

Finding Clinical Psychology (again)

Derek Mowbray
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Never under- estimate the power of inertia

Clinical Psychology getting lost?

Hassall and Clements (2010) suggest a widespread debate about ‘whether the therapy mission can sustain clinical psychology in the future’. This paper is a reflection on the steps I, and others, have taken since the clinical psychologist profession took the money and ran after the MAS Review (1989) without implementing the justification behind supporting its continuation and expansion. Those responsible for the future of clinical psychology couldn’t see that the strategic professional self interest would be best served by meeting the public interest in improving health. This meant an expansion from the narrow confines of clinical therapeutic activities – hence the need for greater numbers of psychologists, and a sharing of level 2 skills with other disciplines to cover the demand, thereby releasing level 3 psychologists to focus on the complex issues of health.

The plot was lost the moment the MAS Review was published. As one of the eight ‘best’ pieces of research conducted in the 1980’s, (The Psychologist 1990), it is possible to imagine the results might feature high on the scientific-practitioner’s implementation list. The fear that this would not be the case was explained in ‘Derek Mowbray: Turbulent Visionary’ (Kitzinger 1989) and ‘Towards a College of Healthcare Psychology?’ (Mowbray 1991). Two years after the MAS publication virtually no progress towards implementation had taken place (Kat 1991). In 2002 Gray and Cate (2002) discovered the vacancy level for clinical psychologists was 17.6%, not a million miles away from the vacancy level of 20% in 1989. The gap between demand and supply was a principal reason for the work of the New Roles Project Group (2007a). Twenty years after the MAS review I wondered what had gone wrong (Mowbray, 2008a). The MAS Review was a ‘big picture’ review; it spoke to those who could see the wider landscape; it was interpreted by those who couldn’t or wouldn’t.

At this point I am reminded about what happened to Martin Baro whose view that ‘Psychology must stop focusing attention on itself, stop worrying about its scientific and social status, and instead propose an effective service to the needs of the population’. In the year of the MAS Review Baro was taken into the quadrangle of the University of Central America and executed (Thomas 2007).

Context is everything

The flip side of Hassall and Clements's description, in the 1980's, of 'the profession (was) being taken sufficiently seriously for a significant review to be commissioned which led to the MAS Report' was a growing unease about any future for clinical psychology. Psychological scientific advances, compared with others applied within the NHS, were relatively slow, and psychologists were seen then, as now, as a significant cost to the taxpayer without a corresponding benefit. There was a shortage of clinical psychologists, apparently caused by the lack of training places, and a substantial amount of psychological therapeutic work being undertaken by unqualified psychology and other staff (Parry 1989). In addition, the attrition rate, whilst low, combined with 18% of newly qualified clinical psychologists not taking up posts in the NHS, contributed to a threat of extinction, as losses were not being replaced quickly enough for the numbers to grow in real terms to meet the demands for more services. Watson (2003) reckoned that by 'the 100th anniversary of Freud's death, in 2039, psychology, like him, would be six feet under' unless something dramatic happened to restore the fortunes of the (wider) profession, and he was writing 14 years after the MAS review publication. The scene was already set in 1988 that psychotherapy could be performed by non-psychology staff. The case for more psychologists was in danger before the review commenced, despite the increasing number of new established positions being created in the full knowledge that there were no clinical psychologists to fill them. There was a question as to whether it mattered if clinical psychologists filled these new positions, as there was widespread uncertainty about what clinical psychologists actually did. I would argue that the answer to that question arrived in the post in the C21st with the Improving Access to Psychological Therapies initiative.

The plot

The outcome of the Review of Clinical Psychology Services (MAS 1989) was my attempt at elevating the significance of psychology applied to health in the eyes of both psychologists and those who pay for their services. There was ample evidence to support this position (see, for example the first comprehensive review of the efficacy of clinical applications of psychology (Appendix MAS Review, Watts 1989)), although, interestingly, some clinical psychologists criticised the methodology of the study (revealing a narrow appreciation of the range of research methodologies) whilst applauding the result.

The focus, however, was not only on psychological therapies. The focus was on wider issues relating to health and healthcare, combined with, as I saw it, a need to capture the responsibility for supervising the application of psychological theories and principles by others, and to take a leadership role in all aspects concerning psychology applied to health.

This clearly meant raising the psychological head above the parapet.

In seeking to redeem the disappointment of the impact of the MAS Review I tried, with others, to keep the original MAS plot going and to fill the gap of inadequate strategic thinking by repeating the purpose of Clinical Psychology, as I see it, and thinking how best to deliver that purpose. This direction has been revisited 20 years after the MAS Review by 'A new ethos for Mental Health' (BPS 2009).

I have proposed a College of Healthcare Psychology in 1990 (Mowbray 1991) (not an original idea, as something like it had been proposed in 1977 by May Davidson), later an Institute (Mowbray 2008a, and 2009b) to draw together all aspects of psychological science to focus on health. Not only would this provide a broader foundation of psychological knowledge applied to health, it would stimulate applied and basic research, be a beacon of light that the world might see, and support initiatives across the whole spectrum of health, including influencing health policy. It would raise the psychological head above the parapet, and, if properly run, would guarantee the focus was on all psychological theories and principles being applied to all areas of health and healthcare. It would, also, break down the artificial barriers created by the BPS divisional system that have been so damaging to so many aspirations of psychologists and detrimental to their reputation as credible strategists.

With John Taylor, and building on previous work in this field and the MAS Review, we proposed the role of Associate Psychologist (MAS 2003, Taylor and Mowbray 2004) to help nudge Chartered and suitably experienced Psychologists towards practising at level 3 (see MAS 1989) by suggesting a role to undertake activities at level 2, now overtaken by Improving Access to Psychological Therapies that achieves the same purpose but leaving clinical psychologists where they were.

In 2006 I produced a paper (Mowbray 2006, BPS 2007a) setting out a vision for new roles in which I expanded on the theme of clinical psychology being engaged in issues concerning the determinants of health policy, and presented a strategic model for alleviating workplace psychological distress (BPS 2007b) that found its way into the final report.

In 2007 I proposed a role for Clinical Psychologists in the light of Health, Work and Wellbeing (Dame Carol Black's review) (MAS 2007). The workplace is often a controlled community and, together, workplaces represent millions of people. Presenteeism¹ is the scourge of performance and productivity, and about 40% of sickness and absence is attributable to psychological distress. Presenteeism needs to be eliminated for this country to compete effectively with the best workforces in the world.

In 2008 I proposed the establishment of Centres for Psychological Health and Wellbeing (Mowbray 2008a and b) to mirror general medical practice and provide psychological services to communities (something that would fit well with the 'Big Society' ideas). Such Centres would be social enterprise franchises, owned by psychologists and others, and be the home to psychologists with different interests, and could easily incorporate others applying psychological therapies. Such Centres would serve all forms of communities and the people within them.

In 2009, at the DCP Manager's Conference in October, I proposed the National Institute for Psychological Excellence as part of my idea for an Institute for Psychology Applied to Health (Mowbray 2009a). This was another attempt at suggesting the pooling of expertise and research relevant to health, and elevating the credibility of psychology in its market place.

¹ Presenteeism is the phenomenon of people turning up for work whilst feeling unwell. For those suffering psychological distress this often means under-performing due to concentration being diverted away from work towards the source of the distress. The estimated costs of presenteeism are one and a half times the combined costs of staff turnover and sickness absence.

With the failure to preserve the generic title of Psychologist, I urged the immediate abandonment of the divisional system of the BPS, on the Manager's Faculty blog (as the Health Professions Council was sufficient to preserve the different psychological interests of members), as I could see no way forward for the science of psychology applied to health with such a series of tribes continuing to breed more tribes with ever higher and thicker walls around their territory.

Few of these ideas have combusted beyond a spark of interest, excepting that of the Associate which owes its airing to the tenacity of a few who got as far as launching training programmes and employing a handful of people.

What is the effective audience for these ideas?

I have been advised that I am addressing the wrong audience; Clinical Psychologists employed by the NHS have a comfortable life and don't want to be bothered with fanciful ideas. Even those who are excited about these initiatives soon revert to discussing other people's opinion and the chances of any idea getting passed the various mountains inside the BPS.

Who is the right audience? In my presentation to the DCP in Scotland in 2008 (Mowbray 2008b), largely repeated at the DCP Manager's Conference in October 2009 (Mowbray 2009a), I listed 14 interested parties controlling the work of Clinical Psychologists. I described two characteristics of this audience – either a champion or a quick fixer. The difficulties for psychologists are those I described in my vision paper to the NWW project group – a lack of a psychological culture and the problem of language, either too simple or in-penetrable. Champions and quick fixers have little alternative but grasp the simple language; the other sort is way out of orbit for most people. Champions, therefore, have the same difficulty as Psychologists in persuading the quick fixers to do anything other than fix something quickly. The appeal of psychological therapies that 'ordinary folk' can apply, and apply using computers, is heaven sent for the quick fixer, but sidelines what psychologists can do.

Despite being advised to the contrary, the profession is also an audience. The problem is - Who is 'the profession'? For someone outside the DCP and BPS it is hard to find the Florence Nightingale of 'the profession' with whom I can consult and discuss wildly exciting matters. I recently asked for BPS endorsement of the new Manager's Code for the NHS that directly links manager behaviour to wellbeing and performance. I wonder how this will be handled and whether anything will happen. In many respects the profession seems to exhibit characteristics of the worst kind of democratic bureaucracy, with nominations for key leadership positions and reluctance to accept them, combined with an overwhelming desire for everyone's comment to count. This lack of clear, obvious, charismatic and vibrant leadership is no good for a struggling profession (despite the best intentions of those involved) with plenty to contribute to humanity.

Opportunity is knocking again

Today the scene is ripe for determined, tenacious and assertive development of psychology as a force to be reckoned with. Anything less will confine the profession to a dark corner. All we need

is a new plot (see above for an outline) with clear, obvious, charismatic and vibrant leadership to make sure it's not lost again.

References

British Psychological Society (2007a) *A Vision for the development of pre-qualification new roles in* Final Report of New Roles Project Group. pp 6-7.

British Psychological Society (2007b) *New Ways of Working for Applied Psychologists in health and social care. The end of the beginning. Summary report. Appendix 1: A Strategic Model for Alleviating Workplace Psychological Distress.*

British Psychological Society (2009) *Psychological health and wellbeing. A new ethos for mental health. A Report of the Working Group on Psychological Health and Well-Being.*

Gray, I and Cate, T. (2002) *Vacancy Survey by DCP Manager's Special Interest Group.* Unpublished manuscript.

Hassall, R and Clements, J (2010). *Clinical psychology getting lost? Accident, strategy, or symptom.* In Press

Kat, Bernard (1989). *Sharing skills and Care.* The Psychologist. October . pp 434-436

Kitzinger, Celia (1989). *Derek Mowbray: Turbulent Visionary.* The Psychologist. October. pp 440-441

Management Advisory Service (MAS). (1989). *Review of Clinical Psychology Services.* May. Cheltenham.

Management Advisory Service (MAS). (2003). *The development of a role of Associate Clinical Psychologist – a feasibility study.* August. Cheltenham.

Management Advisory Service (MAS). (2007). *A role for clinical psychologists in the light of Health, work and wellbeing – Caring for the future.* April. Cheltenham.

Miles, Thomas (2007) *Promoting mental health and wellbeing in communities.* The inaugural College of Fellows Event. The Psychologist. 20. p198

Mowbray, Derek. (1991) *Towards a College of Health Care Psychology?* The Psychologist. August. pp 360-361

Mowbray, Derek (2006) *New roles in psychology – a vision of psychology applied to health. A paper for roundtable discussion 13th July.* Unpublished.

Mowbray, Derek (2008a). *Asking the big questions.* The Psychologist. 21. p986.

Mowbray, Derek (2008b). *Transforming psychology in the NHS.* Presentation to NES and HOPS Leadership Planning Away Day. February.

Mowbray, Derek (2009a) *I do like Mondays – going to work as a psychologist in 2012*. Presentation to DCP Manager's Conference. October.

Mowbray, Derek (2009b) *Institute of Psychology Applied to Wellbeing and Performance – an outline for discussion*. October. MAS. Cheltenham

Mowbray, Derek (2009c) *Grasping the future- it's bright out there*. Presentation to DCP Annual Conference. December.

Mowbray, Derek (2010) *Where are the strategists?* The Psychologist. 23. p171.

Parry, Glenys (1989). *Care for the future*. The Psychologist. October. pp 436-438.

Taylor, John L. and Mowbray, Derek (2004) *A proposal for the development of an associate clinical psychologist grade in the NHS*. Clinical Psychology. 39. pp4-7.

The Psychologist (1990) *Research in the 1980's*. October. p456.

Thomas, Miles (2007) *The inaugural College of Fellows event*. The Psychologist. Extras. March.

Watson, Peter (2003) *Living in a dream world*. The Times. 15th May. Times 2 p8

Watts, Fraser (1989) *The Efficacy of Clinical Applications of Psychology – An Overview of Research*. Shadowfax Publishing Wales.

Derek Mowbray has recently been re-appointed for a fourth term as a visiting Professor at Northumbria University. He is the founder of The Management Advisory Service, Organisation Health Psychologists (OrganisationHealth), PsychologistsDirect, The Resilience Training Company, The Stress Advisory Service and The Stress Clinic. He is the initiator, researcher and author of the new NHS Manager's Code, due for launching in late 2010, which includes the behaviours that managers need to use to build and sustain commitment, trust and emotional engagement of employees, and others in, or associated with, the NHS.

derek.mowbray@mas.org.uk