be asked to sign your name and the date. People who do not need to know who you are will not be able to see your name. Your data will have a unique participant number instead.

We will keep all information about you safe and secure. We will also follow all privacy rules. Completed consent forms will be retained and stored in a locked cabinet at the Salomons Institute for Applied Psychology for 5 years after study completion, and will then be destroyed. Audio recordings will be stored securely on an encrypted device and will be deleted after transcription. Names and other potentially identifiable information will be removed from the transcript. Anonymised transcripts will be stored on CD in a locked cabinet at the Salomons Institute for Applied Psychology for 10 years after study completion, and will then be destroyed. Quotes from the transcribed data will be included in the written report but will be anonymised. We will write our reports in a way that no-one can work out that you took part in the study. Data is stored in accordance with the General Data Protection Regulations (GDPR). Data can only be accessed by the main researcher and the research team.

Contact for further information

If you have any questions, you can contact [redacted] trainee clinical psychologist for further information at [redacted]

Concerns and Complaints

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to address your concerns. You can contact me by leaving a message on the 24-hour voicemail phone number [redacted] Please leave a contact number and say that the message is for me, [redacted] and I will get back to you as soon as possible. You can also contact the researcher's main supervisor at [redacted]
If you remain dissatisfied and wish to complain formally, you can do this by contacting [redacted] Clinical Psychology Programme Research Director, Salomons Institute for Applied Psychology [redacted]

Thank you for taking the time to read this information sheet

Appendix C. Interview schedule

What were you hoping to get out of the role of approved clinician?
Prompts: What were your personal reasons for seeking the role? What were your professional reasons for seeking the role?

What was it like negotiating the role?
Prompts: Is there a system within your trust for how the role is taken up? Was there anything that helped with is process? Were there any barriers involved? If so, how did you manage this?

What was your experience of the process for seeking approval to become an approved clinician?
Prompts: What was your experience of producing your portfolio? What was your experience of the training course? How did you manage the process?

Can you tell me about an early experience of carrying out the role of responsible clinician?
Prompts: What did this involve? How would you describe this experience? Are there any challenges that you face in this role? If so, how do you manage this? Is there anything that enables you carry out your role more effectively?

Did this experience differ in any way to your current experiences of carrying out the role of responsible clinician?
Prompts: If so, In what way? Are there different challenges? If so, how do you manage this? Is there anything that enables you carry out your role more effectively?

How, if at all, does your role as a clinical psychologist influence how you carry out the role of responsible clinician?
Prompts: If so, in what way? Are there specific areas of psychology that you draw on?

To what extent, if any, has the role of responsible clinician influenced how you view yourself as a clinical psychologist?
Prompts: If so, how do you see yourself in comparison to before you obtained the role? In what way would you say you have changed?

How would you describe the kind of relationships you form with patients in your role as responsible clinician?
Prompts: How would you characterise the different relationships? How do you think patients perceive you in this role? How did you feel about that?

How would you describe the kind of relationships you have with other professionals in your role as responsible clinician?
Prompts: Who are these professionals? Can you tell me more about your relationships with these professionals? How did you feel about that?

How would you describe the kind of relationships you have with your organisation in your role as responsible clinician?
Prompts: How would you characterise this? How did you feel about that?

Is the role of responsible clinician the same as what you envisioned taking up?

Where do you see yourself going with this role in the future?

Is this a role that you would encourage other clinical psychologists to take on?

Appendix D. Participant consent form

Canterbury Christ Church University

Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG

CONSENT FORM

Title of Project: The experiences of clinical psychologists as 'Approved Clinicians' in the role of 'Responsible Clinician'.

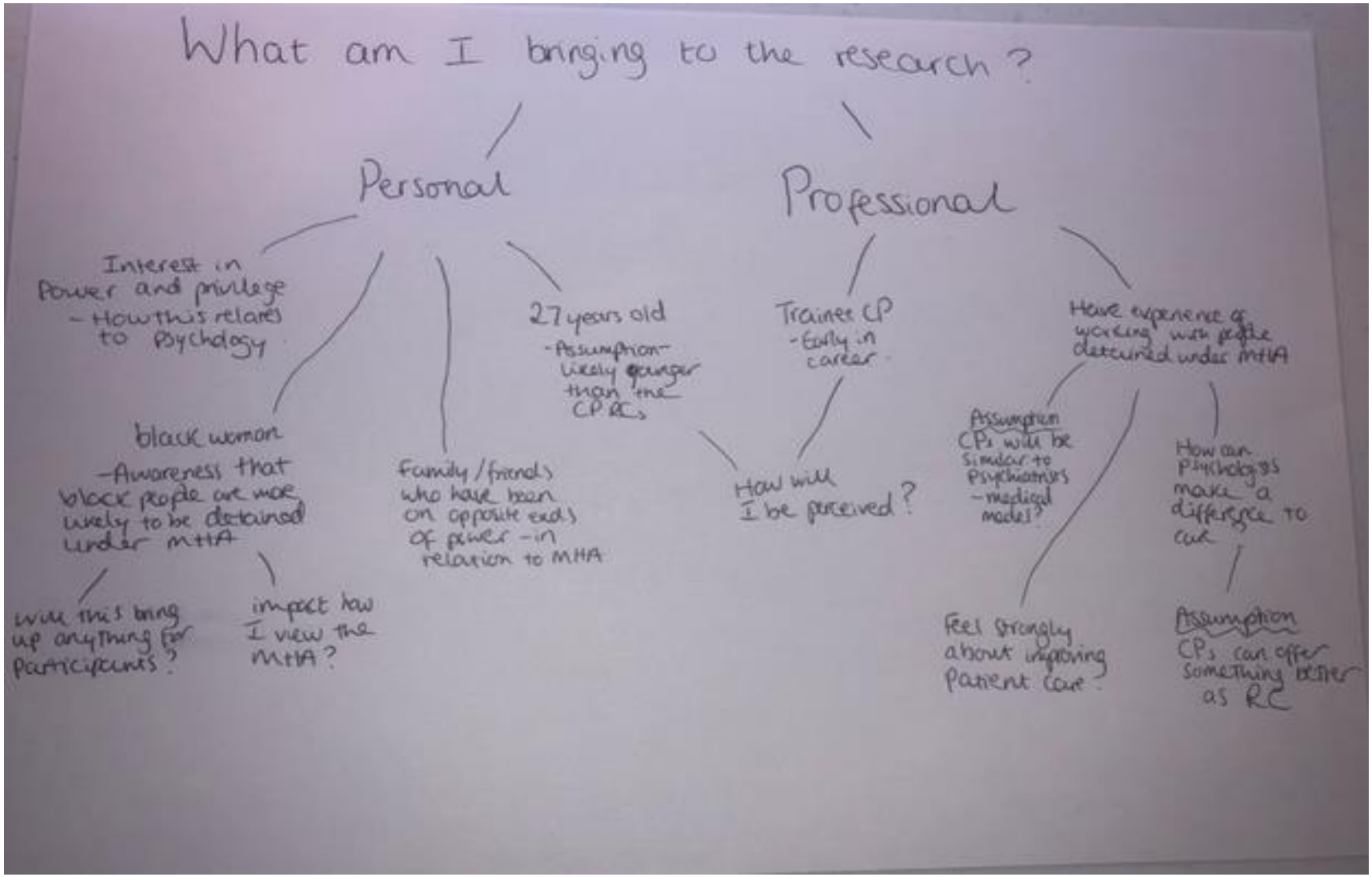
Name of Researcher: [redacted]

Please tick to confirm

I confirm that I have read and understand the information sheet provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
I know that I can end the interview at any time, without giving any reason. If I decide to withdraw, my data will be permanently deleted and will not be included in data analysis, if requested.	☐
I agree to my participation being audio recorded. I understand that the recording will be heard only by staff conducting the study.	☐
I consent to anonymised quotes being used in the written report of the study.	☐
I agree to take part in the above study.	☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

Appendix E. Bracketing interview mind map



Appendix F. Reflective diary excerpts

March 2020

I have spent some time reflecting on my position with regard to whether clinical psychologists should become RCs. At this point I feel quite split as I can see how clinical psychologists may be able to invoke change from the inside out but I am also mindful of what it means to be a clinical psychologist that is engaging with a system that detains people. Perhaps feeling quite split may help to facilitate my openness to participants experiences. I have finally got my ethical approval so I can get started with recruitment.

May 2020

I've sent out emails to everyone that had expressed an interest in the study from the Forum. Hoping they are still interested. Feeling particularly anxious about setting up interviews given the pandemic. The pressure is on, considering I have such a small population to work with. Have people's work practices changed? Will this impact their availability? I'm not sure. Part of me also thinks that maybe it might be easier to set up interviews, given that everything will be virtual now.

June 2020

I've managed to do a few interviews now. Doing my first interview was very anxiety-provoking. I felt out of my depth at times and questioned my knowledge of the topic. I wondered whether this was due to my awareness of the positioning and power differences between myself (trainee, early in my career) and the participants (highly experienced clinical psychologists). I wondered how I came across to the interviewee. I noticed that I was trying to stick to the flow of the interview schedule rather than what the interviewee was bringing. I made sure to loosen up more in the next interview and to be more led by the conversation.

July 2020

A few people haven't responded to my emails yet. I'm assuming most people are very busy. Feeling a bit panicky that I won't get enough people to interview but still holding out hope. I've discussed with my supervisor about sending reminders to potential participants that had expressed an interest. He suggested one reminder would be appropriate.

August 2020

I've had some potential participants get in touch apologising saying they thought they had emailed me back. Glad that the email reminder seems to have worked. Managed to schedule a few more interviews. Hopefully, I'll be done with data collection soon.

September 2020

Feeling quite excited about the interviews I have done. The discussions have been really interesting and enlightening. More interesting than I had initially expected. Despite interviewees being geographically spread, they seem to have a lot of shared experiences. The interviewees all seem to be pleased that I'm doing this research -probably reflecting the lack of opportunity many have had to voice their experiences. I feel pleased to be able to offer the participants this space.

December 2020

I've been stuck on 7 interviews. Hoping to complete one final interview as planned. Feels particularly hard to get in this last interview than it has earlier in recruitment. Feels so close to the finish line yet so far.

January 2021

Completed my last interview, finally! Feels like a huge weight has been lifted off my shoulders. I feel like I have a much better understanding of the role of responsible clinician in the practice, beyond what I have read in the literature. I think I had underestimated how tough yet rewarding the role can be at times. I can't help but think about how little I had known about this role over a year ago. I feel that as trainee clinical psychologists we need to be taught more about the different roles that we can undertake when qualified.

January 2021

Analysing the data feels like a much harder and time-consuming task than any other part of this research process. I've been trying to make sure that my interpretations are grounded in the data. Re-reading transcripts and listening to the audio recordings have been helpful in maintaining closeness to the data. Trying to approach each transcript separately initially to allow new themes to emerge has been trickier as naturally, I feel drawn to establishing links. Taking a physical break before analysing the next transcript has helped to create distance. It has also taken some time to develop emergent themes that adequately capture experiences. I'm hoping that the finished product captures participants' voices in a meaningful way.

February 2021

I met with both supervisors to discuss my themes. Something that my main supervisor said that struck me was not to discard themes that appeared salient but lacked frequency. This was in reference to the sub-theme 'responsibility as lonely'. He mentioned that it was important to include, as some participants may have wanted to express this during the interview but may not have been able to find the words. I recognise that frequency should not be the sole method to determine importance.

March 2021

After coming to the end of the research process, I have spent time reviewing my initial position regarding whether clinical psychologists should become RCs. After hearing participants experiences and hearing the high and lows, they all seemed to feel very positively about clinical psychologists being the role. It was also clear that they had been able to contribute to positive changes in care from taking on this role. I feel more positively about clinical psychologists taking on this role and feel that there is a place for clinical psychologists to do this, if they wish.

Appendix G. Ethical approval from Salomons Committee

This has been removed from the electronic copy.

Appendix H. Health Research Authority (HRA) approval letter

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Appendix I. Coded Transcript

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Appendix J. Data analysis examples and process

Developing themes from emergent themes at individual level (example)

Paralysis to analysis	**Patient resistance**	**Organisational resistance**	**Claiming a rightful space**
Whinging psychologists not taking action Psychology playing victim Psychology's fear of confronting issues with power Psychology's avoidance of acute settings Psychologist's aversion to mental health act If you are better take action Psychologists needing to take charge The inaction of psychology	Psychologists as pushovers Patients' confusion of the role Patient suspicion Patients resisting collaboration Fear of changing relational dynamics Fear of negative judgement Lack of transparency in therapeutic relationship Power threatening relationships with patients Concealment in relationships with patients	Dealing with corporate anxiety Systemic issue Applying pressure Passive resistance Stalling resistance Continued resistance Being persistent Negotiating at own cost Improving knowledge reduced organisational risk Organisational fear of breaking status quo Naively believing in organisational change An uphill battle to organisational change Organisational shift Change is far off	More to prove Ability being questioned Proving it was possible to qualify Capabilities being questioned Needing to justify value Proving the value of other professionals Judgement from others Take the chance or stop moaning
Unjust medical model dominance	**Fear of holding responsibility**	**Burden of responsibility**	**Covering your back**
Medical dominance Importance of psychological but medication dominates Balance the imbalance leave or accept medical dominance	Fear of taking on complex cases Fear in uncertainty Things could go wrong	Emotional turmoil Emotional toll Feeling overwhelmed Toll on personal life Almost reaching a breaking point	Feeling vulnerable Protection in role Justifying your position as RC

Fear of challenging medical dominance Need for equal dominance Space for other professionals to hold power	Holding risk as scary Fear of negative consequences for patient Fearing the worst-case scenario Fear for life Threat from patient Confronting the consequences of responsibility Fearing the consequences of responsibility	**Psychiatry feeling threatened** Threat to position Psychiatry's fear of losing territory Threatening psychiatry's territory Being perceived as a threat to psychiatrists Being perceived as a threat Fractured relationships with psychiatrists Betrayal in relationships with psychiatrist Psychiatrists as untrustworthy Psychology as a threat to psychiatry Psychiatry maintaining territory Shifting territories as a threat Unexpected shifts in relationship	**Underrepresented and undervalued** Psychology is undervalued Not taking action Psychologists feeling unable to do role Frustration with being undervalued Psychology choosing to work with people with more insight Proving oneself
Psychology cementing its value Questioning influence Test whether psych therapy would work Duty to improve patient care Best fit for the patient Meeting patients' needs Being more available to patients Self-reassurance of motivation Value of clinical psychology Not providing best interventions for patients	**Questioning suitability for role** Regret of taking on role Am I a psychologist anymore? Becoming part of the system- Should I Crossing psychologist boundaries	**Shifting from what's typical** Being different to other psychologists Feeling different to the psychology profession Shifting from being a straight psychologist	**An atypical psychologist** An atypical psychologist Security in psychologist identity

Providing different perspectives at panels Going against the grain Increasing transitions from the ward Approaching mental health differently Desire for clinical psychology in the role Improving patients' quality of life	**Recognising power** RC as authoritative Calling me doctor Necessity of the Mental Health Act Having the final say	**Avoiding power** Reluctance to exercise power Unease about sectioning	
Working in partnership Needing to Trust colleagues Support from nurses Support within the MDT Psychiatrists covering leave Confiding in others Positive relationships with nurses	**Repairing relationships with patients** Regular contact with patients Transparency facilitating relationships Patients as partners Giving the patient agency Getting alongside the patient	**Growing confidence** Self-reassurance Psychiatrists presenting as not knowing Less fear of negative perception Valuing difference Staying with uncertainty Safety in not knowing Holding not knowing Owning a position of not knowing Pride Feeling fulfilled Difficult but incredible rewarding Satisfaction in role Confronting responsibility	**Empathy for psychiatry** Recognising psychiatry's strengths The medical model's value

Group theme development

Superordinate theme	**Subtheme**	**Emergent themes**	**Individuals with emergent theme**	**Number of people theme was applicable to**
From psychologist to approved clinician psychologist	Questioning the self	Am I a psychologist? Regretting taking on role Role challenges ethical compass	4, 3, 2 4, 7, 5, 4	5
	Shifting professional self	CP role evolves over time Therapy is less important	4, 8, 6 2, 3, 7, 6	6
	The "responsible" psychologist	Being both RC and psychologist An atypical psychologist	7, 6, 4 4, 7, 2, 5, 6	5
The psychological effects of responsibility	Responsibility as taxing	Emotional toll Losing personal time Impact on personal life Burden	5, 4, 2, 6 1, 6 4, 6 2, 5	5
	Responsibility as threatening	Anxiety Need to cover your back Intimidation	6, 8, 4 5, 6, 4 4, 5, 1, 7	6
	Responsibility as lonely	Fending for yourself Left holding responsibility Others aren't around	5 2 3, 2	3
The system makes or breaks	Unjust medical dominance	Psychology is not prioritised Inability to prescribe Medics have power	5, 1, 4 6, 3, 1 4, 1, 3, 5	5

	The organisation is in the driver's seat	Organisational support Lack of organisational support Nothing changes	8, 7, 3, 5, 1, 6 2, 5, 4 2, 3, 4	8
	Finding a window of opportunity	Psychiatry vacancies as opportunities Slipping through the net Seizing the opportunity	2, 5, 2, 6 4	4
Relationships shift in the face of power	Relationships with patients' rupture	Patient anxiety Patient resistance Power impacts dynamics	2, 6, 4, 3 3, 6, 4 5, 4	6
	Repairing and reconciling with patient	Finding a place of understanding Process of negotiation Dedicating time to patients	2, 4, 6 5, 4 3, 6, 2	5
	Unchartered territory with colleagues	Psychiatry feeling threatened Uncertainty within the MDT Colleagues' curiosity Power shifts dynamics	6, 4, 2 1, 2, 3, 4 8, 5,	7
	A place of acceptance with colleagues	Backing from team Establishing trust	3, 5, 4, 6, 8, 1 7, 2, 6	8
Making our mark: from paralysis to influence	Psychology's inaction and avoidance	Making no progress Psychology's rejection of role A need to separate from psychiatry	4, 6, 2 2, 5, 4, 6 8, 4, 7	6
	Stepping up to the plate	Challenging avoidance of role Preparedness for responsibility A need for change	5, 6, 3, 4 3, 4, 5, 8	5
	Improving psychological care	Being formulation based	2, 7, 3, 1, 8	8

		Challenging medical model Psychological thinking Psychological models	5, 7, 3, 4, 8 6, 3, 4 7, 3, 5, 2, 8	
	Promoting collaborative working	Involving team in decisions Sharing care	3, 1, 5, 2, 8 7, 6	7

Appendix K. Extended list of quotes for superordinate themes/subthemes

Superordinate theme	Subtheme	Quotation examples
From psychologist to approved clinician psychologist	Questioning the self	In the early stages, I had a while of thinking, God, am I still a psychologist? What...what...what is that…this kind of odd hybrid? (P3) For a while, it made me worry, are they right? Have I moved into a role that…that's problematic? That's holding up models that they wouldn't want to hold up? (P2) For the first time… I thought, what have I done? (laughs). Why am I doing this? (P7) I had a bit of an identity crisis earlier on… I've had the issue I suppose of…it's been less spoken but I think some psychologists think, am I a psychologist anymore? (P4) We have to coerce people to stay on the unit against their will so I suppose that sometimes sits uncomfortably within the… the ethos of the ethical, um, kind of um… guidelines really of clinical psychology (P5)
	Shifting professional self	When you go up the ladder, you are expected to do a whole new range of things. So, that was kind of happening anyway. So, my view of myself as a psychologist had moved a long way (P6) Over time anyway, I think I do less and less therapy work. I do far more indirect work or consultation work. I'll do that whether I'm an RC for somebody or not (P2) I've been through an experience and continue to go through experiences that they don't really…a lot of them don't really have an understanding of (P4) And as my sort of experience gained…I did different types of jobs. I ended up working much more with systems rather than individuals because people were presenting (P7)

		So, even before I was in AC, I wasn't doing therapeutic work (P3) I think that also goes alongside being a more senior clinical psychologist. So, I think both of them relate to my increased seniority, my increased age. All of those things (P8)
	The "responsible" psychologist	I've also heard people say I've become one of them, as in psychiatrists. I haven't. I honestly haven't but I think I've got a foot in both camps (P7) I didn't see myself as a treating psychologist. Um, so, I was approaching them as a psychologist but I wasn't delivering treatment. So, the position I had…was different (P6) Before as a psychologist…well a straight psychologist before the AC bit (P4) As I say, I think I saw myself in a different role. So, I'm a psychologist but I'm also an RC (P6) So, I'm not a psychologist like in those settings (P2) It's changed… changed how I operate, but I don't necessarily know if it's changed my view of myself as a clinician (P5)
The psychological effects of responsibility	Responsibility as taxing	I remember that night. I didn't sleep. I phoned the ward at 4:30 in the morning and he had been picked up. Thank God, but that was awful (P4) I would almost every day check the clinical notes to see if anything has happened with them…the patient. Just to kind of satisfy my own sense of peace of mind (P6) The cover arrangements can make it harder to take annual leave as well. Perhaps what I didn't expect because you don't really realise until you're in it (P1) It can get quite rattling and quite weary. Um… and you know carrying high number of… of patients that are due it's a lot to… to keep in mind (P5)

		The weight of that responsibility has been far heavier than I had ever imagined (P2)
	Responsibility as threatening	Realising the types of pressures and the level of responsibility because you realise that if this all comes back, it can all come back to bite (laughs) because it's your name (P7) Balancing the anxiety about if you take somebody off [CTO] and then something terrible happens (P8) Part of me knows that if I continue to do this role, at some point a patient will die. Someone from an overdose or something will go wrong. But I'm terrified of that. I still am (P4) You're ultimately being seen as the voice of a decision that they don't necessarily agree with. That can increase some conflicts. So, for example, I'd gone twenty-five years with never a complaint to my name but then I…I think I've had two voices of concern where a family member has raised something since doing the role in five years (P1) Um, having to really justify why I'm making those decisions and making sure that I kind of set that out clearly, um, you know in my note keeping. So, that if anything if anything untoward were to happen you know at least I've… I've kind of justified myself clearly enough (P5) You can't say well, I'm not doing it, I'm too busy now. I'm afraid that's the way is. They send you the notification and you're expected to respond and if you don't, you're in trouble (P6)
	Responsibility as lonely	Being let loose into the world of… of you know being a clinician without, without having a mentor around to back me up (P5) I think it can be a bit lonely because you are having to carve your own way, but I think when there's more people then it will be less lonely, and it will become more normal (P3)

		I'm the one that holds all that at the end of the day and it feels really…it feels really isolated (P2) It feels like…I could do with more peers. That might be nice. Um, you know, I've found those in various places, not necessarily what I expected but I would really value…yeah, being able to have some kind of thinking space about that (P2)
The system makes or breaks	Unjust medical dominance	They got another Consultant Psychiatrist in. I didn't realise how political it was. It was very difficult. The consultant bodies in most Trusts are very dominant. I was like, how come these guys are so powerful (P4) People thinking that prescribing is a core part of an RC role because we are so used to RCs being medics. So, kind of what I call a deficit model of a multi-professional AC, where people are thinking, 'ok, so what are all the things that you can't do as a psychologist' (P3) I mean frankly I think we are at a disadvantage in that we don't prescribe. Nurses who can prescribe, who can also become an Approved Clinician are in a far better position (P6) Although there has been psychology input, to an extent, um, it felt as though that was kind of an adjunct to psychiatry (P5) It comes sometimes as a cost to your psychology role. It is very rarely sufficient attention paid to the backfill of that role (P1)
	The organisation is in the driver's seat	Right from the start there was support within the Trust (P8) Our Trust was very supportive of this. I mean, I think, to be fair, they put themselves out there really by agreeing to do this because nobody had ever done it before (P7) When I first became an RC…it felt as if organisationally, people might be behind it and it may become something that the Trust becomes…you know, very in favour of and continues to expand, and that hasn't happened. There's been nobody since. Um, so it kind of…I don't know. It just feels like I did it and then no one else has done it (P2)

		We're a long way forward but I can just see how much further there is still to go (P3) I think it will be another 15, 20 years but it has been inhibited by the lack of uptake (P4) The organisation was more receptive to other people doing those roles, um, than it had been before. (P1) [NHS Trust] was very happy to say, 'well, yes, we'll support you, whichever way we can', (P6)
	Finding a window of opportunity	…there was no psychiatrist. There weren't that many other options with what the team could do. It was less about having made a good argument for psychology being able to do it and more about that there wasn't psychiatry available (P2) There weren't enough psychiatrists to fill the roles. So, I think they thought that this would probably help do that (P5) It seemed to change when I ambushed the medical director in the car park. I mean ambushed in the loosest sense (laughs). Basically, I wore her down. I wore her down over time (P4) I don't quite know how I sneaked through the door because out Trust is now not happy to let people do it (P2) They sort of didn't get in our way as it were (P6)
Relationships shift in the face of power	Relationships with patients' rupture	I've had patients that were very distressed or very unwell and saying 'Well, you're not even a proper doctor. Why are you my RC?' (P3) He just kind of couldn't look me in the eye. It felt really different. He was really kind of shaking…very different to his usual kind of presentation (P2)

		What's this about? Why are you asking me…why are you trying to be…? They struggle with this to attempt to be more personable and to listen. (P4) I think some have struggled with my wanting to kind of…wanting to involve families more and involve the patients in a different way (P4) So, it definitely does you know what we were talking about things like coercion and um… you know taking people's liberty away it… it definitely will sometimes impact on relationships with clients (P5) So sometimes a patient would shout at me and storm out of the room (P6) Slightly odd relationship because it can be a bit antagonistic at times. Where the patients get cross with you but they also know that you have authority (P6) Not that the apology necessarily changed anything but they felt that they needed to apologise in order for me to not stop their leave or whatever it was (P6) Sometimes they're just a bit, 'oh, my consultant's a psychologist, that's unusual' (P3)
	Repairing and reconciling with patient	Meeting halfway on… on certain things. There are obviously certain things I can't meet halfway on, if it has to be given it has to be given, but other things like leave, you can compromise with. I'll try and do that as much as possible (P5) I can think with people about what does it mean if you call me Doctor [surname] or what does it mean if you call me [first name]? What feels like it best sums up our relationship? (P2) I will see most of my patients, most days, even if it's just for 5 or 10 minutes if they're really unwell and that's all they can manage. People have to learn to trust me enough to be able to talk about their issues with me. So, I've just got to find whatever ways I can to build the trust (P3)

		Being very explicit when I'm on…when I have to break confidentiality and then I will record things in the notes for everyone to see (P4) Before we go into the room, they are familiar with that position, so it doesn't come as a surprise (P6) We said, 'look, you need to have this treatment right now. Do you want to have it in your bedroom, in the clinic room or worst case…in seclusion? We want to give it to you with your consent' (P4) So, there's lots and lots of face-to-face-work but not…it doesn't look like psychological therapy (P2)
	Unchartered territory with colleagues	He thought it was all shrouded in mystery in the past and now we know what it is… psychiatrists are a little bit threatened by that (P6) Some psychiatrists are really curious about it. They get threatened by it (P4) I think a number of people in the team probably didn't see me as a leader…they saw people as leaders as being really forceful and strong, telling people what to do (P1) If I was to characterise the relationship, probably there is a little bit more of that power imbalance…that I need the care coordinator to be doing certain things in line with the law in a way that as a psychologist, you don't normally have a nurse working alongside you. (P8) Oh, you're doing that, and why did you do that? And can I do that as a nurse or an OT or psychologist? Is that something I could be doing? (P3) They struggle a bit when I want to answer the phone to my service users, when I want to have a joint relationship with them (P2)

		I suppose in terms of the power dynamic that doesn't always sit comfortably. Um, you know nursing staff will kind of defer to me to make that final decision (P5) That was really…I don't know, that was really difficult. Not emotionally difficult but kind of physically difficult. Like how…what…what's our relationship? How do we do it? How do we understand each other? (P2)
	A place of acceptance with colleagues	An additional level of… of perhaps respect that she gained in… for me in terms of, you know, understanding that I can help her make some of these decisions as well (P5) It gave my colleagues also a sense of feeling supported and seeing that I was willing to put...kind of stand behind those theories that I'd been talking about (P3) She's very psychological, I'm probably more medical than a lot of psychologists that I know. And, um, we each trust each other to make decisions for each other's patients (P7) Some of my nursing colleagues were really behind me and I didn't really expect that (P4) I think the confidence of the team with which I was working with grew. They could see that I could do this and they were confident (P6) I trust that if I'm in a situation where I'm aware that I'm not able to make a judgement based on risk because of me and personhood, that there are people I can call on to help me to do that (P2) I had a really good strong team around me. I think that is when the responsible clinician position works best (P8)
Making our mark: from paralysis to influence	Psychology's inaction and avoidance	I see psychologists sometimes sitting in a room. I'm like ok, you've sat there for an hour, are we any further forward? (P4) My psychology colleagues…generally, they don't want to do this. No one else wants to do this (laughs). They'll say quite strong things like it being a betrayal of all the values of being a psychologist (P2)

		I think it's very easy for psychologists to take a 'we are lovely, fluffy psychologists' and 'horrible, horrible psychiatrists' but yeah, it's an important role. The Mental Health Act is one way of doing that. It's not perfect but, you know (P8) You typically hear psychologists saying, 'well, this person isn't sufficiently psychologically minded or they are not ready for treatment so I'm not…they are not for me, so over to you', kind of approach (P6) Um, I think quite a few psychologists wondered why I've taken on that extra mantle of responsibility (laugh) because I know a lot of psychologists would say well this… this isn't for me (P5) The other thing they've said is 'oh, you've gone over to the dark side' (laughs), 'you've gone over to the dark side'…I've had a few people…and they've said that to me (P7)
	Stepping up to the plate	And I thought that as a senior clinician, I needed to step up to that responsibility. I shouldn't shirk that any longer and just say, 'well that patient isn't for me' (P6) A good way for psychologists being able to have more influence. Also, I suppose taking the pressure off psychiatrists (P5) I felt you either had to shut up about it or do something about it (P4) a good way of… of… of psychologist being able to have more influence I think within their teams (P5) So, I think it was about standing shoulder to shoulder with them, if you like, and putting my money where my mouth was and saying, ok, I will take that responsibility as well (P3) Thinking…thinking about what part I could play in helping support people who were being discharged out of long stay hospitals into the community (P8)

	Improving psychological care	…being formulation based about everything and using that as a guide. We are all really clear about what is our basis for making decisions (P2) Using my clinical background to inform a less…risk averse, more psychologically informed approach. Things like how we design a treatment plan that isn't just medically informed. (P5) 'How do you think you got into this position? how do you think this has happened?'. And always trying to encourage some kind of self-reflection and some kind of psychological thinking (P6) There's usually themes to the paranoia. So, we are starting to look at it rather than just taking it as a symptom in itself. So, psychological models of psychosis basically, is what I'm talking about (P7) as psychologists when we're working with a patient, we're thinking about the patient in the context of patients that are around them and the team that are around them, so we are as focused on team dynamics, team functioning, as we are on the individual patient. That's unique to us as a profession (P3) I suppose what I did bring is more the wider perspective of some of the issues of risk around touch perhaps…psychological perspective on what that may be about (P1) In that I'm using psychodynamic, systemic models understand what's going on for the patient (P8)
	Promoting collaborative working	Other professions like the fact that things have become more collaborative. That there's more dialogue (P3) My approach to…being probably more collaborative. They said 'gosh, I've learnt so much'. So, I guess seeing a different way…style of doing things and seeing the outcome of that (P1)

		It's not my patients and your patients. the patients know they've got both of us (P7) I just try to emphasise that these decisions you know can still be joint decisions you know I… I… I will you know try as much as possible to make collaborative decision making (P5) where we do work very collaboratively where people realise that I'm not going to suddenly turn around and say, 'thank you for saying all that, we're going to do this'(P2) Knowing that the day-to-day management of the patient when I wasn't there was being held by people who were responsible, who were senior, experienced clinicians in their own right (P6)

Appendix L. End of study summary for Salomons Committee and HRA

Clinical Psychologists' experiences as Responsible Clinicians: An Interpretative Phenomenological Analysis

I am writing to notify you of the competition of the above research study. This study has been written as a thesis for submission in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology. A summary of the study has been included below.

Introduction

Partly in response to a movement towards a multidisciplinary model of care and competency-based approach, the MHA 1983 was amended in 2007. One of the main amendments to the MHA was the introduction of two new roles: Approved Clinician (AC) and Responsible Clinician (RC). The AC is a person that has been deemed competent by the Secretary of State (in England) or Welsh Ministers (in Wales) to act as an AC for the purposes of the MHA. The RC is the AC who has overall responsibility for the treatment and care of an individual detained under the MHA. More professions became eligible to become RCs, consisting of psychiatrists, psychologists, mental health and learning disability nurses, occupational therapists and social workers. The RC role, which was known as the Responsible Medical Officer (under the MHA 1983), had previously been the sole domain of medical practitioners. The 2007 amendment to the MHA challenged the distribution of responsibility that had inherently been placed within consultant psychiatrists (Kennedy & Griffiths, 2002).

The dearth of research provides limited evidence about the experiences of multi-professional ACs as RCs. Moreover, research has not investigated the experiences of distinct professions in this role. CPs have remained split about whether to take on the AC and RC roles. Given the growing commentary about this role, it would be of importance to capture the unique experiences of CPs in this role. Particularly as CPs are often further removed from practices of control compared to other professions. This study aims to address this gap in the literature by exploring the experiences of CP ACs in the role of RC.

Aims of study

This study aimed to address the following research questions:

How do CPs experience the role of RC?
How do CPs make sense of how they carry out the role of RC?
How do CPs perceive themselves in the role of RC?

Method

Semi-structured interviews were conducted with 8 clinical psychologist Responsible Clinicians. Interviews were transcribed and analysed using Interpretative Phenomenological Analysis (IPA). IPA is primarily concerned with participants' sense-making of their experiences and the meanings specific experiences hold for them (Smith, 1996).

Results

Five superordinate themes and seventeen subthemes were derived from the analysis. The superordinate themes are: from Psychologist to Approved Clinician Psychologist, The Psychological Effects of Responsibility, The System Makes or Breaks, Relationships Shift in the Face of Power, and Making our Mark: From Paralysis to Influence. A summary of the superordinate themes and subthemes, including illustrative quotes, are presented in Table 1.

Table 1

Themes with illustrative quotations

Superordinate theme	Subtheme	Quote	Number of participants contributing to subtheme
From Psychologist to Approved Clinician Psychologist	Questioning the self	*In the early stages, I had a while of thinking, God, am I still a psychologist? What...what...what is that…this kind of odd hybrid? (P3)*	5/8
	Shifting professional self	*When you go up the ladder, as it were, you are expected to do a whole new range of things so that was kind of happening anyway. So, my view of myself as a psychologist had moved a long way (P6)*	6/8
	The "responsible" psychologist	*I've also heard people say I've become one of them, as in psychiatrists. I haven't. I honestly haven't but I think I've got a foot in both camps (P7)*	5/8
The Psychological Effects of Responsibility	Responsibility as taxing	*I remember that night. I didn't sleep. I phoned the ward at 4:30 in the morning and he had been picked up. Thank God, but that was awful (P4)*	5/8
	Responsibility as threatening	*Realising the types of pressures and the level of responsibility because you realise that if this all comes back, it can all come back to bite (laughs) because it's your name (P7)*	6/8
	Responsibility as lonely	*I'm the one that holds all that the end of the day and it feels really…it feels really isolated (P2)*	3/8
The System Makes or Breaks	Unjust medical dominance	*People thinking that prescribing...that prescribing is a core part of an RC role because we are so used to RCs being medics.*	5/8

		So, kind of what I call a deficit model of a multi-professional AC, where people are thinking, 'ok, so what are all the things that you can't do as a psychologist' (P3)	
	The organisation is in the driver's seat	*Our Trust was very supportive of this. I mean, I think, to be fair, they put themselves out there really by agreeing to do this because nobody had ever done it before (P7)*	8/8
	Finding a window of opportunity	*…there was no psychiatrist. There weren't that many other options with what the team could do. It was less about having made a good argument for psychology being able to do it and more about that there wasn't psychiatry available (P2)*	4/8
Relationships Shift in the Face of Power	Relationships with patients' rupture	*He just kind of couldn't look me in the eye. It felt really different. He was really kind of shaking…very different to his usual kind of presentation (P2)*	6/8
	Repairing and reconciling with patients	*Meeting halfway on… on certain things. There are obviously certain things I can't meet halfway on, if it has to be given it has to be given, but other things like leave, you can compromise with. I'll try and do that as much as possible (P5)*	5/8
	Unchartered territory with colleagues	*He thought it was all shrouded in mystery in the past and now we know what it is… psychiatrists are a little bit threatened by that (P6)*	7/8
	A place of acceptance with colleagues	*An additional level of… of perhaps respect that she gained in… for me in terms of, you know, understanding that I can help her make some of these decisions as well (P5)*	8/8
Making Our Mark: From Paralysis to Influence	Psychology's inaction and avoidance	*My psychology colleagues…generally, they don't want to do this. No one else wants to do this (laughs). They'll say quite strong things like it being a betrayal of all the values of being a psychologist (P2)*	6/8
	Stepping up to the plate	*And I thought that as a senior clinician, I needed to step up to that responsibility. I shouldn't shirk that any longer and just say, 'well that patient isn't for me' (P6)*	5/8

	Improving psychological care	*…being formulation based about everything and using that as a guide. We are all really clear about what is our basis for making decisions (P2)*	8/8
	Promoting collaborative working	*My approach to…being probably more collaborative. They said 'gosh, I've learnt so much'. So, I guess seeing a different way…style of doing things and seeing the outcome of that (P1)*	7/8

Discussion

This study aimed to explore clinical psychologists' experiences of being a RC. The findings suggest that clinical psychologist RC engage in a process of reconciling their clinical psychologist identity with becoming an RC. They were also able to shift from a place of having little influence to being able to influence patient care psychologically. However, the role of the organisation and existing medical hierarchies was apparent for participants in determining the ease or difficulty in navigating the RC role. Further obstacles were also experienced in the role. There was a sense that at times being an RC can feel lonely, burdensome and threatening for clinical psychologists. Similarly, most participants experienced early shifts in their relationships with patients and colleagues as a result of becoming an RC; however, most were able to reconcile or maintain positive relationships over time. Clinical implications included a need for reflective spaces, peer support and CP-led mentoring schemes to enable them to shape their identity, process their emotions, and support continuous learning. Future research is needed to explore the more nuanced experiences of being a clinical psychologist RC in specific settings and to examine the impact of clinical psychologist RC on length and pattern of sectioning and patient satisfaction.

A summary of the findings will also be sent to the participants.

Appendix M. Research summary for participants

Dear Participant,

I am writing to you to provide a summary of the research study and findings following your participation. Please see below.

Background

There is a dearth of research into the experiences of clinical psychologists in the Responsible Clinician (RC) role. There has been growing commentary within the clinical psychology profession regarding whether clinical psychologists should undertake this role, and clinical psychologists have remained split on this issue. Some have argued that the role will enable clinical psychologists to hold greater power in the process of decision-making with regards to patient care (Kinderman, 2002). However, some have expressed concerns about competing duties of care between the role of clinical psychologist and RC (Holmes, 2002). For example, the duty to detain as an RC and the duty to seek consent and work with service users collaboratively as a clinical psychologist (Taylor et al., 2009). This study was therefore felt to be of importance to capture the unique experiences of Clinical Psychologists in this role.

Method

Semi-structured interviews were conducted with 8 clinical psychologist RCs. Interviews were transcribed and analysed using Interpretative Phenomenological Analysis (IPA). IPA is primarily concerned with participants' sense-making of their experiences and the meanings specific experiences hold for them (Smith, 1996).

Results

Five main themes and seventeen subthemes were derived from the analysis. The superordinate themes are: from psychologist to Approved Clinician psychologist, the psychological effects of responsibility, the system makes or breaks, relationships shift in the face of power, and making our mark: from paralysis to influence.

From psychologist to Approved Clinician psychologist

This main theme captures participants process towards a reconciled identity which integrates being a clinical psychologist with being an Approved Clinician/Responsible Clinician. Some participants reported that they were confronted with an initial sense of self-doubt about becoming an RC, and questioned what the role would mean for their sense of self as clinical psychologists. Most participants described an evolution in their perceptions of self as clinical psychologists, informed by career progression, time and experiences, which ultimately prepared them for the RC role. For some participants, there was an attempt to reconcile their positions as both clinical psychologist and RC. Most participants perception of being a clinical Psychologist was one that was conceptualised as taking on more of a leadership role, allowing them to integrate the RC role with their clinical psychologist identity.

The Psychological Effects of Responsibility

This main theme describes the psychological impact of holding responsibility on participants. Many participants provided insight into their internal mental states when navigating the RC role. Participants described the emotional, mental and time-demanding nature of being an RC. Most participants described being fearful of the consequences of holding responsibility, such as concern about things going wrong. A minority of participants described feelings of loneliness in being an RC due to being the sole person holding responsibility or not being connected with other clinical psychologist RCs.

The System Makes or Breaks

This main theme acknowledges the role of the wider system, specifically the organisation and existing medical hierarchies, in predicting the success or failure of clinical psychologists being able to undertake the RC role. Participants discussed the unfairness of a system that is geared towards and favours the medical model. Some participants describe this as a hindrance to carrying out the role. All participants discussed the organisations' role in determining whether clinical psychologists were able to become RCs. The trajectory taken seemed to vary in participants' organisations, with some organisations being more supportive than others. Participants commented on the opportunities that presented themselves in their organisation, allowing them to become an RC.

Relationships Shift in the Face of Power

This main theme highlighted how participants' relationships with patients and colleagues adapted and changed in the context of holding power. Participants spoke of challenges faced in their relationships with patients from assuming a position of greater power. However, participants described their ability to repair and reconcile relationships with patients. Participants also described feelings of uncertainty or the unknown within their relationships with colleagues due to them becoming the RC. Although, participants described an eventual sense of progression within their relationships with colleagues where there was an acceptance of them being RC.

Making Our Mark: Paralysis to influence

This main theme encapsulates participants movement from inaction to influencing care psychologically as RC. Participants commented on their perception of the profession as being inactive and avoidant in matters that relate to decisions around patient care under the Mental Health Act, and the RC role. Participants described a desire to move away from a position of inaction and avoidance and to accept the challenges that come with being an RC. All participants talked about their ability to influence patient care in a psychologically informed way through stepping into the role. Also, participants described their push towards more collaboratively working within their teams.

Conclusion

This study aimed to provide insight into clinical psychologists' experiences of being an RC. Clinical implications include the need for ongoing peer support and mentorship for clinical psychologist RCs. Future research may explore the more nuanced experiences of being a clinical psychologist RC in specific settings. Also, further research could examine the

impact of clinical psychologist RCs on length and pattern of sectioning and patient satisfaction.

Appendix N. Guidelines for journal submission

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