Practice to Policy:

Clinical psychologists' experiences of macro-level work

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:

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Date: 17th June 2016

Acknowledgements

I would like to dedicate this thesis to my supervisor Professor Chris Barker. Thank you for always going above and beyond to teach and support me, for sharing the wealth of knowledge and expertise you have in research so that I could grow and develop in the process. Thank you for being the first person to really take the time to teach me the fundamentals of good writing, you tirelessly kept me on track, giving me a space to make mistakes and learn from them. Your calm and focussed attention to detail is something I will take with me on my own professional journey.

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Overview

Many clinical psychologists are venturing beyond their traditional therapeutic roles to undertake macro-level work, engaging with social change, policy and public health. However, no research has systematically examined clinical psychologists' roles in policy work and the implications for the profession.

Part 1 of the thesis is a literature review of one area of macro-level policy aimed at improving the social determinants of mental health. It reviews nine intervention studies of housing improvement policy initiatives in the UK and their impact on mental health. Overall, study quality was moderate. There was limited evidence that such interventions improved mental health from some well-designed studies. Further evaluation of housing policy is needed to capture the full range of positive and negative effects on mental health.

Part 2 presents the findings from a qualitative study of 37 eminent clinical psychologists' experiences of macro-level policy work. It examines the processes involved, skills and competencies needed and the barriers and facilitators encountered. Interview transcripts were analysed using Thematic Analysis and resulted in six themes, organised into two domains. Clinical psychologists have core research and clinical skills that have the potential to be translated into work within much broader political systems. However, there are areas for development which involve drawing on applied sciences such as epidemiology, social and organisational psychology. Training, clinical, professional and research implications are offered.

Part 3 is a critical appraisal and reflection on the research process. It focuses on the advantages and disadvantages of being an 'inside' researcher, the scale of the study and discusses the terminology used in the study, particularly the term 'activist-practitioner'

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Part 2

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Part 1 Literature Review

The impact of housing improvement policy on mental health in the UK

Abstract

Aims: Social inequalities are positively associated with poor mental health. Changing socio-economic conditions through social policy interventions can improve population level mental health. Improving living conditions can improve physical health, but less is known about the impact on mental health. The aim of the review was to explore the evidence relating to housing improvement policy initiatives and their effect on mental health.

Method: A systematic search of the literature was used to identify housing improvement interventions (2005 - 2015) in the UK that measured mental health outcomes. Three areas of policy interventions were included: housing improvements, area-based regeneration and warmth and energy initiatives. A combination of electronic database searches was used to find key studies. The methodological quality of the studies was assessed using the Effective Public Health Practice Project Quality Assessment Tool (EPHPP).

Results: Nine studies met inclusion criteria for the review, two reported findings from housing improvement interventions, five reported findings from area-based regeneration initiatives and two reported findings from warmth and energy initiatives. Four studies were in England and five in Scotland. One used a randomised controlled design, six studies used non-randomised controlled designs and two were uncontrolled studies. Overall, study quality was good although all studies were limited by constraints posed by large social interventions. Only two of the nine studies reported significant improvements in mental health, one found an increase in stress associated with the intervention and six found no improvements.

Conclusions: The findings of this review were weak. Housing improvements have the potential to both improve mental health and increase stress due to the disruption

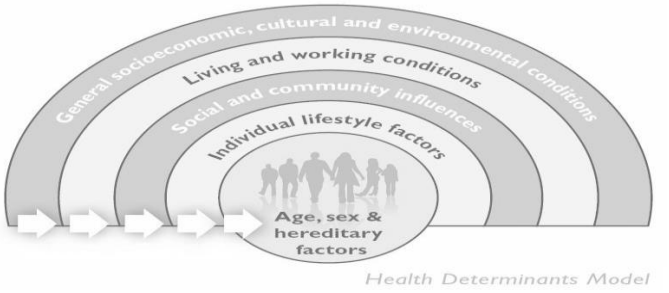
caused by building work. Increasing warmth in the home and reducing fuel poverty may also improve mental health, but more rigorous studies are required. Further research is needed to establish the types of interventions that are most effective and the characteristics of people who find them beneficial and how policy is implemented.

1. Introduction

The relationship between social inequalities and health has been evidenced for over 150 years (Marmot, Friel, Bell, & Houweling, 2008; Marmot, 2015; Newman & Baum, 2015; Wilkinson & Marmot, 2003). A body of evidence demonstrates that mental health difficulties are influenced by social and economic status, and living and working conditions (Marmot, 2014). Health inequalities are a global social justice issue, outlined in the World Health Organisation report from the Commission for Social Determinants of Health (2011).

The determinants of health model/ Rainbow Model (Dahlgren & Whitehead, 1991; 2007; Figure X) depicts the layers of influence on a person's health. In the centre are fixed factors such as heredity or biologically determined factors, e.g. sex. The surrounding layers indicate social factors that have been shown to influence health outcomes: personal lifestyle, family and peers, the physical and social environment and wider socio-economic, cultural and environment conditions.

Figure 1. *Dahlgren and Whitehead (1991) Rainbow model*



The Rainbow Model provides a framework for public health planning and designing policy interventions. 'Downstream' interventions target factors at an individual level (inner circle of the rainbow), such as psychological or behavioural interventions, whereas 'upstream' interventions (all outer layers of the rainbow) target the structural and environmental factors in society. Upstream interventions are

policy-led interventions that aim to improve population level health. Such interventions work by increasing access to something that may be unequally distributed (Brownson, Seiler & Eyler, 2010). The stream of the intervention is the 'problem' that has been identified e.g. high rates of mental health problems in deprived communities. The intervention in response to that would be a policy to address it, e.g. improving housing conditions. Upstream interventions seek to "create conditions in society for people to have control over their lives through material, psycho-social and political empowerment" (Allen, Balfour, Bell, & Marmot, 2014).

In a similar vein, Bronfenbrenner's (1979) well known ecological model of human development uses a four-level framework (micro-; meso-; exo- and macro-levels) to conceptualise different levels of system intervention, e.g. family, school, community and political context. Macro-level interventions aim to achieve social or political change that in turn can impact on the other levels in the system. Therefore, by improving living conditions through policy change at a 'macro-level', it is possible to improve a person's mental health at a 'micro-level'.

Public health research in mental health is concerned with evaluating such population level interventions. From this viewpoint, mental health is a population level issue. However, capturing mental health outcomes at this level has proved challenging. The tendency has been to focus on measuring 'mental ill health', which has limited the measures available for researchers (Bond et al, 2013). There has been a move from a focus on negative mental health (mental disorder) outcomes to capturing positive mental health (mental well-being) outcomes (Van Lente et al., 2010). The incorporation of measurements of mental well-being, e.g. quality of life, has resulted in more sensitive measurements of mental health (Parkinson, 2007).

1.1 Living Conditions and Mental Health

A body of literature supports the link between poor housing and poor mental and physical health (Bonnefoy et al., 2003; Evans, Wells & Moch, 2003; Shaw 2004; Stafford & Marmot, 2003). Living in a deprived community puts one at a greater risk of developing mental health difficulties (Swewel, et al., 2009). Living conditions have a direct and indirect effect on mental health (Evans, 2003). Characteristics that directly impact on mental health include warmth, noise and housing type. Indirect effects on mental health include living in a neighbourhood which provides opportunities for social support. Researchers have characterised the main aspects of living conditions associated with poor mental health. They include housing type (e.g. high-rise buildings or cramped conditions), housing quality, internal environment, overcrowding and neighbourhood noise (Guite, Clark & Ackrill, 2006).

Over the past decade, housing improvement initiatives have been high on the political agenda and have received more research funding (Guite Clark & Ackrill, 2006; Weich, Blanchard, Prince, Burton, Erens & Sproston, 2002). Housing interventions in the UK have been grouped into three key areas (Acevedo-Gracia et al., 2004): housing tenure, internal housing conditions and area regeneration.

An example of a housing improvement initiative is the Warm Front project (2000). This UK initiative was developed to tackle the health and environmental stressors associated with cold living conditions (Fuel Poverty Strategy, Department of Health, 2001). Warm Front required local authorities to provide energy efficient measures and new central heating systems to vulnerable households in deprived areas of the UK.

Researching housing improvement initiatives poses challenges. This type of natural research is opportunistic and is dependent on the socio-political agenda. It is

also dependant on naturally occurring intervention groups, dictated by the local authorities implementing the policy. For this reason, existing research has mostly been cross-sectional, with a lack of adequate control groups. Furthermore, until recently there had been ‘‘no tradition of the systematic evaluation of the health impact of housing design or innovation’’ (Lowry, 1991). Housing and health policy in the UK needs to be built on a body of rigorous empirical evidence (Thomson & Thomas, 2015).

1.2 Previous Reviews

In response to increased pressure to tackle housing and health there have been a number of reviews in this field (Bambra et al., 2009; Gibson et al., 2011; Liddell et al., 2015; Maidement et al., 2014; Thomson et al., 2013). These reviews are outlined in more detail in Table 1. The aforementioned reviews looked at physical and mental health outcomes and one review looked at mental health outcomes only (Liddell et al., 2015). All of the reviews included non-peer reviewed studies and a range of outcome measures.

Bambra et al. (2009) carried out a meta-analysis commissioned by the Department of Health Policy Research Programme to synthesise the global evidence on interventions targeting the social determinants of health. They found nine systematic reviews of ‘living conditions and housing interventions’, which varied from rental assistance programmes to environmental changes to neighbourhoods. Findings were variable, although there was evidence that general housing improvements were positively associated with ‘social outcomes’ such as reductions in fears of crime and increased social participation.

Gibson et al. (2011) reviewed five housing improvement reviews, mostly targeting disadvantaged neighbourhoods. The strongest evidence was for the impact of warmth and energy initiatives on health. The evidence for structural changes to internal housing conditions on mental health was less clear. It highlighted the need for more robust controlled studies. Thomson et al. (2013) carried out a synthesis of systematic reviews on specific housing improvements in developed countries. They excluded studies using a cross-sectional design to strengthen the methodological findings, but included non-peer reviewed studies. They reported 39 studies that explored the effect of studies using randomised, non-randomised or uncontrolled studies to evaluate housing improvement initiatives. It included UK policy initiatives only. A limitation of the review was that the data was not amenable to meta-analysis due to variability in sample size, intervention and analyses. Warmth and energy initiatives had the strongest evidence for improving mental health. Area-based regeneration was less clear, which may be as a result of the huge variation in such large scale initiatives.

The final two reviews looked at warmth and energy initiatives in developed countries. The first of the reviews (Maidement et al., 2014) was a meta-analysis of 36 studies. Two studies in the review reported significant improvements in mental health (Liddell & Morris., 2010; Thomson et al., 2009). Liddell et al. (2015) was the first and only systematic review to solely report mental health outcomes. The nine studies were divided into two domains: positive mental health (wellbeing) and negative mental health (specific mental disorders). The focus of the review was to develop an understanding of the differential effects of housing on mental wellbeing. Living in a cold home increases the likelihood of stress and worries relating to fuel poverty and poor mental health.

Table 1: An overview of previous reviews

Author	Focus of the Review	Types of Interventions	Outcomes	Methodology	Main Difference from Current Review
Bambra et al. (2009)	Social determinants of health	Interventions targeting the social determinants of health	All health and social outcomes	Meta-analysis, quantitative and qualitative methodology.	Developed and developing countries Included physical health Included all social determinants of health and associated interventions (which including housing and community interventions). Included non-peer reviewed
Gibson et al. (2011)	Housing and health	1) Housing conditions 2) Area characteristics 3) Housing tenure	Physical and mental	Synthesis of Systematic reviews, quantitative and qualitative methodology	Included non-UK interventions Included physical health Did not include warmth and energy interventions Included non-peer reviewed studies
Liddell et al. (2015)	Warmth and energy initiatives	Household energy efficient measures	Mental health	Systematic review, quantitative and qualitative methodology	Included non-UK interventions Warmth and energy interventions only Included non-peer reviewed studies
Maidment et al. (2014)	Warmth and energy initiatives	Household energy efficient measures	Physical and mental health	Meta-analysis, quantitative and qualitative methodology	Included non-UK interventions Included physical health Warmth and energy interventions only Included non-peer reviewed studies
Thomson et al. (2013)	Housing and health	Housing improvements	Physical and mental health and socioeconomic outcomes	Meta-analysis, quantitative and qualitative methodology	Included non-UK interventions Included physical health Housing improvement interventions only Included non-peer reviewed studies

The authors presented a ‘cumulative stress model’ to understand the impact of warmth and energy on positive and negative mental health.

1.3 Aims of the Current Review

The findings of the reviews outlined have contributed to a body of evidence on the impact of housing improvement initiatives on mental health. There is evidence that warmth and energy initiatives in particular can contribute to mental health gains. However, all reviews highlight the need for more robust controlled intervention studies in all areas of housing improvements. Furthermore, housing policy initiatives are being developed at a pace that requires regular research and review.

There has not been a review of all housing initiatives (housing improvements, area- based regeneration, warmth and energy) using purely quantitative methodology measuring mental health outcomes. In order to address these recommendations, the current review directly relates the findings to the UK policy context.

2. Methods

2.1 Inclusion and Exclusion Criteria

The inclusion criteria were that studies must:

1. Target adults (over 16) in the general population
2. Evaluate housing improvement initiatives in the UK
3. Include a standardised measure of mental health
4. Use quantitative methodology (randomised and non-randomised controlled trials and uncontrolled pre-post studies) and collect outcome data at least two time points.
5. Be published in peer reviewed journals in English in the last 10 years

Studies were excluded from the review if they:

1. Targeted specific populations e.g. people with mental illness or learning disabilities

2. Solely measured physical health, substance abuse or offending behaviour

4. Solely measured non-health outcomes e.g. fuel poverty

5. Used purely qualitative methodology or a quantitative cross-sectional design.

2.2 Search Strategy

Initial search terms were generated based on previous reviews (Bambra et al., 2009; Gibson et al., 2011; Liddell et al., 2015; Maidment et al., 2014; Thomson et al., 2013) and scoping searches. The titles and abstracts of studies identified in previous reviews were also searched for relevant terms. The final set of search terms broadly mapped onto two conceptual clusters; one set of terms to target the interventions (housing improvement terms) and another cluster to target the mental health outcomes (mental health terms). To allow for variations in keyword terms (e.g. depressed and depression) truncated terms were used. The following keywords were generated:

Housing intervention terms and mental health terms were combined together using AND; the following search strategy was then used:

(housing intervention terms) AND (mental health terms)

The databases of PsycINFO, PubMed, CINAHL and Google Scholar were systematically searched for relevant articles published between October and November 2015.

The search was limited to English language, peer reviewed journals from 2005 to 2015. Studies from outside of the UK were excluded by hand.

Table 2: Summary of Final Search Terms

Housing Improvement Terms	*Mental Health Terms*
Housing improvement*	Mental health
Housing invest*	Mental illness
Housing renewal	Mental disorder
Housing ten*	Mental wellbeing
Neighbourhood renewal	Psychol*
Living environment*	Psychiat*
Living condition*	Depress*
Regenerat*	Anxiety
Fuel poverty	
Warmth and energy	
Central heating	
Warm home*	

2.4 Data Extraction

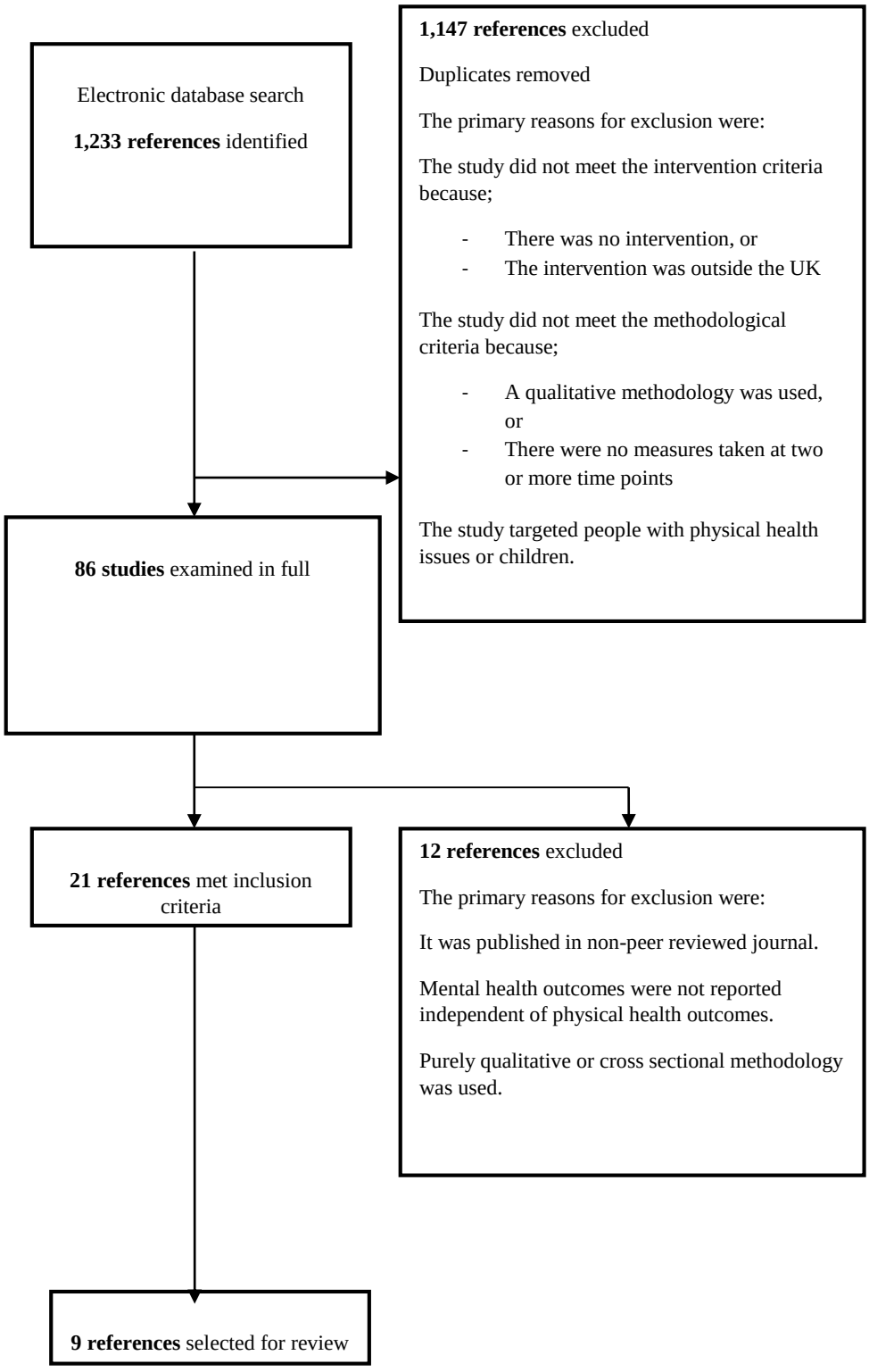
Key data was extracted for each of the reviewed studies, including author, date, journal, title of the study, design, sample size and characteristics, control group, design, details of the intervention, mental health outcome measure and study findings. The studies were organised by policy area across three domains: (1) housing improvements (2) area-based regeneration and (3) warmth and energy.

2.5 Assessment of Methodological Quality

The quality of the studies included in the review was assessed by the Effective Public Health Practice Project Quality Assessment Tool (EPHPP; Jackson & Waters, 2005; Thomas, Ciliska, Dobbins & Micucci, 2004). This tool was selected as it was designed to evaluate public health research and it has content and construct validity (Jackson & Waters, 2005; Thomas et al., 2004). The EPHPP assesses the overall quality of quantitative studies across six domains: selection bias,

2.3 Study Selection

Figure 2: The process of study selection and the primary reasons for exclusion



study design, confounding variables, blinding, data collection methods and participant withdrawals and drop-outs. The blinding domain was excluded because it did not apply to the design of the studies included in the review. Table 3reports the EPHPP tool criteria for strong, moderate and weak quality ratings for each domain. Each domain was rated as strong (3 points), moderate (2 points) or weak (1 point) based on the information extracted from each study. Judgements about the overall quality were made by the author and then checked again by my supervisor where there was doubt. Each study was given a global rating by calculating the mean score. The final rating was based on the number of weak ratings the study received. Studies with no weak ratings were rated as strong, studies with one weak rating were rated as medium, and studies with two or more weak ratings were rated as weak.

2.6 Synthesis

Following the quality assessment, a synthesis of the studies was carried out. The focus was on study design, sample (intervention and control), intervention, mental health outcome measures and the study findings (Table 4). Studies within the three policy domains were compared and reported upon separately. Outcomes were considered in terms of statistical significance.

Table 3. *Quality Assessment Ratings for the Six Domains of the EPHPP Quality Assessment Tool*

Domain	**Strong Rating**	**Medium Rating**	**Weak Rating**
Selection bias	Very likely to be representative of the target population and greater than 80% participation rate	Somewhat likely to be representative of the target population and 60-79% participation rate	All other responses or not stated
Study design	Randomized controlled trials or clinical controlled trails.	Cohort analytic, case control, cohort or an interrupted time series	All other design or design not stated
Confounders	Controlled for at least 80% of confounders	Controlled for 60 - 79% of confounders	Confounders not controlled for or not stated
Data collection methods	Tools are valid and reliable	Tools are valid but reliable or vice versa.	No evidence of validity or reliability or not described.
Withdrawal and drop out	Follow-up rate of >80% of participants	Follow-up rate of 60 - 79% of participants	Follow-up rate of <60% of participants or withdrawals and dropouts not described

3. Results

The characteristics of the nine studies that met the inclusion criteria are outlined in Table 4. The studies were clustered into three domains: housing improvements (two studies), area-based regeneration (five studies) and warmth and energy initiatives (two studies). Five studies took place in England, five in Scotland.

One study used a randomised control design, six used a non-randomised control design and two were uncontrolled studies. Two out of the nine studies reported significant improvements in mental health, one reported an increase in stress associated with housing improvements and six reported no significant improvements.

3.1Quality Assessment of Included Studies

The quality ratings of the studies (rated by the EPHPP) are shown in Table 5. Overall, the quality of studies was mixed. The majority received a global rating of moderate (seven studies), one was rated as weak and one as strong. Studies were categorised as weak if they were weak in more than one domain. The weak ratings given to the studies highlighted the methodological challenges associated with large scale longitudinal studies and difficulties in randomisation and response rates. Barton et al., (2007) was the only randomised controlled design and was an example of a well conducted study.

Table 5. *Quality Assessment of Reviewed Studies*

Study	Selection Bias	Study Design	Confounders	Data Collection	Withdrawal and Drop-Outs	Total Score	Global Rating
Barton et al. (2007)	Strong	Strong	Strong	Strong	Strong	3	**Strong**
Critchley et al. (2007)	Weak	Moderate	Weak	Strong	Weak	1.6	**Weak**
Curl et al. (2015)	Weak	Strong	Moderate	Strong	Moderate	2.2	**Moderate**
Egan et al. (2013)	Weak	Strong	Strong	Strong	Moderate	2.4	**Moderate**
Gilbertson et al. (2012)	Moderate	Moderate	Moderate	Strong	Moderate	2.2	**Moderate**
Kearns et al. (2011)	Weak	Strong	Moderate	Strong	Strong	2.4	**Moderate**
Petticrew et al. (2009)	Weak	Strong	Strong	Strong	Moderate	2.4	**Moderate**
Thomas et al. (2005)	Weak	Strong	Moderate	Strong	Moderate	2.2	**Moderate**
Thompson et al. (2007)	Weak	Strong	Strong	Strong	Moderate	2.4	**Moderate**

Note. Total score is the average of five domain scores, maximum total score .

Table 4. *Characteristics of the Reviewed Studies*

Study	Design	Intervention Group	Control Group	Intervention Category	Intervention Characteristics	Setting	Mental Health Measure	Study Findings
Barton et al. (2007)	RCT	N= 50	N= 69	HI	**Watcombe Housing Study** Upgrading Houses (central heating, ventilation, re-wiring, insulation, doors and re-roofing)	Devon	GHQ12 SF36	No significant improvement in mental health
Critchley et al. (2007)	US	N= 888		WE	**Warm Front Scheme** Provided new central heating or significant heating repairs	Birmingham Manchester Liverpool Newcastle Southampton	EQ-5D GHQ-12 SF-36	No significant improvements in mental health. Residents were more likely to experience anxiety and depression if living in a cold home but not improved by intervention.
Curl et al. (2015)	NRE	N=1334	N= 602	HI	**GoWell** Focussed on four types of housing improvements 1) Central heating 2) Front doors 3) Fabric works 4) Kitchen and bathrooms	Glasgow	SF-12	No significant improvements in mental health. There were positive associations with mental health and fabric works, kitchen and bathrooms and new front doors (only when fitted with kitchen and bathrooms).
Egan et al. (2013)	NRE	*D* n= 443 *HI* n= 315	N = 283	ABR	**GoWell** Compared different aspects of regeneration 1) Demolition (D)	Glasgow	SF-12	Housing improvements significantly improved mental health. Demolition had no

					2) Housing Improvements (HI) 3) Control			negative effect on mental health.
Gilbertson et al. (2012)	US	N=2685		WE	**Warm Front Scheme** Provided new central heating or significant heating repairs	Birmingham Manchester Liverpool Newcastle Southampton	EQ-5D GHQ-12 SF36	Central heating significantly improved mental health.
Kearns et al. (2011)	NRE	N= 334	N= 389	ABR	**SHARP** Re-housing residents to new social housing	Scotland	SF-36	Regeneration had an indirect impact on mental health.
Petticrew et al. (2009)	NRE	N= 339	N= 332	ABR	**SHARP** Re-housing residents to new social housing	Scotland	SF-36	No significant improvement in mental health
Thomas et al. (2005)	NRE	N=1344 (C&I)	N=n/a	HI	**Single Regeneration Budget (SRB**) Regeneration scheme on a council estate that included housing improvements to existing properties.	Manchester	GHQ-12	Increased stress was associated with housing improvements.
Thomson et al. (2007)	NRE	N=50	N= 50	ABR	Neighbourhood renewal Replacing ex-council homes with newly built housing	Scotland	SF-36	No significant improvement in mental health

Abbreviations

Design: RCT: Randomised Control Trail; NRE = Non-randomised experiments; US= Uncontrolled studies
Sample: I&C= In the Thomas et al. (2005) study the intervention and control group sample size was reported as a total number.
Intervention: HI= Housing Improvements; ABR= Area-based Regeneration; WE= Warmth and Energy
Measures: SF-12 and SF-36 = Medical Outcomes Study Short Form Health Survey; GHQ-12= General Health Questionnaire; EQ-5D= EuroQol; Own = Author's own measure.

3.1.1 Selection Bias

Firstly, selection bias was in the most part weak (seven studies) due to difficulties randomising samples to intervention groups and drawing from deprived populations (low socio-economic status, high unemployment). Furthermore, although target samples were large, response rates to surveys were low. Barton et al. (2007) received a strong rating as they used randomisation and received extremely high response rates at baseline and two additional time points (80 % or more). Gilbertson et al., (2012), received a moderate rating as like Barton et al. (2007) they achieved a response rate of over 60%, which is good for a study carried out in a deprived area.

3.1.2 Study Design

All studies, evaluated 'natural experiments' by collecting outcome data from residents undergoing some form of housing improvement initiative. All studies were longitudinal with the GoWell project still on-going at the time of publication. The seven experimental designs used control groups. Four of those studies used households that were waiting for some aspect of the intervention (or eligible) and two used a neighbourhood matched on variables such as deprivation and housing type. One study compared two intervention groups (housing improvements and demolition) to waiting list control (Curl et al., 2015). The two uncontrolled studies both evaluated warmth and energy initiatives and surveyed the same households before and after they received new energy efficient measures (Critchly et al., 2007; Gilbertson et al., 2012).

The quality ratings for study design were mostly strong. Seven studies were well conducted experimental studies, randomised and non-randomised. Two studies were rated as moderate as they were uncontrolled studies. The one study that used a

randomised controlled design, randomly assigned housing improvements at either year one or year two (waiting list). The six non-randomised experiments strengthened their designs by using appropriate control groups, e.g. households who had declined energy efficiency measures.

3.1.3 Confounding Variables

Confounding variables in these studies were age, socio-economic or employment status. The quality of ratings for confounding variables was highly mixed (four rated as strong, two as moderate and three as weak). This was due to differences in reporting of confounders and how they were controlled for. Four studies matched their control groups at baseline (Barton et al., 2007; Egan et al., 2013; Petticrew et al., 2009; Thompson et al., 2007), on variables such as age, gender and family structure. One study increased the accuracy of this further by using an electronic database to increase accuracy (Egan et al., 2013).

3.1.4 Data Collection

All nine studies received a strong rating for data collection as they used a standardised outcome measure of mental health. All studies used self-report measures that were either sent by post, completed online or as part of an interview (face to face or telephone). The most frequently used outcome measures were the SF-36 and SF-12 (eight studies), which are both versions of the Medical Outcomes Short-Form Health Survey (McHorny, Ware & Raczec, 1993). This short self-report questionnaire measures health-related quality of life in the general population. It has physical and mental health components which can be reported independently. It is a

valid and reliable instrument commonly used in public health research (Abbott, Hobby, & Cotter, 2006; Ware, 2000).

The EuroQol (EQ-5D) was used in the two studies evaluating the Warm Front scheme (Critchley et al., 2007; Gilbertson et al., 2012). The EQ-5D like the SF-36, is a quality of life measure that measures physical and mental health outcomes (EuroQol Group, 1990). Mental health components of the measure can also be reported independently.

Four studies used the General Health Questionnaire (GHQ-12) which screens for common mental health problems (Goldberg & Williams, 1988). A score of one to zero is allocated for each symptom question depending on whether the respondent has experienced it. A total score of four or more indicates the presence of a common mental health problem.

3.1.4.1.1 Withdrawal and Drop-Outs

Withdrawal and drop-out ratings were generally moderate (six studies), explained by the difficulties with retention in longitudinal cohort studies, e.g. people moving away. Two studies were rated as strong because they achieved follow up rates of more than 80%.

3.2 Sample

There was great variability in the sample size. Total sample sizes ranged from 100 to 2685 (median 723). The sample size was generally correlated with the size of the geographical area covered by the intervention. The studies with the largest samples evaluated national policy initiatives that included area-based regeneration in 15 neighbourhoods in Glasgow (GoWell) and improving warmth and energy in five

UK cities (Warm Front). By comparison the studies with the smallest samples (Barton et al., 2007; Thomson et al., 2007) evaluated local policy initiatives to upgrade the homes in single neighbourhoods.

The respondents in the studies were all adults, classified as the main householder. The respondents were sometimes chosen quasi randomly (e.g. next person to have a birthday) or identified by the household. One study required all adults in the household to complete the measures (Barton et al., 2007). The average age of the sample was 41years old, there were on average more women. Eight studies were carried out in deprived inner city areas and one was in a rural area of Devon. The majority of studies used the index of deprivation or local statistics to classify the socio-economic status of the neighbourhood.

3.3 Interventions and Findings

The interventions and study findings are presented in three policy domains: housing improvements, area-based regeneration and warmth and energy initiatives. Overall, only two out of the nine studies reported significant effects (Egan et al., 2013; Gilbertson et al., 2012). One reported an increase in stress in the intervention group and six reported no improvements.

3.3.1Area-based Regeneration Initiatives

Area-based regenerations (ABR) are large scale policy initiatives aimed at health inequalities in the most deprived areas in the UK. By definition they include: clearance of old housing stock, new homes, demolition and neighbourhood-wide improvements ranging from new street lights to new community centres (Kearns, Tannahill & Bond, 2009). The ABR initiates are all located in Scotland, where

mental health improvements were one of the key policy objectives (Scottish Government, 2011).

The GoWell project was the focus of two studies. GoWell is one of the largest scale studies of urban generation to date and its evaluation is still ongoing. It was set up to evaluate the short, medium and long terms effects (positive and negative) of housing investment in 15 deprived areas in Glasgow over a 10-15 year period (Egan et al., 2010). It has collected data on a multitude of outcomes, including mental health.

The first intervention study (Egan et al., 2013) compared three groups; housing improvements group (existing properties were upgraded to meet government standards); demolition group (residents living in clearance sites, exposed to demolition work of neighbouring property); and a control group (households waiting for improvements or ineligible). Data was collected at baseline and two year follow-up. The study, rated as moderate in overall quality, reported significant improvements on the SF12-v2 in mental health in the housing improvements group. Contrary to assumptions about the adverse effects of regeneration on residents, living in a demolition area it did not negatively affect mental health compared to controls. There were no changes to mental health in either demolition or control groups.

The second GoWell study (Curl et al., 2015) was carried out seven years into the project. At this stage, most of the neighbourhoods had received their housing improvements and the researchers were able to compare survey data from three time points across five years. Furthermore, they were interested in isolating the specific improvements to measure their impact individually and as paired comparisons. This was in part to justify the expenditure on such improvements and understand how to maximise the benefit on residents' mental health. The improvements included (1)

fabric works, (2) ‘Secure by Design’ front doors, (3) central heating, and (4) kitchen and bathrooms. This study was rigorously conducted, in ways not captured by EPHPP tool (rated as moderate). For example the scale and period that it covered allowed it to analyse medium and long term effects on mental health. It was the only study known to date to isolate specific improvements in this way.

The findings were all reported as ‘positively associated with’ and trending towards significance, but they did not find statistically significant effects, so no definitive conclusions can be drawn. Fabric works had positive associations with mental health in the first one to two years but not thereafter. It was hypothesised that this was due to initially brightening up the exterior of the neighbourhood allowing more light in winter. New front doors had positive associations with mental health in the first year, linked to a reduction in anxiety about crime and break-ins, although it did not appear to last. Central heating had positive associations with mental health three to five years after heating systems were replaced. Central heating is the most disruptive of all of the improvements as well as potentially increasing heating bills, therefore increasingly the likelihood of fuel poverty. New kitchens and bathrooms had positive associations with mental health after a year and continued beyond this period. This may be related to a period of adjustment to the new environment. Furthermore, residents were given choice in the design and colour of their kitchens and bathrooms which may have given them a sense of control.

Two studies reported findings from the Scottish Health, Housing and Regeneration Project (SHARP). This multi-site regeneration project was set up to evaluate short (one year) and long-term (two year) effects of moving social tenants into newly built homes in 38 areas of Scotland. The control group was households who lived in similar style houses to the intervention group in neighbouring areas.

They also divided groups up into three sub-groups (elderly, adult-only and families). It measured the effects of new housing on mental health and associated psycho-social outcomes such as neighbourhood safety. It aimed to build on findings that psycho-social risk factors such as isolation mediated the impact of housing conditions on mental health (Thomas et al., 2005).

The first SHARP study (Petticrew et al., 2009) reports the findings before, after (1 year) and at follow up (2 years). The study, rated moderately, was able to demonstrate that new homes dramatically improved damp and cold but did not improve mental health, measured by the SF-36. This first SHARP study did not report on psycho-social outcomes for this time frame.

The second SHARP study (Kearns et al., 2011) reported findings two years post- intervention. It was interested in both mental health outcomes and additional psycho-social benefits associated with a new home. The study, rated moderately, found no significant improvements in mental health measured by the SF-36. It did report improved psycho-social benefits such as improved perceived status, identity and sense of progress which were associated with non-significant improvements in SF-36 scores. There were differences in scores depending on the family structure and age of residents, with families reporting the most gains.

The fifth regeneration study (Thomson et al., 2007), like SHARP, evaluated the effect of moving residents to new homes in West Scotland. The project replaced a small number of ex-council homes that had damp and mould with newly built homes and compared them to a local estate matched by housing type. The study, rated moderately, found no significant improvements in mental health. However, rents increased considerably as a result of the intervention and over half of the residents

were on housing benefit. This potentially resulted in additional stress explaining why there were no improvements.

3.3.2 Housing Improvement Initiatives

Housing improvements studies were classified as interventions that solely improved or upgraded existing housing in a neighbourhood, either internal (new kitchens) or external (new roofing). Two studies evaluated the impact of such improvements. The larger of the two studies evaluated the impact on health of a Single Regeneration Budget (SRB) initiative to improve council houses on an estate in South Manchester (Thomas et al., 2005). The control group was houses on a neighbouring council estate. Improvements included central heating, damp proofing, lighting and electrics, roofing, bathrooms, plumbing, kitchens and new windows. The researchers were interested in the degree of psychological stress (positive or negative) associated with the improvements. The study also measured the degree of restricted opportunities, e.g. 'lack of money to enjoy life', which are risk factors for developing mental health problems. The study, rated as moderate, found that stress significantly increased after housing improvements (measured by the GHQ-12) compared to controls. Self-reported psycho-social risk factors, such as restricted opportunities, were positively associated with poorer mental health outcomes. The level of stress was also predicted by the age of the householder, with younger adults experiencing more stress. It would be interesting to know more about whether there were any hidden costs in the interventions, such as rental increases, which may have been confounded by low unemployment rates in a younger cohort.

The Watcombe Housing Study in Devon (Barton et al., 2007) also evaluated the short-term effects of improving roofing, electrics and central heating systems. In

addition residents received ventilation and insulation. At a local council meeting, households from the estate were randomised to either receive the improvements in the first year (intervention group) or have deferred them for a year (control group). Although this study was rigorously conducted (rated as strong on all domains) and achieved warmer, drier, energy-efficient homes, it did not find any significant improvements in mental health (measured by the GHQ-12 or SF-36). However, it had a short follow up period and would have benefitted from following up residents to see if there were any longer term benefits to the improvements.

3.3.3 Warmth and Energy

Warmth and energy initiatives are interventions targeting both fuel poverty and cold living conditions. Warm Front was the government's largest energy initiative in England and received around £1billion in funding. It provided grant funded packages consisting of new insulation and improvements to central heating systems. Households were classified as being in fuel poverty if they need to spend more than 10% of their gross income maintaining adequate indoor temperatures (DEFRA, 2001). Two studies evaluated Warm Front's impact on mental health. The first study (Critchley et al., 2007) targeted households that had received Warm Front packages. It required households across five English cities to regularly record temperatures in their living room and bedroom over two winter periods alongside health measures. The uncontrolled study, rated as weak, did not find significant changes in mental health scores measured by the SF36, GHQ-12 or EQ-5D.

The second study (Gilbertson et al., 2012) analysed data from a four year period before and after residents had received the Warm Front packages, to evaluate the impact of both thermal comfort and fuel poverty on mental health. The study

collected a vast amount of data on health, room temperatures, diaries, electronic logs and property surveys. It also collected three measures of mental health to strengthen its findings. This well conducted study, rated as strong, found residents with increased thermal comfort were significantly less likely to experience depression and anxiety, measured by the GHQ-12. They did not find any significant findings on the EQ-5D and SF36.

4. Discussion

The nine studies included for this review found little or no evidence of improved mental health associated with housing policy interventions. Two studies found significant improvements in mental health, one associated with area-based regeneration (Egan et al., 2013) and one with warmth and energy measures (Gilbertson et al., 2012). One study reported an increase in stress associated with housing improvements (Thomas et al. 2005) and six found no significant effects. Although findings were modest, all studies evaluated complex social interventions in some of the most deprived areas in the UK, covering a broad spectrum of housing policy. The findings have interesting implications for population-level mental health initiatives and continued policy planning to address health inequalities.

Area-based Regeneration

The Department of Health has been funding ABR since the 1970s based on the assumption that it improves the health and wellbeing of communities (WHO, 2008). Researchers have since been trying to test these assumptions to maximise both the health impact and justify public expenditure. The ABR studies included in this review are examples of the scale in which ABR takes place in the UK and the complexities associated with measuring associated mental health outcomes. Whilst the reviewed studies were all in Scotland, they can be compared to The New Deal for Communities in England in the late 1990s (Batty et al., 2010).

Egan et al., (2013) found that internal and external improvements to existing homes (GoWell) had short term mental health benefits. Large scale demolition work has always come under great scrutiny for its assumed negative impact on mental wellbeing, however this was not the case. This is important if regeneration can be shown to improve health and can reassure policy makers of the benefits from such

huge investment schemes. For that reason this study highlighted the importance of evaluating the positive and negative impact that regeneration to an area has on its residents. However, although significant the effects were small and must therefore be treated with caution. One reason for the effect of regeneration not being as large as expected could be the disruption, building delays and fears of rent increases (Egan et al., 2013; Thomson, Petticrew & Morrison, 2001).

The other main aspect of ABR initiatives is to clear old housing stock and provide new housing. There was no evidence that moving people to new homes had short or long term effects on mental health (Kearns et al., 2011; Petticrew., 2009; Thomson et al., 2007). However, psycho-social benefits were reported such as improved status, identity and sense of progress. These benefits were positively associated with improved mental health (Kearns et al., 2011; Kearns et al., 2001). However, moving people to new neighbourhoods can involve being displaced from neighbours, social support and an existing community. This may have cancelled out the psycho-social benefits associated with new housing. There is also evidence that new neighbourhoods are not always viewed as better (Thomas, Petticrew & Morrison, 2001).

Housing Improvements

In contrast to Egan et al. (2013), the smaller scale study by Thomas et al. (2005) found that housing improvements significantly increased psychological stress. This could be due to the disruption caused by repair work in the home. To further understand these findings, the authors followed up with an additional qualitative study (Thomas et al., 2005) with a sub-sample from the intervention group. Many of the residents reported that despite improvements to their homes, issues such as a lack

of opportunities for their children and the poor reputation of the area still prevailed. They experienced the improvements to be superficial, compared to a newly built home in the area. Residents had worries about rental increases as a result of the improvements, which they linked to increases in their stress levels. This was supported by research suggesting that rent prices do increase as a result of improvements (Thomas, Petticrew & Morrison, 2001) and that satisfaction may worsen as opportunities and lifestyle factors do not change (Huxley, Evans & Leese, 2004).The way in which improvements are experienced by residents is clearly complex, as are the mechanisms relating to improved mental health. There are challenges in providing isolated home improvements, e.g. damp proofing, in the context of living in a socially deprived neighbourhood with multiple stressors. Involving residents in the planning and delivery of housing policy initiatives has the potential to improve their experiences of change (Barton et al., 2007), as does giving people more choice and control over the improvements (Clark & Kearns, 2012).

Warmth and Energy

The link between thermal comfort in the home and improved mental health appears self-evident, however the pathway is not well understood. One of the reasons for this is the lack of rigorously conducted experimental studies relating to energy policies. This could be because there is compelling evidence of the impact of cold temperatures on physical health and the political salience of winter deaths on politics and the public (Marmot et al., 2011; Rudge & Nicol, 2000).

There may be an indirect link between thermal comfort and mental health. For example, Gilbertson et al. (2012) found that fuel poverty, often the reason homes are not heated properly, is a cause of stress and associated depression and anxiety.

These findings support previous reviews of warmth and energy initiatives that show that living in a cold home increases anxiety (Maidment et al., 2014; Liddell et al., 2015). However, these findings were not supported by Critchley et al. (2007).

Both of the studies covered huge geographical areas and property types. Warm Front packages vary considerably (from new central heating to insulation) and the interventions received by households were not consistent. There is evidence that people in fuel poverty (who were eligible for Warm Front) already had higher levels of mental disorders (Harris et al., 2010). Therefore both studies would have benefited from control groups and much longer follow-up periods to ensure that all of the outcomes were captured (see Curl et al., 2015). Furthermore, in order to improve mental health associated with cold homes, policy makers may need to consider hidden costs and offer residents additional support with debt and income maximisation.

4.1 Study Quality and Methodological Considerations

Overall, the quality of the studies included in this review was assessed as moderate by the EPHPP. However, the tool did not capture all aspects of the research design, such as the scale of the intervention (single neighbourhood versus multi-site) or isolating specific improvements over longer periods of time (Curl et al., 2015). The tool does not distinguish between self-report measures such as the SF-36 and clinician-rated interviews. Self-report measures in general rely on the participants' understanding of their mental health. The blinding rating from the EPHPP tool was excluded as it was generally not possible to blind participants.

Despite the limitations posed by natural experiments they are under used in public health and provide a good framework for evaluating the social determinants of

mental health (Petticrew, Cummins & Ferrell, 2005). In the last ten years, the period of this review, there has been a significant drive to improve the methodology used in housing research in the UK. The studies in this review are examples of those using improved methodology.

The RCT by Barton et al. (2007) sets a model for how social interventions can be evaluated. It demonstrates how local authorities and public health researchers can effectively deliver policy interventions in a way that results in well conducted empirical research. As the residents were actively consulted throughout the process and identified their housing needs in the planning stage, they were heavily invested in the research aims and outcomes. This level of engagement was demonstrated in the high levels of response rates and low attrition in the study. Furthermore, residents have continued to be active in the dissemination of the findings at a local and national level. The experience of residents in this study strongly contrasts with that discussed in Thomas et al. (2007), who were not well-informed about the improvements.

Curl et al. (2015) also designed their study to directly address methodological criticisms of previous research. This large scale study allowed them to measure short, medium and long term effects of a multifaceted intervention. The study has shed light on how different specific components of housing improvements may interact with mental health on different time scales, albeit not significantly. This allows policy makers to target certain improvements to those who may benefit the most. However, as with all longitudinal research the risk of bias from attrition is high. The residents who benefitted the most (or least) may have moved on by the end of the study. Another methodological challenge of natural experiments is controlling logistical aspects associated with environmental interventions. For example building

work being delayed led to inconsistency in when outcome measures were collected (Barton et al., 2007).

All of the studies were limited by selection bias, as they were carried out in deprived neighbourhoods. The populations in these areas are of low socio-economic status and more at risk of experiencing traumatic events, crime, unemployment, unstable homes, poor physical health and poverty (Marmot, 2014). It is questionable whether in this population it is possible to isolate mental health difficulties associated with housing as one of many social determinants to health. Population-level interventions also run the risk of missing those who need it the most, or targeting those who need it the least (Thomson, Thomson & Sellstorm, 2013). This has typically been why studies have focussed on targeting interventions to specific groups, e.g. heating for the elderly.

4.2 Limitations of the Review

A limitation of this review is the heterogeneous nature of the studies, which has impacted on the generalisability of the findings. Quantitative studies are at risk of missing the complexities associated with social interventions and associated pathways to improved mental health. Importantly, measuring mental health outcomes on psychiatric measures potentially missed out indirect effects associated with mental wellbeing, such as stress-related health behaviours (Sandal & Wright; Kearns & Mason, 2015). It also limits opportunities to develop more complex theories about the mechanisms implicated in improved mental well-being (Thomson, 2008). Psycho-social factors and restricted opportunities (Thomas et al., 2005) may have provided more insight into the impact of the interventions. Qualitative research was excluded from this review. However, including mixed method designs would have

allowed for more exploration of the data. The GoWell study for example carried out interviews and focus groups that allowed for richer interpretations.

Excluding studies that had not been published in peer reviewed journals meant that, for the most part, studies were rigorously conducted. However, previous reviews had been more inclusive (e.g. smaller scale studies published by local authorities or universities), resulting in larger reviews. By limiting the studies to the UK it is difficult to draw conclusions about other policy contexts.

4.3 Research Implications

The studies in this review are good examples of the on-going systematic evaluation of housing interventions, contributing to the evidence base on how to address the social determinants of mental health. Experimental designs using control groups are necessary, particularly when measuring the impact of warmth and energy initiatives. Barton et al. (2007) demonstrated it is possible to conduct an RCT on housing improvements, and other areas of housing policy would benefit from similar designed research.

Future research would benefit from being in varied locations and populations to increase the generalisability of the findings. It would also be interesting to understand the effects of subgroups of adults, from young single householders to families with children. A number of studies in the review observed differences associated with age. Furthermore, research needs to follow up residents for more than 2-3 years to consider whether there are longer term improvements in mental health when using measures such as the 3F-36.

4.4 Clinical implications

Policy-makers need to consider how 'preventative' health care strategies, such as these macro-level interventions, can address health inequalities when they are targeting populations with high rates of mental health problems and morbidity (Commission on Social Determinants of Health, 2008; Marmot., 2010). There is a question of whether vulnerable people living in severe deprivation need more practical and emotional support to fully benefit from housing interventions. For example there was evidence that such improvements came with disruptions and therefore residents may need to be supported through the process of change and adaptation. Outside of the UK, relocation counselling is offered to residents to ensure residents get the maximum benefits from any housing improvements. It is also used to ensure that relocation is appropriate to the needs of residents in minimising stress (Varady & Kleinhans, 2013). This would be a useful addition to some of the interventions included in this review.

Curl et al. (2015) consulted clinical practitioners on their findings at each stage to strengthen the validity of their interpretations. Effective partnership working is a key component to all of the studies and opportunities for mental health professionals to be involved in housing initiatives could be considered.

The studies have highlighted the importance of policy addressing the multiple needs of people living in poverty. For example, improving people's housing without providing opportunities for employment does not fully address their quality of life (Thomas., 2005), or moving people to new homes without considering the impact of community displacement.

The complexities associated with these social interventions support Bronfenbrenner's (1979) ecological model. It is important to see people in the

context of their lives and multiple interacting layers of influence around them, if we are to fully address mental health needs in the UK. The review further underlines the need to evaluate housing policy interventions in order to capture a range of positive and negative effects on mental health. Whilst findings were generally weak, there is a continued argument that policy makers should be addressing the large inequalities in living standards experienced in the UK.

The review has highlighted the importance of 'control' and 'sense of agency' on any housing policy changes, therefore highlighting the importance of participation in all aspects of the social policy-making process as being a key factor to creating mental health benefits. The systematic evaluation of participation in social policy-making and both positive and negative effects is imperative.

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Part 2 Empirical Paper

Practice to Policy:

Clinical psychologists' experiences of macro-level work

Abstract

Aims: Many UK clinical psychologists are venturing beyond their traditional therapeutic and assessment roles to undertake macro-level policy work. However, no research has systematically examined clinical psychologists' roles in policy work and the implications this has for the profession. This qualitative study examined the influences, processes, skills and knowledge that underpin their macro-level work, and the challenges and facilitators encountered.

Method: Participants were 37 clinical psychologists from a broad spectrum of psychology who had engaged in macro-level work. They were selected by purposive sampling and snowballing to take part in a semi-structured interview about their experiences of policy work and social action. Transcripts were analysed using Thematic Analysis.

Results: The analysis yielded six themes, grouped into two domains: (1) 'Getting There', which described participants' professional journeys to macro-level work, including their early influences and career paths, and (2) 'Being There' which described their experiences of working in this way, the challenges and facilitators in the process and the skills and knowledge that they drew upon. Their recommendations for the profession were also analysed.

Conclusions: The depth and breadth of the experiences shared by such prominent clinical psychologists have allowed for a striking insight into ameliorative and transformative policy work, with the potential to inspire and enable other clinical psychologists to work in this way. Clinical psychologists possess core research and clinical skills that have the potential to be translated to work within broader political systems. However areas for development include drawing on applied sciences such as epidemiology, social and organisational psychology. Training, clinical, professional and research implications are also offered.

1. Introduction

The profession of clinical psychology is primarily concerned with treating individuals in psychological distress (Hall, Turpin & Pilgrim, 2015). Witmer (1907), the founder of US clinical psychology, conceptualised the role of clinical psychology as extending beyond clinical settings, drawing on psychological knowledge in order to engage in preventative social action. However, the development of clinical psychology followed a different path (Humphries, 1996). The emergence of psychotherapy as a core activity began after the Second World War. Prior to this, individual therapy was an infrequent and heavily supervised activity (Louttit, 1939). After the war, the demand for therapy increased and this became clinical psychologists' core activity (Benjamin, 2007; Kelly 1961). The profession has been through dramatic changes in its relatively short history, from behaviourism to the cognitive revolution. Nonetheless, its theoretical models have on the whole remained focused on intra-psychic phenomena, i.e. cognitions and emotions (Humphreys, 1996; Pilgrim & Treacher, 1992). In instances where preventative healthcare has gained some momentum, it has still focussed on individual responsibility (Blair, 1992; Albee, 1979).

Comparative analyses of the role of clinical psychologists in the UK, the USA (Pilgrim & Treacher, 1992) and Ireland (Doren & Carr, 1996) confirm the prevalence of intra-psychic approaches. For example, in the early 1990s a national survey of BPS registered clinical psychologists found that the large majority were practising individual therapy (Norcross, Dryden &Brust, 1992). Comparable surveys in the USA also showed that the majority (76%) of clinical psychologists were delivering psychotherapy (of which 98% was individual therapy), and cognitive

therapy in particular (Norcross, Brust & Dryden, 1992; Norcross & Karpiak, 2012; Norcross, Karpiak & Santoro, 2005).

Recently, clinical psychology in the UK has been affected by the Improving Access to Psychological Therapies programme (IAPT; Clark et al., 2009), which has drawn more clinical psychologists and other professions into delivering individual therapy, particularly Cognitive Behaviour Therapy (CBT) in IAPT settings. Alongside IAPT, there has been a resurgence in the use of psychiatric diagnostic categories to organise mental health policy, guidelines and services (Pilgrim, 2010). These developments have caused some psychologists to be concerned about the future of the profession and its narrow remit of intervention (Moore & Amoako, 2010; Humphreys, 1996; Newnes, 2013).

Other areas of psychology, such as critical and community psychology, propose a broader focus. Community psychology views psychological distress as arising within a social, cultural, historical and political context (Levine, Perkins & Levine, 1997; Orford, 2008). This view then guides how problems are defined and where in the system to intervene. Community psychology emerged in the United States in the 1960s, in the wake of the civil rights movements, and was formally recognised as a new discipline of psychology at the Swampscott Conference (Bennett, 1966). The APA established its community psychology division in the 1970s and the BPS its section in 2010. Community psychology remains underdeveloped in the UK, compared to other countries such as Australia, the USA and Canada (Burton &Kagan, 2007; Burton, Kagan, Boyle & Harris, 2007; Orford, 1992). Explanations for the underdevelopment in the UK have included differing social policy contexts, training curricula and a lack of community-based workers (Burton & Kagan, 2003).

Significant progress has been made in our understanding of the impact of an unequal society on health and wellbeing (Marmot, 2015; Prilleltensky 2012; Pickett& Wilson, 2010). This has been of increasing interest to clinical psychologists as the current economic crisis impacts on the health of their clients (Barr, Kinderman & Whitehead, 2015; Harris, 2014; Harper, 2015). Furthermore, there have been more visible debates within the profession about the potential contribution of macro-level change and community psychology principles in response to the impact of the economic crisis on mental health (Carr & Sloan 2003; Psychologists Against Austerity, 2015; Stuckler, Basu, Suhrcke, Coutts, McKee, 2009). The World Health Organisation proposed that "...social justice may provide an important corrective to what has been a growing overemphasis on individual pathology" (WHO, 2009: Summary). However, clinical psychology does not have a public health arm and unlike medicine has historically had little involvement in health policy (Simon, 1970). In instances where preventative healthcare has gained some momentum it has largely remained focussed on individual responsibility as opposed to the social context (Albee, 1979).

Some clinical psychologists have drawn on these ideas and moved beyond the realm of individual work to intervene at a wider systems level. Bronfenbrenner's (1979) ecological model of human development uses a four-level framework (micro-; meso-; exo- and macro-level, to conceptualise the complex systems, such as family, school, and community, that may impact on an individual's wellbeing. The model was originally proposed in a developmental context but is now used more broadly (Harris, 2014; Nelson, Kloos, & Ornelas, 2014). This framework may be applied to conceptualise the possible role of the clinical psychologist in the following way:

1. Micro-level: e.g. individual or family therapy
2. Meso-level: e.g. interventions within a child's school
3. Exo-level: e.g. intervention with a local community group
4. Macro-level: e.g. working to change national policies on health and social care

Macro-level intervention aims to achieve social or political change that in turn impacts on the other levels in the system. Policy-level intervention is one of the main aims of Community Psychology in the UK (Williams, 2015). Nelson and Prillethensky (2005) describe two main approaches to intervention at a macro-level: ameliorative and transformative. Ameliorative interventions work to change policies relating to the treatment of individuals, such as improving access to individual therapeutic activity. An example of this approach in clinical psychology is the national roll out of the IAPT programme (Clark et al., 2009). Transformative interventions strive to change policies relating to broader social issues, for example, focussing on changing power relationships and oppressive structures, which are contributing factors to psychological distress (Nelson, 2013). An example of a prominent clinical psychologist actively engaged in a transformative macro- level work is Orford (1992, 2008). He has reframed gambling, from an exclusively micro-level problem (individual addiction) to a macro-level problem which requires transformation of the power structures supporting it, for example via campaigning against fixed odds betting machines and harmful gambling policies. He has used his position as a clinical psychologist to contribute to national policy change (Wardle, Griffiths, Orford, Moody & Volberg, 2012).

Zlotowitz (2013) has proposed the term 'activist-practitioner' to describe clinical psychologists such as Jim Orford who are engaged in macro-level work and

social action. Other related terms used to capture this distinct contribution include ‘psychologists in action’ (Kinderman, 2013); ‘public psychologist’ (Chu et al., 2012); ‘researcher-activists’ (Nelson, 2013); and ‘social materialist psychologist’ (Cromby et al., 2012). There appears to be considerable overlap with these terms, which broadly describe a psychologist concerned with transformative approaches to preventing poverty, inequalities and disempowerment (Lee, Smith & Henry, 2013; Ratts, 2009, 2010; Toporek, Lewis & Crether, 2009). ‘Activist-practitioner’ will be used in this research. Prilleltensky (2001) believes psychologists working within this remit are underpinned by a set of core values: collaboration, democratic participation, respect for diversity and social justice. However, in the UK especially, we know very little about what values, philosophies and skills drive some clinical psychologists to work in this macro-level way.

The USA is further ahead in thinking about macro-level work as part of the role in clinical and counselling psychology. The American Counseling Association (ACA) has been the most progressive in developing the role of ‘social justice counselors’ (Ratts, Toporek & Lewis, 2010). It has defined a set of core competencies which appear relevant to the role of the activist-practitioner in the UK. They are the ability to:

- distinguish issues that can be best resolved through social and political advocacy;
- identify the appropriate mechanisms and avenues for addressing these issues;
- seek out and join with political allies;
- support existing alliances for change;
- work with allies: lobby legislators and other policy makers;

- maintain open dialogue with communities and clients to assure that the social/political advocacy is consistent with the initial goal.

The ACA has also included social justice training on their doctoral courses alongside placements related to social policy (Burnes & Singh, 2010; Schmidt & Nilsson, 2005; Singh et al., 2010).

There are a number of barriers to clinical psychologists in the UK working at a macro-level. This can be linked to the dominance of micro- and meso-level interventions in clinical training, as well as the structure and positioning of clinical psychologists within the NHS. Hosticka, Hibbard and Sundberg (1983) use the term 'policy-knowledge gap' to describe the lack of knowledge about policy within psychology. They also found that clinical psychologists feared that policy work was 'overly social' and engagement with it might result in a loss of political neutrality. Clinical psychologists and policy makers also have different agendas and professional cultures (Caplan, 1979; Shinn, 2007), which may make working together more challenging. Furthermore, there is no career structure to support those who do work at a macro-level (Burton, Kagan, Boyle & Harris, 2007). Much of the literature in this field is theoretically based (Hage & Kenny, 2009; Nilsson & Schmidt, 2005) and we know very little about the experiences of clinical psychologists who have worked at this level, in particular, what has enabled them. However, the UK does have a broad public health agenda, which would fit with the remit of this study. Public Health England is planning to develop public mental health in the UK (Stansfield 2015) and develop competencies for a wide range of professionals to design and deliver effective intervention. This could be a helpful development for the profession (Harper, 2015).

1.1 The Current Study

The present study aimed to understand the role of the clinical psychologist in macro-level work, particularly policy work. It used a qualitative approach to explore the experiences of clinical psychologists who have engaged in this work in the UK at some point in their career. Since little is known about this topic, an exploratory qualitative approach was considered to be the most appropriate.

The study looked at how these clinical psychologists have moved beyond individualised approaches to engage with a wide range of policy issues. It examined what processes were involved in this work, the skills and competencies required and the barriers and facilitators they encountered. It attempted to map their career paths from 'Practice to Policy' and gain a much richer understanding of the role clinical psychology can play in policy development.

The study aimed to address the knowledge gap between theory and action, in order to develop a practical guide for other clinical psychologists who wish to engage in macro-level work. It aimed to answer the following questions;

1. What kinds of macro-level policy work do clinical psychologists engage in?
2. What career paths have they had and what has influenced them to work in this way?
3. What steps have they gone through to engage in this work?
4. What are the barriers and facilitators in this process?
5. What role do personal and professional skills play in their work?
6. How do these clinical psychologists think about the term 'activist-practitioner'?

2. Method

2.1 **Recruitment**

Clinical psychologists were eligible to participate if they:

1. were qualified to a masters or doctoral level
2. had engaged in macro-level policy work in the UK at some point in their career.

Purposive sampling and snowballing methods were used in order to recruit suitable participants. The selection of participants went through four phases:

1. Identifying well known clinical psychologists in the field

Initially a sample of clinical psychologists who had a high profile in macro-level policy work was identified, e.g., by their reputation, activity on professional networks (e.g. BPS division of clinical psychology and community psychology sections) or their published work.

2. Surveying local clinical psychologists

An email was sent to the UCL DClinPsy course team, asking them to identify clinical psychologists in their speciality who met the inclusion criteria. This helped to ensure that the sample included participants from a broad range of clinical psychology sub-specialities (e.g., intellectual disabilities or child and adolescent mental health), gender, age and ethnicity.

3. Snowballing

Once interviewing the initial participants had begun, a snowballing procedure was used on the initial participants, asking them to identify other clinical psychologists who met the study's inclusion criteria. Suggested psychologists were then contacted, as in phase 1.

4. Monitoring the emerging sample

The emerging sample was regularly monitored to ensure that it was as diverse as possible, including gender, ethnicity and age. The final participants were chosen to represent as broad a spectrum of demographics as possible. Recruitment ceased when the sample consisted of a wide range of clinical psychologists from across key sub-specialities. This ensured that clinical psychologists from adult mental health backgrounds were not over-represented in the sample.

Eligible participants were sent an email informing them about the study (*Appendix A*). Those who expressed an interest in taking part were sent written information about the study (*Appendix B)* and the consent form (*Appendix C*). Signed consent was obtained on the day of the interview.

2.2 Ethical Approval

Ethical approval was obtained from the University College London Research Ethics Committee on the 26th March 2015 (*Appendix D*).

2.3 Characteristics of Participants

Of the 61 eligible participants identified during recruitment, 43 were invited to take part in the study. Forty potential participants consented to take part, two declined and one dropped out after arranging the interview. The reasons given for non-participation related to work commitments and a lack of time. Unfortunately, three participants who consented to take part were unable to be interviewed before the submission of the thesis, but plan to be at a later stage in 2016. The total sample is 37.

There are missing demographics for four participants. There were 16 women and 21 men in the sample, ranging from 30 to 84 years old (median 61.5 years old).

They qualified in clinical psychology between 1957 and 2014, with the average year of qualification as 1981. Participants were mostly qualified to a PhD level and DClinPsy. They had engaged in a wide range of policy areas, with the most common being adult mental health, CAMHS, and learning disabilities.

2.4 Design

Qualitative methodology was used to explore the experiences of clinical psychologists engaged in macro-level policy work. As one of the aims of the research was to produce guidelines and recommendations for the profession, Thematic Analysis (Braun & Clark, 2006) was chosen to analyses the data. Thematic Analysis systematically synthesises the data into clusters and themes that can be communicated for the purpose of this research. This methodology was used over other forms of data analysis, e.g. interpretive phenomenological analysis (IPA), as there has been little research in this area and the depth of interpretation was not required at this stage. This methodology is also suitable for large data sets.

2.5 Interview

The semi-structured interview schedule was designed specifically for the study (see Appendix E). The interview schedule grouped questions into six main areas: (1) Career path and influences, (2) Example of policy work, (3) Barriers and facilitators, (4) Skills and competencies, (5) Training and recommendations, (6) Dissemination.

There were a number of broad questions, with follow-up questions available to prompt the interviewer, such as, “Can you tell me how you overcame those barriers?” The interview schedule was designed as a guide for questioning but allowed space for participants to bring in experiences that could be responded to

spontaneously. Five pilot interviews were carried out with a clinical psychologist and trainees with experience of macro-level work. This process ensured the relevance and utility of the interviews or questions. Feedback from these pilot interviews resulted in a number of changes in terminology such as the use of the word transformative.

Initial questions relating to the participants' career path were guided by the Coordinated Management of Meaning theory (CMM; Pearce & Cronen, 1980). This social constructionist theory is a flexible way of organising conversations, in order to help people reflect on the meaning behind their actions across different layers of context, such as influences from family stories or wider cultural values. This style of conversation helped participants to map the contextual influences on their paths into policy work. After these initial questions, participants were required to outline a specific example of policy work, from which followed the other areas of questioning. In order to ensure that the interviewer did not overly focus on barriers to policy work, questions about facilitators to policy work were asked first. The research team drew on their experiences working within clinical and community psychology that told them that there was an over-focus on barriers to policy work. The aim of the research was to be enabling and explore what facilitated the process.

At the end of their interviews, participants were asked about their ideas for disseminating the findings of the study. Time was also given at the end of the interview to reflect on the interview process.

The majority of participants reported that they found the process of reflection interesting, as they had not been asked about their policy work in any detail before. Four participants sent follow-up emails to the researcher, with positive comments

about the interview. None of the participants reported distress associated with the interview.

Twenty-two interviews were completed face-to-face, twelve by Skype and three by telephone. Interviews were arranged at a convenient time and location for the participants. The researcher travelled to all locations inside of the M25 when possible. All interviews were recorded with the participant's consent, using an encrypted electronic recording device. On average the interviews lasted one hour. Interviews were transcribed using Express Scribe software (NCH Software, Canberra, Australia) and transcripts were password protected. All data was stored according to the Data Protection Act (1998). Participants were given the option to remain anonymous if they wished, and privacy and confidentially were protected. However, non-anonymity was offered to the participants after the themes of their interview had been sent to them.

2.6 Data Analysis

Data was analysed using Braun and Clarke's (2006) method of Thematic Analysis. They outline a six stage procedure: (1) familiarisation of the data through repeated reading, (2) generating initial codes, (3) organising the initial codes to generate themes, (4) reviewing and refining common themes across the full data set, (5) defining themes and subthemes and (6) selecting quotations to illustrate themes. NVivo qualitative data analysis software (QSR International) was used to support the data analysis. The software was chosen because it supports the analysis of large data sets.

2.7 Credibility Checks

Qualitative research requires credibility checks to ensure that that the analysis is trustworthy (Barker & Pistrang, 2005; Mays & Pope, 2000; Morrow, 2005; Shenton, 2004). My supervisors reviewed interview transcripts at the beginning of the data collection phase. They reviewed how the data was being coded throughout the analysis and coded some transcripts independently to ensure credibility.

2.8 Researcher Perspective

Qualitative research requires the researcher to disclose their theoretical perspective and assumptions to enhance the validity of the analysis (Braun & Clarke, 2013; Caelli, Ray & Mill, 2003). I am a white female in my mid-thirties and I carried out this research as part of a professional doctorate in clinical psychology. I have a background in psychology and sociology and had worked in these fields for eleven years prior to training. My pre-training work often took place outside of the traditional realms of clinical psychology, such as within community organisations or actively developing pathways for groups that do not tend to access statutory services. I have been a member of community psychology networks and organisations in the UK and Australia, which has led me towards research and practice more aligned with the community psychology philosophy. Prior to training, I had professional contact with several of the participants. I had previously worked with five, two were known to me through community psychology networks and four through research and teaching as a student. A number of the participants were also well known to my supervisors as they were eminent in the profession. Furthermore, I have experience of macro-level policy work and activist activities including contributing to policy documents and local service developments. My personal opinion, which I attempted

to ‘bracket’ during the study, is that this is a rewarding and important area of work for clinical psychologists.

Supervision from my research team helped me to reflect on these issues and ‘bracket’ my assumptions (Fischer, 2009). Bracketing was used to ensure that the research was not driven by my ideas and assumptions about clinical psychologists’ suitability for policy work. I kept a reflective journal throughout the research process, noting my thoughts and assumptions after each interview and tracking my own learning about policy work. I used supervision to reflect on how my developing views impacted on the data collection and analysis (Willig, 2008).

3. Results

The 37 participants provided detailed and vivid accounts of their individual journeys from ‘Practice to Policy’. The analysis yielded six themes, grouped into two domains: (1) ’Getting There’, which describes participants’ early personal and professional experiences of beginning to understand and undertake macro-level work and (2) ‘Being There’ which describes their experiences of working in this way, the challenges and facilitators in the process and the skills and knowledge that they drew upon. The domains, themes and subthemes are presented in Table 1.

1. Getting There

The first domain encompasses participants’ journey to macro-level policy work. Participants often began with reflections on what had fascinated them about psychology early on, along with influential ideas and experiences that had shaped the way they viewed the world. As they trained and worked in clinical psychology, their professional journeys unfolded, working in dynamic contexts, teams and facilitative environments for policy work.

1.1 Early Influences

Participants described a range of early influences that had motivated and inspired them to think and work in the way they do. Participants shared the ideas and theories they were stimulated by and the experiences that had shaped their views and values.

1.1.1 Social and Political Ideologies

Participants were excited by a whole range of theories and ideologies that chimed with their values or experiences of the world. They were individuals with a thirst for knowledge and tended to avidly read in order to develop a deeper

Table 1. Domains, themes and subthemes

Domains	Themes	Subthemes
1. Getting There	1.1 Early Influences	1.1.1 Social and Political Ideologies 1.1.2 Personal Experiences and Values 1.1.3 Propensity for Change
	1.2 Professional Journey	1.2.1 Limitations of Psychology and Psychiatry 1.2.2 Inspirational Professionals 1.2.3 Facilitative Organisations 1.2.4 Professional Positioning to Influence 1.2.5 Building Professional Profile 1.2.6 Seeing Opportunities and Taking Risks
2. Being There	2.1 Challenges	2.1.1 Power and Politics 2.1.2 Measuring Outcomes 2.1.3 Personal Impact 2.1.4 The Media 2.1.5 Professional Constraints
	2.2 Facilitators	2.2.1Relationships 2.2.2 Collaboration 2.2.3 Confidence 2.2.4 Passion and Perseverance
	2.3 Translating Existing Skills and Knowledge	2.3.1 Research 2.3.2 Communication 2.3.3 Understanding others' Perspectives 2.3.4 Consensus Building 2.4.5 Consultation 2.4.6 Clinical Skills and Knowledge
	2.4 Developing New Skills and Knowledge	2.4.1 Public Health 2.4.2 Understanding the System 2.4.3 Strategy

understanding of the context around them. They were influenced by theories and ideologies which placed humans in social contexts, and promoted critical thinking, activism and reflections on human suffering.

> *I used to read a lot of Foucault…Craig Newnes's and David Smail's work. (P14)*
>
> *Ideas like community psychology and liberation psychology have been very interesting, and feminism. I think as a result most of my life in activism has been around feminist causes. (P6)*
>
> *I'm a committed Christian, so I have a particular world view, and that has shaped me to a large extent, that's the position I'm coming from. (P35)*

A rarer theme was participants who had studied politics, or wondered if that might have been a better fit than clinical psychology. They had also been politically active in their personal lives.

> *I'd always during that time been kind of interested in politics and issues to do with privilege…and issues about power. (P30)*
>
> *I was a member of the Young Socialists party. (P21)*
>
> *I was interested in politics, society and social change and so on and I think in terms of my interests, I would have been far better doing politics or sociology or a proper social science. (P1)*
>
> *I was very active in the gay rights movement in my career as a social activist. (P36)*

1.1.2 Personal Experiences and Values

Participants described a range of life-affirming experiences that had exerted a significant influence on them personally and professionally. These included personal experiences of mental health difficulties, whether their own or someone close to them, working or living in other countries, becoming a parent, and wanting to make the world a better place. These experiences connected participants to macro-level issues on an emotional, as opposed to purely intellectual, level.

Before I studied psychology I travelled quite a lot and walked through [another continent] and I think that profoundly opened my mind to the idea that whilst humans are the same everywhere we do things differently everywhere, so just kind of on a macro-level that really opened my mind. (P33)

I'm afraid I came into training with a very firm set of ideas even before the age of 12…I kind of understood enough about my own experiences, of what I read, of being extremely sceptical about the medical way of understanding distress and that was always my aim to kind of change things for the better from my point of view. (P11)

Values of justice and human rights also motivated the participants to want to tackle broader issues such as health inequalities.

I like to think that I'm driven by principles of justice and fairness and I still feel that if there's a wrong there, people are suffering, there is injustice. (P25)

1.1.3 Propensity for Change

The majority of participants had a 'just get on with it' attitude that guided them through experiences that were unfamiliar. They had a strong belief that if they were put in a position of authority/leadership they could change systems for the better and were willing to take on the responsibility for making this happen.

I've always had an interest in trying to shape and manage things, and I think to be perfectly honest, as much as thinking that was a good thing to do or clinical psychology should do, it was a temperamental thing. (P37)

Someone's got to take on being head of the department and though it's not what I am looking for, the other person clearly doesn't want to and is running scared of it, so I do it. And then you find out that no one else is going to do it. (P34)

I mean one of the things that I've always enjoyed is finding something that's new and interesting and moving on to the next thing not wanting to […] get stale, stagnant and stuck. I enjoy learning new things and just having a go at things and seeing how I get on really. (P36)

1.2 Professional Journey

Although participants were at various points in their careers, it was evident that moving beyond individual practice to work in a more transformative way was a gradual and dynamic process of doing 'bits and pieces', often over the course of many years. It inevitably involved starting out as a newly qualified clinical psychologist and learning how to navigate and to position oneself in complex organisational and political systems. This theme is dominated by the participants' ability to see opportunities when they arose and to take risks in order to position themselves to have more impact.

> *I have written about the over-simplification of the distinction used in psychology between amelioration and transformation. I argue that the two have to go hand in hand, that sometimes you get the transformation by starting with amelioration. And I think that is important particularly for people starting out on a career because you can't always step up to transform, you have got to start where people are and some transformative approaches begin from doing good quality amelioration and scaling it up. (P1)*

1.2.1 Limitations of Psychiatry and Clinical Psychology

In the early part of participants' careers as clinical psychologists they began to see the complexities of people's lives and the limitations of what their training had taught them.

> *As soon as you're a psychologist and as soon as you start working with people, you can't disentangle, the social, the sociological, the political from the psychological, yeah, they're all affected. (P20)*

> *It sort of struck me fairly early on that people didn't need a psychologist they needed a life and that crudely people's needs were jobs, homes and friends, somewhere decent to live, someone to love and something to do. (P8)*

They often described defining moments in their practice where they were faced with a realisation that what they were doing, although worthy, was having minimal impact.

> *I'd sit in the GP surgery, all these people coming in, mainly middle-aged women saying they felt anxious and depressed and talking about how they're scared to go out because it's dangerous. I just felt completely and endlessly inadequate and ill prepared to do anything about it. Other than to provide this ill thought out band aid and I really struggled with the ethics of it all. (P5)*

Their experiences left the majority of participants feeling disillusioned about psychiatric practice and the limitations of an individualised understanding of distress. These included historical reflections on times when psychologists were subordinate to psychiatrists.

> *I loved working in a multidisciplinary setting, but it gave me a real sense of the system to do damage as well. (P17)*

Participants also reported experiences of feeling helpless in their role as a 'therapist' when presented with the complexities of clients' lives that included issues of poverty, discrimination and social inequalities which clinical psychology was unable to address.

> *I guess I always felt pretty helpless in my role as a therapist…If there is a thing that I often felt it was a sort of helplessness in the face of the overwhelming awfulness of the stuff going on for people and that always gave me a somewhat of a sense of cynicism, scepticism, doubt about how impactful I could be in my role as a therapist. (P2)*

> *There are so many intangibles and social and economic impacts on mental health and that we have to always understand those in anything that we are doing and that actually getting people into work and out of debt will probably make more difference to your suicide figures than any amount of crisis care. (P19)*

1.2.2 Inspirational Professionals

Participants had all been inspired by and learnt from particular individuals whose work they admired. Interestingly, these were often not clinical psychologists but professionals such as psychiatrists who were working in a radical or different way.

> *I was very fortunate to work in a service set up by an amazing psychiatrist, social psychiatrist...his way of operating was really about whole lives. That it was not just about what you do at a micro level, but the systems within which you function. (P8)*

> *A number of my colleagues were members of the Socialist Workers Party…and the epiphany for me was also because I could see a couple of clinical psychologists who would be doing outstanding work at this hospital, who were trying to get people back into the community. (P23)*

1.2.3 Facilitative Organisations

This subtheme encompasses all of the ways that organisations' contexts facilitated the participants' professional journey. The majority of participants described organisations and managers who were supportive and encouraged them to work in different ways.

> *To try and do that completely on your own in a system and structure that doesn't support you is very difficult. So that is why having other people around who will support that and perhaps give you kind of leads in, informational leads in are kind of helpful...the structure that surrounds one is terribly helpful. And some people seem to manage despite that it's extraordinary. But certainly for me, having the structure that was enabling and was supportive enough was absolutely critical. (P34)*

> *It gave me a sense of 'I can achieve stuff', as that was in the culture. (P17)*

> *When we look at why clinical psychologists don't do it [policy] we seem to think it is about the individual, but it's not. The reason why clinical psychologists don't get involved with political activities is that their employers don't give them the time off to do it because what we need is contracts of employment that allow us to do the job as the job should be done. (P21)*

Participants also made connections between certain organisational settings and the scope for policy type opportunities.

I think we are in a quite privileged position in public health. I mean obviously talking to the local public health department is a good start if you want to develop an understanding of it. (P19)

In particular, the advantages of being in an academic context where research and policy were a core activity were emphasised.

I've never sort of tried to overuse my University connections and things like that but what people saw was that I was attached to a respectable institution, it indicated that at least they gave me some authority compared to if I had no affiliation whatsoever. (P25)

I've had opportunities to write for example, because at least half of my time I was in an academic environment where you're encouraged to write. The institution has given me brownie points if I write things and publish things and encourage you to do that very strongly…I've worked in places where there's been a policy orientation to the research that's been done and so I can see how I've had lots of opportunities to move in that sort of direction. (P9)

Certain fields of clinical psychologists were seen as having more opportunities for macro-level thinking and impact, especially the third sector and the field of learning disabilities.

Now for me, the places to go were definitely outside mental health…for the ambitions and interests that I had, I went into an area where the doctors were very scarce, where there was an appetite for change and reform, where there was a bit of money sloshing around. (P1)

This included the importance of supportive leadership and managers and colleagues who inspired and developed them.

A new boss came…and she's been so supportive, she supported me right through setting up and encouraged me and gave me time off to do it (P29)

The majority of participants were in the latter parts of their careers, which meant there were historical reflections on the changing culture of the NHS, the workforce and opportunities for innovation.

The circumstances were completely different then, there were many less psychologists around and partly the whole structure of health services were kind of determined by you do x, y and z, so there was a tremendous freedom in

that sense too. From quite early on people innovate to try different things, in a way be your own boss in a small kind of way and that's a big difference from now. (P34)

1.2.4 Professional Positioning to Influence

The majority of participants started their transition into policy-level activities by putting themselves in positions where they could have more influence, e.g. sitting on committees, health boards and becoming increasingly involved with the BPS.

They surveyed the membership, saying "we've been asked to consult on this, do people want to have an input in it?" so I volunteered what I knew from working with particular communities…So I put myself forward to be involved with that. When you're on the committee you're closer to that level of influence I guess. (P6)

I became a member of the DCP…that opened up another avenue for getting into policy. (P11)

A dominant theme in participants' journeys was teaching and directing clinical psychology training courses. Participants had often tried new and innovative teaching whilst in these positions, viewing it as a good platform to influence the profession.

Then I began to get interested in clinical psychology training. And I got sort of drawn more into the development of the training…I moved to being more focused on clinical psychology training, and sort of politics and the context of British psychology. (P30)

Oh I loved it! It was terrific...it was such good experience…you know a fabulous opportunity to enrich your knowledge about things. But that's when I started to get involved in the BPS…I started to work on a macro-level. (P36)

Being a clinical psychologist in itself was a platform for having a voice.

It was interesting because it was around the time…policy makers were wanting to get people with a professional background that were visible to the media in to do policy work. Because they could see that that would enable them the translation of what that was back out to the public. (P27)

We talk so much about the level of the power in clinical psychology and we forget that power is not always a bad thing. Sometimes power can give us the potential to affect change…that are not detrimental to other people…knowledge about how to find routes into legislation. (P14)

1.2.5 Building Professional Profile

Participants were ambitious individuals who, intentionally or not, had developed successful profiles within the profession. Their careers had incorporated the dissemination of their clinical or academic work which made them more visible within and outside of psychology. This professional profile subsequently opened doors to policy opportunities such as being invited to advise the government, or contribute to a new policy document.

I did one of the first studies on [field of research] which got huge press coverage and got me to advise on various things and I was going over the pond to advise over there…I got approached by the All Party Parliamentary Group. (P10)

I think we were in the fairly early stages…people got to know that there was a psychologist interested in this subject so when the idea of doing this first national study came up, my name was mentioned and I was invited to be the advisor. (P9)

I remember they had to nominate some people to work on the themes so I was asked if I would work with [psychologist], so it was by personal invite. (P13)

In building a professional profile, participants had often reached very senior positions, increasing their visibility and opportunities for macro-level work.

The first thing I did when I was appointed to the university was think "Ok, I've got a platform now and how can I use it to promote the values that I've been working for?". (P4)

I don't think I was going to get it or anything, I just knew that if I wanted to get my face known then I ought to do something that would make that happen, so I applied for the job. I did my best to make myself indispensable really (P28)

You can only work so far as a clinical psychologist working in an individual discipline but the world is much bigger and I was fortunate enough to be in a leading position in a team (P8)

1.2.6 Seeing Opportunities and Taking Risks

A dominant theme emerged among the participants, of developing a skill in seeing opportunities in the landscape of their careers and seizing them. It clearly kept their careers exciting and interesting whilst also putting them in positions that were new and uncertain. This was an opportunistic yet considered process of weighing up the costs and benefits of having influence.

> *I think what I mean by that is the ability to take who you are and what you know and your passion and put it in a place which is unfamiliar but you have an instinct that there is something there that you can to some degree exploit…I was in the middle of doing a lot of other stuff and I was supposed to be writing a book and I really thought…"Is this something I want to do?" And then I thought yeah actually I really do want to do this because again I could see how it's about taking clinical psychology into a public arena that can make positive and meaningful change to mental health wellbeing. (P27)*

> *I'd say that was providence again, some people would say it was luck…there was a knock on the door and he said "Hello I'm [name]" and he was interested in the problem of [policy area] …and they were collaborating with psychologists. So he wanted to see if there was anybody who would be interested, and well it was like looking a gift horse in the mouth, immediately I jumped at the opportunity. (P35)*

> *I didn't make any progress in several years until I met [prominent policy figure while we were just waiting in the queue for a cup of tea, just introducing ourselves and talking about what we did. It turned out from doing that that we both had an interest in mental health. (P26)*

This was also an active professional stance which involved asking for opportunities.

> *So I was being really clear with my seniors at that point about, I think I'm quite skilled, I think you need to use my skills better, where's my next opportunity, develop me (P33)*

Participants also spoke about taking risks including the risk of doing something unfamiliar and out of their comfort zone.

> *There's that saying, if you are offered a seat on a rocket ship, you don't refuse it…So, I thought this is a huge journey I can go on…it won't be*

comfortable, it will be totally exciting, and I'll learn so much, it will develop me faster than anything I can do right now. It could all go wrong but you know, if you don't try. So I took a risk that I never thought I was capable of taking and I haven't looked back (P33)

When they first asked me to it, I was shitting myself. I didn't want to, I didn't know what they wanted…but then I thought "you know what, this is a chance to have a voice, I don't even know what this panel is, how it works, who it's made up of, but I know it's something obviously really important. It's something that seems influential because everybody is falling over themselves to meet what has been asked"...so I thought "ok, let me do this" (P6)

I think there's often a sense of risk, there's lots of capacity for thinking "I'm not doing well enough, who am I to challenge?". I think if you're a scientist and it's allegedly morally neutral and objective. That's fine isn't it? You follow the rules and if you make mistakes there not about peoples passions and emotions. Or at least they're not that powerful. Whereas if what you're doing is trying to readdress power imbalances, or trying to engage at an emotionally or compassionately different way, I think that's riskier. (P4)

By taking risks there were also increased opportunities for learning by mistakes.

I learnt mostly by screwing them up repeatedly. So my first interviews when I started out like 20 years ago are just painful to watch and disastrous. My first policy briefs were terrible, my first interactions with policy makers were inept, I didn't know what I was doing so I learned in a way that was far more difficult than it might have been, stumbling along (P12)

You've just got to dip your toe in the water and just see how it goes. I think as a profession we need to forgive people more when they make mistakes (P14)

2. Being There

This domain encompasses participants' experiences of working at a macro-level. As participants described a piece of work in detail, they reflected on the processes, knowledge and skills required in the work and some of the things that had helped and hindered this way of working. Macro-level work varied enormously and it was not possible to conceptualise this work with clear boundaries, it was fluid and complex, requiring years of on-going commitment. What was apparent though was that this was distinct from traditional clinical psychology practice, with fruitful opportunities for wider systems change and impact.

2.1 Challenges

The challenges associated with macro-level work are presented first, as they provide a contextual framework to position the work, bringing to life the differences in working at this level. The work requires operating at the interface with policy makers and politicians, and their experiences were hugely dependant on the political climate and current government. Working to higher-level priorities could be frustrating for participants, who felt powerless and burnt-out at times. The structure, identity and training of the profession were also described as barriers to clinical psychologists engaging in this work.

2.1.1 Power and Politics

Participants depicted the challenges associated with working in a political system which holds a lot of power and yet is at times at odds with the priorities the clinical psychologists viewed as important for society.

> *Where are the drivers on mental ill health? They're in the world…it's the way we live. But the problem of course is that it's all political. You know, inequality is a driver for mental illness, so what do we do about that? Well the answer is pretty obvious about what we should do about it but who's going to do it? (P16)*

Participants reflected on the difference between academics and policy makers, their priorities, timescales and use of evidence.

> *Yes, speed of delivery. As I'm sure you know, if you look at the literature on the use of research in social policy, one of the things that always comes out is the disjunction between the time scale of policy makers and the time scale of academics and researchers. (P5)*

> *It was a challenging meeting and I was told I had 10 minutes, you have to be very focussed and very clear. You're not talking to experts in clinical psychology or experts in mental health. (P26)*

You're finding a line of best fit between lots of different pressures. And usually a very short time as well. I mean you've usually got nothing like the amount of time you really need to do it. (P28)

The political climate and who was in government at the time changed the policy priorities and landscape of the work.

They dropped the name [of the organisation] which had become quite unpopular. Because we have waves of people [policy makers] wanting to encourage Black minorities and waves of people saying no they don't want to encourage Black minorities depending on what the political climate is. (P29)

And it actually never got published, because the numbers looked too big. And the government didn't want to publish it. (P30)

Competing for funding or research grants was described as challenging, as was the power of corporate industries and lobbying organisations with competing agendas.

…they're getting all the money and all the publicity around this and I feel just really frustrated by it all, actually. A particular frustration for me is that I've had a terrible time trying to get funding to do the kind of research I do. And I've spent ten years writing grant applications to get funding for [field of psychology]. (P16)

There are corporate industries that make a lot of money from bad health behaviour. So if you are a psychologist that's working on something like obesity, problem drinking, tobacco…there's great wealth on the other side of the table that does not want things to change. (P12)

There are really powerful lobbies. Not least provision of psychiatry, psychology, drug companies. Lots of people who have an investment in keeping things as they are. Politically as well. I think there's a lot investment in seeing certain problems as being as individual failings, weaknesses or vulnerabilities rather than structural. (P6)

There were also challenges being within a system but not part of it, being able to hold both positions.

It's very hard to do that sometimes because you're just too anxiously wanting to be part of the gang and worried about not being. It's asking, "Am I an insider or an outsider?" You're kind of a boundary spanner really. It's this

difficult role you got to have a foot in both camps. And getting used to that, not minding it, and enjoying it is a bit of a learning curve I think.

2.1.2 Measuring Impact

Participants described the differences in measuring the impact of their work. Having a wider impact was clearly a motivating factor, but it was much harder to define and quantify. Some participants described examples of policy work that spanned a decade of their professional life. It was difficult to ascertain a clear start, middle and end point in the work.

I think the challenge for me now though is that I feel like we made an impact but it's hard to know if we are making a difference. I know we are making a difference to some people along the way, but that's not a huge leap from therapy. But how do we know whether we are making a difference at a policy level? (P14)

It is complex, it is slow. Things don't change overnight and that's a little bit frustrating I think at times. (P22)

The scale of macro-level systems and 'problems' can be overwhelming to conceptualise, particularly as compared to clinical practice, where you may see changes in outcomes in individual therapy.

So there are challenges in terms of that if you really want to transform mental health care in the UK one of the interesting things to getting involved in it with genuine passion is you realise how big a bloody problem it is. So if you take this 'one in four' statistic, which is a bit shit, then you're talking about providing care to about 12 million people? That's kind of challenging! (P21)

Because it's meant some serious sacrifices in terms hours and time, working evenings and weekends. (P3)

2.1.2 Personal Impact

For all of the reasons already discussed, this work had the potential to create a tension between personal and professional boundaries, sacrificing participants' own time outside of the work.

The boundary that you're taught between work and home as a clinical psychologist, it's gone out the window, went out the window ages ago. So, I have a very sort of fluid relationship between the two. And, you can't, you can't change the world unless you're prepared to take on that level of commitment, I've never seen anybody do it. (P33)

The personal sacrifices you have to make…you've got to get on with your life, you've got to have another life, you've got to make sure you look after your well-being because if you have nothing else in your life then you'll probably go bonkers. (P25)

As highlighted in participants' early influences, they invested a lot of themselves in their work and were emotionally connected to the issues with which they were engaged. However, this came with costs to their well-being, putting them at risk of burn-out.

I think it's important to recognise if we do these extra things, we go the extra mile and we get more activist about stuff. It's not because we intellectually engage with it. It's because we emotionally connect with it and so it's inevitable that is going to have an emotional impact on us…huge challenges on a personal level because it's hard knowing where to draw the line, so that it doesn't affect my family (P14).

One of the skills is prioritising and getting good at deciding what the most useful thing to do is because the danger is, I think a lot of people, particularly early on, of getting burnt out. There's many things to do and you try to take them all on…because in all these networks, nobody's really sure if somebody is working more or less than you on an issue quite often…so I think there's something about knowing your limits. (P7)

Some of the other barriers to do with conflicting demands…wanting to work in this systemic and preventative way does mean that there are huge competing forces on your time and that can be tough. (P15)

In some cases this was a result of challenging the status quo, and when speaking against power and politics one may personally suffer.

But in terms of, in terms of higher level policies…getting involved with government policies, that's fine at that level…once you are going to stand up and go against…the establishment sort of thing, then I think you have to realize that you may well suffer. (P25)

It's just exhausting frankly…you just keep putting yourself up for rejection and getting rejected…people just don't see that bit. (P16)

2.1.3 The Media

The use of the media featured in many of the accounts and was viewed as an essential platform for having a wider impact. However, there was a rare yet significant theme that the use of media came with some challenges, such as personal attacks on social media or being misquoted.

> *It's quite interesting how much misogynistic attack I've been subject to on social media, quite shocking really…I've got involved in quite unpleasant debate which I've now stopped getting involved in now. (P11)*

> *A second thing is sometimes seeing science get mangled. You know, you say something… I was just reading some colleagues of mine who wrote something about guns and it got totally twisted in the media to say almost the opposite of what they had intended to say. And that's really frustrating because we're used to having more control of the people who are consuming our scientific journals. (P12)*

2.1.5 Professional Constraints

A dominant subtheme was participants' views on the challenges associated with the profession of clinical psychology. This included historical perspectives on the development of the profession, structural issues, identity and attitudes of many clinical psychologists and challenges associated with 'self-interest'. Some participants described being called a clinical psychologist a hindrance and did not use the professional title or identify solely with it.

> *The people who are at most ease within their own professional and personal identity are those who can let it go. It's the other people, who sometimes desperately have to hang on to it. And that's not easy to do and it's not comfortable but the more we can do it, the more effective I think we would be and the most persuasive. (P24)*

> *In fact it is a handicap that I would align myself to a profession. I align myself with a patient group. I align myself with children and families. (P18)*

> *I think you know radically you might have to get out of clinical psychology to be a better clinical psychologist or a different clinical psychologist with radical things to say. (P13)*

The profession I think is so absolutely wrapped up in its own self-interest, has no engagement with broader issues of social justice whatsoever. And is completely and utterly blinkered in its focus on clinical services. (P5)

The majority commented on the narrowness of the profession, in terms of its primary focus on therapy, as an obvious barrier to more opportunities for macro-level involvement and influence. As illustrated under the first domain, 'Getting There', participants conceptualised their role and responsibilities as clinical psychologists as being much broader but there was frustration that this was not more widely adopted and that psychologists were not more visible and active in society.

But I just think there's a kind of inertia in the profession. It needs a rocket. I would like to see more, because you know I think there's a huge amount that we can contribute, we just need to engage differently with it and take some responsibility. (P37)

The general public need to see that psychologists are human. And we care about human stuff. We don't just sit in our offices and live off our salaries…we are willing to go the extra mile…"the best way to know your community is to go be with your community". Yet so much of clinical psychology is not part of the community. It's clinical. It's an hour a week. (P14)

And I think that partly speaks to me the fact that we still don't have a clear professional identity in the minds of the public. And I think that's a real problem. (P27)

I was just increasingly fed up that psychology just wasn't visible. Psychologists, they just aren't there in the media. You change over to The Today programme and you get people that aren't psychologists talking about psychological things. (P20)

The narrow focus on therapy in our selection, training and employment was seen as a barrier to clinical psychologists wanting to work at a policy level.

I think there's an over-preoccupation of therapy as a vehicle of change…therapy is fine and I enjoy being a therapist as well but I think it's quite seductive…I think we've aligned ourselves overly with the therapy role, I think that's a major stumbling block for us…It's a very individualised,

Western, white…so it doesn't lend itself very easily to social policy change. (P4)

I would say there are things in the training of clinical psychologists that is a hindrance…I guess so much of our training is geared towards the individual and internal…I think there is generally the idea that we are therapists that work with individuals. That in itself is a hindrance to getting involved in this kind of work. (P6)

We select the wrong people, went as far as to say that as long as we recruit people who want to be therapists and train them in this way they will not want to take this work on. And you can see people there thinking "oh that's all terribly interesting, but it's nothing to do with my job". I think part of the issue would have to be selection. (P5)

There was a dominant discourse about the British Psychological Society (BPS) being a barrier to having a wider impact. There were lots of examples of participants writing to the BPS or looking to it for professional backing and not receiving it.

The Psychologist refused to print the letter that I sent them about it so it's kind of nuts really and said "we don't really see what this has to do with psychology". I think I wrote to them about the poll tax and they said they weren't going to print the letter because they don't see the relevance for psychology and I just think well it's making all of our clients poorer. (P7)

I don't see them as being an effective mouthpiece for the profession, especially since now we're all health professions and we don't have to join. I'd like to know what the BPS does for its money (P10)

Participants spoke of their disillusionment with the BPS and feeling uncertain of its impact in society on issues of injustice.

We are politically scared…I remembered the BPS responded basically saying we cannot say this about the government's position at the minute because we're not a political organisation…they were just flip-flapping in the middle, yet every other major health organisation was coming out and saying "No that's wrong". (P22)

What has the BPS done for us? What have they done? Or more importantly, what have they done for everybody else. You know where is psychology in the world? (P16)

The majority of participants saw it as the profession's responsibility to speak out, yet in the most part, not having this view or attitude. There also seemed to be a tension between our training of 'sitting on the fence', hypothesising and posing questions of others when, in a policy context, we might be expected to adopt a decisive and 'expert' position in a short and pressured window of opportunity.

> *One of the biggest shifts…is that you're no longer asked, what do you think? You're asked, what do you think we should do? What do you recommend? I don't want to hear your formulation, I want to hear what you want us to do now. And, as Clinical Psychologists, we ask questions, we look for formulations, we're constantly shifting our formulation deliberately, we never sit in a rigid place with a formulation…so it's taught me to never sit on the fence, never. (P34)*

> *No one can make a decision, because everyone wants to think about everything and co-create everything and that's just not realistic when you also have an organisation that has to function as an organisation. And I think there's something about our clinical training that sets us up a bit to fall into that trap. (P31)*

2.1.5 Organisational Constraints

Just as the organisational context was a facilitator in participants' journeys (in the domain, 'Facilitative Environments'), it also emerged as a challenge in how to integrate macro-level work into mainstream work. The outcome-focussed culture of the NHS was a structural barrier to this work happening as part of clinical psychologists' role.

> *The way you have to account for the way you spend money, the way you have to deliver KPIs [Key Performance Indicators] against everything you do, the reductionist mechanistic approach that is taken, it all feels like it squeezes innovation, creativity, inventiveness. (P2)*

> *It's really interesting...other ways of getting out of a sort of a barbed wire enclosure which is what it feels like it's becoming in the NHS. Whether that's through a different organisation, through academic situation, through training, through writing, through activism, lots of different ways. (P13)*

2.2 Facilitators

Despite the challenges, participants were animated when talking about all the systems they had in place to support them personally and professionally.

2.2.1 Relationships

The ability to form, maintain and utilise relationships was central in every aspect of this work. There was a sense that relationships are what clinical psychologists are good at and therefore a skill that participants had been able to capitalise on in the process. The first area was the importance of having built good trusting relationships with policy makers. Good evidence alone was not enough to have influence on policy.

> *There was a level of trust there so they trusted me to do the work…both sides of the debate trusted me not to trample over the things they thought were important. (P17)*

> *As part of building your professional profile or putting yourself in positions of influence it seemed it was important to be seen as an academic that policy makers could trust. (P5)*

Unlike clinical practice, much of this work was unsupervised so it was vital that participants had mentors or informal supervisors who helped them navigate the challenges they faced. There were examples of formal paid coaching and informal peer mentors.

> *I had sort of various mentors along the way, or people who sort of probably don't even know they acted as mentors to me but people I've looked at and thought, yep I like the way that you're operating there and you know how are you doing that and just watching and learning and trying to observe the process. (P13)*

Having allies was central to working in this way. Allies were often not clinical psychologists but other professionals and a few participants reflected on this as being important.

> *Finding your allies is another important issue, and those allies are at different levels. So in terms of people, co-workers, people you can collaborate with who may be carers or service users or members of the public or particular campaigners. (P15)*

> *He really was somebody who was very influential and…he wasn't a psychologist at all…I have a feeling that one of the important things about policy work and clinical psychology is to form alliances, make friends and be influenced by people who come from other walks of life other disciplines. (P9)*

> *I have good friends and allies within psychiatry, the critical psychiatry network and people who I think of as allies and friends and I think we are on the same lines and there are plenty of clinical psychologists who I disagree with. (P11)*

A group of friends, peers, professionals with whom you can test ideas out and who understand your position seemed to provide support and alleviate the isolation associated with this work.

> *It's quite good to have a sort of home base…with the group of people who you can come back to who are representative of the profession.. who you can consult with and report to....that are reasonably in touch with a larger group within the profession. To be able to tell you when you're going out on a limb, or that's not going to work, or it's not going to be sold, keeping you kind of on track. (P30)*

> *So, you know, just the support, as it can be hard and sort of isolating so to have other people who care about the issue who give you the emotional support, the intellectual support, and just help you in the practical things. (P12)*

Participants stressed the importance of drawing on contacts, existing relationships and networks, formal and informal, when they needed a favour.

> *He used to write speeches for the Prime Minister and is really connected and I met him one day and said, "Do you know what, I really want to speak to*

[Government Department] to make sure mental health is going into this thing. Do you have any connections?" and he's like, "Yeah I know [name of organiser]." So I said, "Can you set up a meeting?" (P31)

Part of it is just using your influence and your contacts and so on. But being careful to try to develop those outside the service you work in is absolutely vital. (P1)

2.2.2 Collaboration

All participants were clear that this work was not done in isolation and, whilst there has been a focus on their professional profile, they could not have achieved an impact on their own. Collaboration is about working with others, joining up with people, acknowledging the importance of partnership working and drawing on expertise to have more power and influence. There is a skill in getting people on board that is discussed elsewhere, but joining people up was a central component of policy work.

It's seen as lefty nonsense but you know that's how stuff happened, people get into groups together and organise together…that's where a lot of things happened really. (P7)

Collaboration brings diversity of viewpoints, skills and experiences which are helpful.

It's important we're not all psychologists, because we're all probably coming from a similarish view. (P4)

You want people who've got passion and a bit of humour about activism…people who never give up…you get people who put together intellectual argument. But you work as a team…you don't get all of that covered in one person. (P21)

Effective team work is also central to how the work gets done, as the range of professional backgrounds increases.

It's collaboration, because if there's a culture of competition…that just serves to alienate people and actually if you could pull together the best people, you're going to get the best solution. (P31)

I wouldn't want to claim responsibility, it was a team effort. Everybody worked together, we had a small implementation team who worked brilliantly together. I was just one person in that team. (P18)

2.2.3 Confidence

Confidence helped to navigate many of the situations described by the participants. It was difficult to determine whether this was a personality attribute or a skill that had been developed and learnt. However, it was undeniably important in being able to speak out with conviction and bring others on board with what you are suggesting or doing.

Sometimes you have to just be prepared to be confident and say your piece very clearly and not to be shy or hide. (P10)

I think you have to come from a position of confidence about your knowledge and what you're doing. (P13)

It is a legitimate use of clinical psychologists' skills and it's something that we could and should be doing, it's not rocket science! I think mainly what stops people is not lack of competence it's lack of confidence. (P17)

Confidence may also have come with age and experience, which was reflected on by some. This could be linked back to participants' position and power.

Thinking back on my career, one was always worried, nervous about it. But as you get more experienced and you get older you become able to say "hang on, listen to me, this is really how I see it and this is I think what's going on". (P9)

It's a life skill isn't it? I mean I am older, I've had a lot more life experience than someone new to clinical work…it took a long time to develop confidence...now I just get straight to the top (P19)

However, despite this, a number of participants passionately believed trainees had enough experience and knowledge to be able to comment on the world around them, as we have enough knowledge to speak confidently on how social injustice impacts on clients.

What's the bloody point of education if it doesn't give people equipment, the mental equipment, to comment on the world around them? And when it comes to doing a profession, what sort of profession do we really think we're doing? Oh no, my profession doesn't equip me to say anything useful about the world. Just, just get on with it. (P21)

The people that we're bringing into Clinical Psychology are really bright, they have to have been confident and ambitious to get there but what do they do with that part of themselves after a few years? Does it die…get diluted? What happens to that bit? (P33)

2.2.4 Passion and Perseverance

This was uniformly a group of individuals passionate about their work and who saw the importance of taking on work that really inspired and interested them.

I always think," What can I take on that's going to interest me, motivate me?" I think that's really important and so keep doing what interests you and somehow the other things get done (P13)

I think it's about passion, because most things come about not through official processes but by hard work and passion. (P21)

It was unclear whether these were skills or attributes but passion combined with perseverance and hard work appeared to create a 'perfect storm'.

Well, you just keep going and going then you hit a dead wall, so you move sideways and you keep going…and if you don't see it like that it's overwhelming. (P31)

You have to be prepared to occasionally front up, be embarrassed if you get turned away, and just not give up, you go back again, so there's a certain persistence. And also you have to work hard. I think this mollycoddling for people that we do gets in the way to be honest. (P37)

It's very important to never give-up. When you're trying to do something quite big, like changing policy, it's not the case that you just present the argument and that's it. You think something is the right thing to do but the first 30 or 40 times you present it, yet it doesn't seem to quite get the attraction you want, keep on persisting. Try try try and try again and don't be demoralised.(P26)

2.3 Translating Existing Skills and Knowledge

This theme encompasses all of the skills and knowledge that participants saw as fundamental in having influence at a macro-level. Interestingly, participants found

the process of reflecting on the skills they use and whether they were 'clinical' or not thought provoking. Participants were rather mixed in their opinions on whether their training helped or hindered their work, but uniformly agreed that they had existing core skills that could be developed and orientated to be used in a different way.

> *My own sense is that psychologists have got in the main a very useful set of skills of knowledge; they just need to feel comfortable about using it in a different environment and adding with them other skills, but there is no reason why most of us couldn't do it. (P24)*

> *I think it is interesting because I often kind of disparage my psychological background and say, "I don't really do it," but people always said to me, "But you tackled the management task differently from other people." And I think it is partly because I almost treated the whole thing as a matter of enquiry - a matter of investigation - or an in-action research - to try to figure out how things worked and what it would take to change things. (P1)*

> *I wouldn't have said that they were new bits of knowledge…I think the competencies they already have. It's about applying them in the right place…which might involve, communication, engagement, constructing a narrative, building an argument, formulating, all of those things, they've just not applied them to the system in the way I've been describing, they'd just apply those competencies to patients…as long as you could get them to orient themselves a bit a more in a different direction, re-orient themselves, then, then those people would find they had the skills. (P28)*

A few participants thought that 'competency frameworks' in clinical psychology were not helpful. In fact we needed to think more flexibly and grow in confidence in using our skills more creatively.

> *This idea of competencies, I challenge you [researcher] and say your first sentence of the guideline should be something like "Why do we need guidelines? Because what we are about to say to you is what we know already". You know what I mean. (P27)*

2.3.1 Research

Participants spoke about the importance of their research skills in being able to confidently understand and present evidence, synthesise and interrogate data, build an argument and distil key messages.

I'm there to tell people what the evidence is. And that's my unique contribution. So I came over with a presentation, not an academic presentation because those are death in politics, but you know like a 15 minute summary of what we knew about the evidence (P12)

Evidence was the vehicle via which policy makers and clinical psychologists communicated.

Because you can't just go and say "listen it doesn't exist"….the feedback essentially was "you're on to something". But for you to get political lobbying support you need a lot more backing in terms of statistics and research because if you are going to make changes in policy you have to have stuff to show. (P3)

They said "Look, if it's not counted it doesn't count in politics"…If you can't provide the information that a minister wants. If you can't provide a good sound case, not just a sound plea that things will be better. But some hard evidence that things are desperately wrong, then people really aren't going to pay that much attention to it. That the politicians and civil servants are having to make difficult decisions about what the priorities are. (P5)

You're an advocate for trying to put the evidence across in a way that people can understand, in the end, policy makers will make their judgments. We're not policy makers ourselves, but the way we put across the evidence, is really really important for policy and we have to adapt our language accordingly. (P10)

2.3.2 Communication

Effective communication and the ability to tailor verbal and written communications to a variety of audiences is clinical psychologists' *raison d'être*, such as it being a key feature of every clinical psychologist job specification. However, participants emphasised the importance of needing to refine their ability to communicate clearly, concisely and in a jargon-free way. The subtheme includes communication skills across a wide range of mediums that are accessible to diverse audiences.

I had to quickly develop a whole new language for describing stuff because 'community psychology', 'agency', 'empowerment' is not going to cut it…I had to learn to say a core message but maybe six or seven different ways depending upon who was in front of me…I had to learn it out of sheer frustration as I'd have maybe 10 minutes, less than that often, to get a message across and it was taking me half an hour and people were falling

asleep. With a minister, you have two minutes, and if you can't nail it in a lift going up to a meeting, the opportunity is gone. (P31)

Being able to communicate with the media was a relatively unfamiliar yet necessary skill relating to this work. Participants compared the skill to that of breaking information down in a way they may do in clinical work to make it accessible

I think, a lot of clinical psychologists tend to think the answers are various degrees of grey rather than black and white. And what press are often wanting is a black and white answer. And I had to learn is to sort of accept that I could be more black and white in how I responded to the media...without thinking "Oh my god, if my colleagues heard this they'd think I was being far too simplistic!" But, then you realise that your colleagues have to do it as well, so it's much more important, because your colleagues are a tiny proportion of the population, to a get the message across to adolescents or the young people. (P10)

The ability to talk to the media is very useful, I write a lot, I do a lot of interviews. When you're trying to pass a law or create a program or get a point across, the ability to speak, not in a jargon but in a normal informed way with reporters is very valuable. (P12)

Think of yourself as a gateway to understanding. Don't think of yourself as having to give the definitive answer, but an evidence-based answer that allows people to go away and so some thinking. So naming, being clear about my role, what we say and clear about the evidence. (P27)

There were numerous examples of when participants had been influential in their written communication for policy makers, including accomplished presentation skills.

Because of the level you're working at people are very busy and they probably get 40-50 page reports per day and they can't all be retained. You're trying to make communication easier so the important features don't get lost. (P19)

I wrote something for the House of Lords, which was very brief, because you have to be able to write incredibly brief reports to go to the government because no one has time to read anything. (P10)

It's not the same as science writing but the ability to take a study of something, to understand and write it in a page that an intelligent, non-specialist can understand. (P12)

Communication was also seen as a necessary component of marketing clinical psychology's skill set and ideas. However, additional skills are required to do this to a high standard, such as learning strategies for communicating the message, and knowing one's audience.

> *We have to be able to sell ourselves, we have to sell our ideas to patients. It's not a bad thing, it's a good thing to sell ourselves. I think we're ashamed, we're kind of like "um don't look at me". (P33)*

> *Doing media interviews to the general public which broadly help people to understand a policy development in mental health I've realised are very important skills (P26)*

2.3.3 Understanding other Perspectives

This subtheme captures the interpersonal aspects of putting oneself in the shoes of others and being able to consider their viewpoint and motivations. This was seen as a core skill in clinical practice, but here it is applied in other systems such as working with other professionals.

> *You could really irritate people by having a go at trying to persuade them of your great idea as well. But the competence that goes with it that we've got is putting yourself in the shoes of someone else. You're doing that with your patients, you've got to do that with your managers, you've got to do that with the psychiatrists, you've got to do that with everyone around. You've got to try and get a sense of how they are seeing the world and therefore what it is, how what you are going to say is going to be viewed by them (P34)*

> *It's essential I understand what it is they are trying to achieve, even if I have a better idea, I don't start by saying that. It's essential I understand where they are coming from and how I can help them achieve that. (P18)*

> *It's another competence that is blinking obvious, think about it from the other person's point of view. Some people never do. (P32)*

> *I think you have to look at not only how the systems work which is critical but also the motivation of different actors within them. So, some people wanted to be famous, some people believed in all the research lark, some people wanted to do good and some people wanted a quiet life. (P8)*

2.3.4 Consensus Building

The ability to put yourself in other people's shoes was a central tenet in being able to then build consensus. Participants described this as also having the ability to hold a line, keeping in mind the change you are trying to effect whilst respecting the range of views held by others. It is also an interpersonal skill that includes empathy, patience and persistence.

> *If you want to be influential in policy it's extremely important that you understand the technology of the word 'influence'. It's flowing with…you flow in with…you don't influence by being a barrage. You don't block. That's not influence. You go alongside. Then once you're a little bit on board and people trust you then it will matter what you say. And people will listen to you. But you don't assume people have to listen to you ever. (P18)*

> *Keeping people informed and letting people know before you start that this is what you're thinking about. Do they have any thoughts about it?... It's kind of polite and diplomatic..(P19)*

> *But I don't think that's just enough, because you can put a case strongly in a way that irritates everybody and they'll ignore you anyway. So I think those softer skills, those influencing skills, those skills can sort of understand how the world looks from those other people's point of view…You're taking that view into account, rather than just ploughing on thinking you know it. Acting in an egocentric way, either professionally or personally. (P24)*

2.3.5 Consultation

Participants described using consultation, including the process of formally consulting and discussing ideas and documents, with as many people as possible in the process. It was the skill of understanding whose views needed to be garnered and being able to incorporate them in a way that is meaningful.

> *I rewrote the document and sent it round several times for people's comments and then incorporated them until eventually we could find something everybody could agree on because as you can imagine there were lots of different opinions on things. (P17)*

> *It goes through an external consultation process, an internal regroup process production…step forward, external consultation again, return to our little*

group, produce something, keep moving forward like that. It's also sort of not be scared of putting something up and having other people criticise it, it's sort of anything goes. (P13)

Consultation was also the skill of redressing power and deciding whose voices to privilege. There were participants who emphasised the importance of grass roots policy change, community psychology and social action as means to policy making, and therefore shared experiences of putting marginalised voices at the centre of the consultation process.

I remember he said to me "You know you are bringing all your professional expertise but why don't you just go and ask people please. Go and ask young men what they think and want." And that was quite helpful and you know, it sort of pre-dates the service-user movement. (P2)

As part of the consultation process of working with others, the skill of being able to compromise emerged. To compromise was to be flexible in one's position or professional role in order to work in different ways and recognise the value in doing so.

So it's kind of the real politics of policy making. And being happy and willing to get involved in it and roll your sleeves up. And it's not good science at times. But I was never in this for doing good science as an abstract idea. But to use science as a tool for social change (P5)

By the time I really had kind of got my head around the whole thing, I was in you know a position of being a full-time bureaucrat, you know having to make the compromises and so on (P1)

2.3.6 Clinical Skills and Knowledge

The participants gave powerful descriptions of how their clinical knowledge and skills were translated for use with wider organisations and political systems.

The skill set is being able to understand what's human emotion, what's anxiety about change and steer a path through it. Again as you do with patients, when they're bouncing off the walls in the middle of a total emotional dysregulation crisis and you just have to be the solid rock in the

room and say it's fine, we're going to get through this because this is the right thing to do. And that is the safe skill set (P34)

You can establish a therapeutic relationship as we are trained at work with individuals and couples. I was basically doing couples therapy, I was doing it with two groups, so all the clinical stuff you learn as a psychologists it almost comes naturally in a way. (P20)

The most widely cited clinical skill was formulation. This defining characteristic of clinical psychologists' skills included the ability to formulate beyond clinical practice with individuals and families, to communities, organisations and political systems.

Formulation skills are extraordinarily useful, so you are able to pull together a multifactorial model of what's going on, what the influences are and therefore, what interventions are required. (P33)

The idea of general clinical formulation, having a framework for thinking. I was like 'God, you can apply this everywhere'. You can apply it on a client basis, you can apply it to a community, you can apply it in a development context, you can apply it in a meeting, in a government. It's a really helpful, analytical approach. (P22)

OK, formulation, it might be helpful to take a metaphor for individual clinical work. You know if you see a patient, then you want to know about their background. So it is with this. You want to know the history of things. You want to know, an individual's strengths as well as their needs and where they want to get to. Which is usually to change without changing at all. And systems are exactly the same. (P28)

2.4 Developing New Skills and Knowledge

This theme captures some of the skills and knowledge that appeared to have been acquired outside of core clinical psychology training. However, just as there is an overlap between many of the skills discussed, there was not a definitive line between what participants had enquired in training or in the process of 'getting there'. However, these subthemes are areas of knowledge that could be expanded on

to work more effectively in macro-level systems. In the most part knowledge came from other applied sciences, such as epidemiology and organisational psychology.

2.4.1 Public Health

Participants provided powerful dialogues about the importance of developing a public health component to their role. Population-level thinking captures all of the various ways that participants viewed humans in socio-political contexts. With additional knowledge on epidemiology, clinical psychologists can re-frame issues in a way that requires preventative and policy orientated interventions.

> *There's not really much evidence at a public health level that all the things we've done have made a lot of difference. We still have you know we have sky rocketing rates of depression in young people. Why? Well because it goes back to the contextual thing…we need to be engaged in public health. (P16)*

> *Most clinical psychologists want to help people, that's why they went into the field. It's a very noble thing to help people one at a time…but if you're motivated by impact, there is something deeply satisfying about getting your hands at the policy world because you can magnify the amount of good you can do with your life…it's hard work but the pay-off can be very, very large. (P18)*

> *If you're just sitting providing a clinical service thinking about why people don't turn up for appointments, it's a very simple personal level. When I was a clinician I used to breathe a sigh of relief when people didn't turn up because it's meant an hour's gap in your schedule, whereas now I think not so much at an individual level but a population level. It's often people who don't turn up who are in the greatest need in some respects, with the wider influences on them. (P19)*

A small number of people referred to community psychology as a useful framework for thinking and action.

> *At the rates you have to pay clinical psychologists not a lot of people can do that and that is where Community Psychology came from in North America in the first place. It was the realisation that you can never help enough people at that level to do the work that was needed and what is more, you didn't need it. Now that is not to say you don't need some expert clinicians but you*

have got to think again about systems for organising psychological help. (P1)

2.4.2 Understanding the System

Participants saw developing knowledge of organisational systems as essential in macro-level work. This knowledge could be developed using systemic thinking and recognising the complexities of organisational systems.

I've worked with people who can't get organisations…they are constantly puzzled and frustrated by the fact the organisation doesn't work in the way they think they should. I think if you have got to grips with systemic thinking, it is about understanding, the Gestalt thing, that the whole is more than a sum of its parts. It's about patterns of influence…in terms of inputs, outputs, seeing conditions, human interests and power within the system. (P1)

In the first instance when you're joining a new group you are very careful to find the norms. You become someone who is experienced as knowing what the values and norms are in that particular social context. I think it's very important when you come into new policy context. That you do not impose your own values but you identify what the values are. And you first of all show that you are competent in promoting those values. So that you win the confidence of the people that you are working with. (P18)

Whilst this knowledge could be viewed within a framework of systems theory, it also touched on organisational psychology, in relation to how organisations and their actors operate and function.

A Trust, or an outpatients department or a GP surgery, is a business, it's a small business and there will be, you know, an economy, a financial economy associated with that system. And there'll be a finance director and they know where the bodies are buried. So in change within the NHS, conversations with the Finance Director could be way more important than you might imagine. And that conversation will help you understand where the pinch points are in the system and therefore, there'll be opportunities to help to alleviate those or to you know, you know, where there's spare cash potentially. (P28)

I would really like all clinical psychologists to hear my talk on the politics section...about what they're going to encounter…or what they're going to encounter in their first job, in a real situation in regards to who's in charge you know who's in charge of the money and who makes the decisions. (P35)

It can also be helpful to understand your position in a system at the same time, gaining knowledge as you work within the system.

> *It's important to use the methods we've been taught, accurate observation and description as you can judge by people's behaviour and their emotional reaction to things, who's actually pulling strings, who's actually got influence, who are the culture carriers?. Who are the people afforded authority versus influential authority? You try and study it and understand the psychological processes that are driving the system…This is what I meant by the standing back and be part of the system and not of the system. You've got to be in the system as a participant but you're also an observer and you to keep this balance between not being pulled in. (P36)*

2.4.3 Strategy

Participants described the importance of having visionary strategies that employed skills in action planning, goal setting, organisation and dissemination. In their experience, policy is born of a clear vision and executed strategy.

> *If you think of any leaders who are influential it's not because they have been on some stupid leader management course it's because they have a rightly or wrongly have a clear vision. (P11)*

> *You had to have a really clear view where you wanted to try get to, not necessarily what the outcome was going to be, but sort of where you wanted to get to and by what point in time and sort of set up a sort of process that was going to help you get there (P13)*

> *You need a strategy really, you need different tactics at different stages, so there's times when it's important to have scholarly debates and there's other times when you need to get out on the street or get attention to the media and cause a bit of aggro, you know, you got to get things noticed and talked about and those things shouldn't be decided by how you're feeling, it should be based upon something that is needed at any particular time. (P7)*

Strategy also included skills in being able to translate the policy strategy and prioritise targets and goals.

There were 39 targets for mental health services and we would do a tick box thing. I remember saying to people, I do not know a single live person who is a senior clinician or a manager, who can keep 39 targets in the mind. You cannot do it. So I said, let's get real ok. Out of these 39, which are the most risk, such as risk for patients, where are we going to get the greatest gain. For heaven's sake let's actually focus on those…So I think a very important part both at the macro-level is being clear agreement on goals. Making sure you've got the high priorities, prioritising those, monitoring them. (P32)

4. Participants' Recommendations

Participants were asked what recommendations they would make regarding this area of work. This was an opportunity for them to present solutions to some of the professional challenges they had experienced. Their responses concerned the future direction of clinical psychology and policy, and how to develop the existing UK training programs.

The first issue to highlight is that macro-level work was advocated as one work stream within clinical psychology; it will not be for everyone, nor does it need to be. However, 'consciousness raising' about wider social and political issues, and facilitating some clinical psychologists to take opportunities beyond their therapeutic endeavours was seen as imperative.

I don't think it's that 90% of clinicians are going to want to do this, but I think to just understand that perspective, put their individual practice into a wider framework…understanding the community needs around mental health. (P19)

I'm not suggesting every clinical psychologist do it. It's a bit like the old rubbish about every clinic psychologist should do a bit of research, it's a complete and utter waste of time and money. Instead of 10 people doing a session a week, just get one person half time. (P37)

There were differing opinions among participants about when is the 'right time' to develop skills and knowledge concerning macro-level work. As many participants had themselves learnt through experience, they expressed the view that

clinical psychologists in training do not yet have adequate experience to fully benefit from training in macro-level work. Furthermore, some participants had experienced trying to teach trainees on similar topics such as organisational challenges, albeit unsuccessfully, which they attributed to a lack of interest at this point in the trainees' careers.

> *The question being is "What do you say to new trainees at the beginning?" The crucial thing is that at that point they don't know what they don't know. Sometimes we [course team] would raise something which to us was a pressing issue, and it was just like wading through treacle, they didn't know what we were on about…but I would say probably a more important question is how, once people are qualified and they are in the job, how do you as a manager create opportunities for them to become involved in projects at a CPD level…Because going on a course can sometimes seem quite arid. So my view would be, it is the responsibility of senior staff to see that more recently qualified staff to have opportunities to learn in that way. (P32)*

> *It's kind of seeing people that you aspire to, to be your role models or whatever, senior people in the profession. So I guess that's more about inspiring people than about competencies. I mean I guess it would be easy enough to bring this more into the curriculum actually and to assess it. (P17)*

> *Well it's difficult to move beyond that role in that stage of your career, isn't it? Because you haven't accumulated enough sort of influential authority or gravitas to be taken seriously at executive levels. And I mean one of the things I do a lot of is mentoring people at that career stage where they're trying to break into macro work in getting you know. (P36)*

A few participants saw it differently, and viewed training as an opportune time to inspire and empower trainees, and challenge the belief that this work is reserved for those in senior positions.

> *I guess one of the things is to be bringing it into training throughout and I think sometimes there is a bit of a feeling like you can only do this kind of thing, you know, when you're like 50 or something you know and that's kind of nonsense really because I think one of the things is we first of all need to kind of empower trainees to feel that it's ok to have kind of politics and values…it saddens me and it really irritates me, I don't think any trainee has ever been thrown off a course for their political point of view…I don't understand why trainees are so paranoid about having some kind of political view. (P7)*

4.1 Clinical Psychology Training

The landscape of clinical psychology training in the UK varies by course and is rapidly changing. Participants were involved to a greater or lesser degree in DClinPsy courses and therefore emphasised that their suggestions were based on the knowledge they had of training syllabuses. The overarching theme was that training was the opportunity to really inspire and empower trainees in order to expand their professional horizons to realise the potential they have to impact on society.

> *It's not training to do something but it's education really in terms of broadening out people's understanding of the role. Because a lot of the programmes are like "this is how you do this", how-to training in that sense. And the 'this' is often individual therapy, or if you're lucky, a bit of family therapy, it's not this kind of stuff. So I think it's about how people think of themselves as well. And I think we have a responsibility as trainers not to just continue the idea that clinical psychology is about individual therapy. (P17)*

4.1.1 Teaching Syllabus

Policy

Participants recommended teaching about policy. This included teaching from policy makers and politicians, understanding the historical context of policy and how it is made, the various different ways clinical psychologists can work with policy makers, and how to make greater connections with policy departments.

> *I think we should bring policy makers in…and I think we should go out to them. I think there should be a lot more interchange, so that we are influencing, you know, training of policy people and other health professions, as much as we're listening to them. There's not enough communication. (P10)*

> *Bringing politicians in. Bringing policy makers in. And getting them to teach. We spent so much time with clinical psychologists in clinical psychology training. We need more professions. We need accountants to talk about accountancy if we are going to be involved in the business model of the NHS.*

We need politicians to talk to us about how to infiltrate the political system. (P14)

We had somebody from the House of Commons come and tell us about how you can influence the House of Commons…that was great, so why can't the trainees have that? (P17)

We want to hear how you make policy. How policies are created, talk about your work. What do you do when you get up in the morning? How do you make a decision? Who are the people you consult? Why? What do you want to learn when you are consulting people? What are the decisions you made that went against you? Why did they go against you? What are the decisions that you were able to take through? Why do you think you were successful? (P18)

I think learning the history is quite an interesting theme in community psychology and policy making. I think if you can get into a policy area you do start to get into the history and how we've got here. (P9)

This would also include teaching policy analysis skills to trainees, as well as a deeper understanding of policy contexts in areas outside of mental health.

I would really like us to put some policy analysis in and not just mental health policy that mental health policy sits within the context of a broader construct of I say the future of the welfare states…I mean psychologists that don't understand the welfare benefits and reforms…If they [young people] are on JSA they're getting no money, how the hell do they eat? Well, nick stuff or sell drugs. In a sense we have to understand the material context in which people live that those kids and that's policy analysis…it's not about cognition why you haven't got no money, you just really haven't. (P8)

Applied Psychology

Another recommendation was for training to include teaching from other psychological disciplines, such as educational, organisational and social psychology. This was because macro-level work is also underpinned by important ideas from these fields that can be usefully drawn on. It prevents clinical psychology being too 'insular'.

Teaching should be much more multi-professional, I think the training is far too inward looking. Why don't we do more joint training? …It's getting hold of a range of ideas from different sources. It's too insular and too protected, there's not enough engagement with the real world. (P37)

I would really like to see more social psychologists in clinical psychology training to actually understand some of the processes of exclusion, discrimination or marginalisation or to understand some of those processes of community and… Anthropologists who have some fab ways of looking at things I would rather psychologists spent a bit less time learning how to do psychology and a bit more time thinking about the role of that explanatory paradigm in the context of others. (P9)

I think one of the issues is probably around social psychology models and occupational health as well as clinical psychology ones I've found were really helpful. Otherwise clinical psychology does tend to be very deficit focussed and individualistic. The NICE guidance for wellbeing at work I think has been influenced by occupational psychology which has been very helpful. (P15)

This is basic social psychology if you think about it. I think what we know from attitude change models…then you know that in an argument where both sides are presented and one is a more powerful one, it's more persuasive. So there are some rules, if you like, from social psychology and attitude change theory. (P28)

An area that featured heavily in participants' recommendations was community psychology. Given the nature of the research and participants' involvement in the field this was an obvious 'fit' for training. Participants hoped to see this approach more 'mainstreamed', with the philosophical underpinning more centrally placed in teaching and clinical placements.

Within this country we don't even include community psychology at all at undergraduate level, unlike European countries and America there's community psychology in the mainstream…this is something I kind of regret, I haven't done. I think that would be a really big big change for good. Because I think young people come in wanting to make a world a better place and then to learn all that individualistic stuff and its demoralising. Whereas if they had that strand of community psychology of population health that

would keep that alive for them. So that would be one strong recommendation. (P4)

The community psychology fringe has always been a fringe, hasn't it? It's always been a small number of people who get committed to that kind of stuff, but it's never spread. It's always been around individuals. I guess it needs some kind of way institutionalising that. (P5)

Teaching from Corporate and Voluntary Sectors

This includes drawing from other sectors such as private business and the voluntary sector, in order to learn more about how to navigate different business contexts. This would also include a corporate understanding of management and leadership to navigate the different organisational settings open to clinical psychologists. This will also support clinical psychologists in working effectively in partnership and in collaborating effectively with other sectors.

I think I still got a long way to go but I think that some help with that in clinical training would be really useful and this plays into my belief that if we are going to sort social problems, there has to be an interaction in skills set between statutory, private and voluntary sectors…but we need to be doing this way more and the NHS needs to be doing it. I think clinical training could benefit massively from having a few corporate companies come and run some workshops on communicating. (P31)

I think I was influenced quite a lot by ideas of continuous quality, management and total quality management and continuous quality improvement. Which before it went out of fashion were very very important and ironically, the NHS had to rediscover things again and again and again. It's amazing. (P36)

4.1.2 Teaching Methods

This captures participants' recommendations to diversify teaching methods, with the view this would increase their sense of agency and repertoire for using their skills beyond individual practice.

Trainees as Agents of Change

How do clinical psychologists finish their training and feel confident? Can confidence be taught? A number of participants highlighted this as a failing of current training and recommended the courses consider different to support trainees to feel an increased sense of agency, confidence in their views and values, and in taking initiative in the workplace from the outset.

> *Part of what I believe in terms of what makes a good therapist is someone who empowers patients with agentiveness. I think we have spent 3 years depriving our trainees of any resemblance to agentiveness at the beginning of the programme. They come in really bright eyed and bushy tailed and they become absorbing machines and there is less agentiveness by the end of the program…and I think that's in terms of your bigger agenda item in terms of getting psychologists to be policy influencers, getting agentiveness enhanced in our training would be the nonspecific that I would want to bring back. (P18)*

A concern was raised by some participants about the potential of competency frameworks to 'kill' innovation and confidence. Whilst the standardisation of clinical psychology interventions was welcomed, there was a risk that trainees could feel incompetent when trying to move beyond a prescriptive model. As many participants clearly articulated, macro-level work comes with a degree of uncertainty and can be overwhelming. So the question posed was whether trainees can be supported to tolerate uncertainty and not shy away from macro-level work.

Writing Skills

There were recommendations that trainees should be more able to write for popular culture, such as newspapers, to make psychology more accessible for the public.

> *If I was running a clinical training course I would say one thing everyone has to do is by the end of their 3 years in order to pass the course…I don't know*

exactly that [laughs] …is get something published in popular media. Everybody has at least one thing published in popular media. Could be a local newspaper. It could be a website. It can be a column piece…and then get people like me to sort of tell you how to do it. (P27)

Well I guess you could, you could assess, it couldn't you? You could get people to do a project that is about getting out there, not just a case report or something, and actually make that an assessment on the course, why not? Or taking a journal paper and writing it in a way that somebody down the pub can understand! That would be a great exercise. (P17)

Leadership Agenda

Some participants placed macro-level policy work under the ever pressing leadership agenda in the NHS and clinical psychology training. However, they suggested a focus on influencing skills, as they had described, which were essential for effective leadership and working with policy makers.

The idea of clinical leadership in the NHS is a constant issue…so you're not suggesting something dramatically new I think it's something on the collective agendas that has been there for a while. (P21)

We don't get positioned as leaders in our course. We don't position ourselves but also we don't get positioned as leaders. We are always the psychologist in the shadows who leads from the back who might influence a multidisciplinary team through, you know, Jedi mind tricks or something but not through actually leading it. (P22)

4.1.3 Policy Placements

Clinical placements offer trainees opportunities for work-based learning and the recommendation was that these could be diversified. Placements could include public health departments, private and voluntary sector organisations where macro-level work is a large part of their role. The opportunity to work with policy makers would offer unique and exciting opportunity for trainees who would like to develop skills and knowledge in this field.

And that's going into a setting that's not probably typical for psychologists and there you will learn everything; how the system works and why it works. It's hard to learn it in the psychology department; you don't have many people in psychology departments who know how to do this kind of stuff. (P12)

In retrospect now I wonder, it probably wouldn't be possible, but whether we could get placements in public health departments for trainees. (P5)

Rather than try to reinvent the wheel, particularly given that a lot of psychologists wouldn't even know what the wheel was supposed to look like, I would say why doesn't our department create a psychology and policy programme with a policy school or a policy institute where they know all this stuff. And, you know, maybe we'd have something on mental health policy, a credential, and the policy people would take 3 courses and learn about mental health and the psych people would take 3 courses in policy or something like that, I think, to find partnerships…there's more expertise and mentoring available and also more valuation of this work in public health schools and in policy institutes and public policy schools than there's likely to be in a clinical psychology department. (P12)

4.1.4 New Pathways within Clinical Psychology

Some participants suggested new and radical ways to change pathways in clinical psychology training. They described some of the limitations of their own experience of training and put forward different ways to solve the issues.

I almost wonder if we need to run two types of training or completely change the way in which we train Clinical Psychologists…We're too expensive, we can't be afforded, our models of care aren't sophisticated enough, we're not commercial enough, we can't sell ourselves and we're not trying to change the world and it needs changing. So, in order for the profession to survive I think it needs to branch out. I don't think it's that difficult but it feels risky to people, and I think we should send our clinicians out into the world, assuming they're going to have a portfolio career and maybe give them a model on setting up your own business…what is your skill set? How do you market it? If you had to grow a business, how would you do it, because the NHS is a business, we have to grow it…You need to be able to write a business strategy and uh a product sheet…I would teach that, I found in retrospect, my Clinical Psychology training was far too long and far too slow. And if you compare three as a Clinical training with a year or two as an MBA, they're just worlds apart. (P33)

4.2 The Profession and BPS

4.2.1 BPS Psychology and Policy Section

A number of participants suggested that there was scope for having a clinical psychology and policy section within the BPS. Alternatively this could be about clinical psychologists joining more with existing policy schools or having a policy 'arm' that psychologists could more readily get involved with. These ideas also touched on professional isolation associated with working at a macro-level, often without any other clinical psychologists. This would offer more opportunities for joined up thinking and working in this way.

4.2.2 Media Training

Media training was one aspect of training that participants recommended. This could be at any point in their career, in training but also via the BPS. Many of the participants had been on training they had found helpful but that no longer existed. Participants alluded to this training returning within the BPS and being a helpful development. This reflects some of the more challenging experiences participants described in working with the media and the importance of developing communication skills that were congruent with media culture.

> *I think just being told about, about these things and what's best to do, and what not to do, how do you approach your MP, how do you approach the Media, how do you, how do you deal with um, uh, how do you deal with a patient who walks in there and says, well I saw you in the front page of the, I saw you in the Evening Standard the other day, how do you deal with that. (P25)*

4.2.3 Clinical Psychology and Public Mental Health

Participants saw the future of clinical psychology as having a much more embedded public mental health arm. The recommendation was for the BPS to

consider ways in which clinical psychology also worked with public health in preventative action.

> *I would really like us to be much much more out there around looking at population and public health. I think psychology has a huge amount to offer around public health. (P4)*

This would also place clinical psychologists in a much wider array of settings such as public health, government organisations, local authorities, the voluntary sector and NGOs.

5. Discussion

"You can make one of two choices in your life - build a building or go on a journey" (Newborough, 1980)

This qualitative study explored the experiences of a sample of eminent clinical psychologists who had worked at a macro-policy level in the UK. They had engaged in ameliorative and transformative policy work, in local, national and international settings in areas such as learning disabilities, child and adult mental health, drugs and addictions and health psychology.

5.1 Professional Journey

Participants had uniformly embarked on a professional journey, one that involved a departure from standard clinical psychology practice and took them into positions to have a wider impact in society. Their journeys involved forming collectives and collaborating with others, from other professionals, policy makers and service users to create rich learning experiences, which were the focus of this study. This process of moving beyond individual practice to work at a macro-level was gradual and dynamic (Burton, 2013). Participants had also navigated and contributed to the changing landscape of the NHS and British clinical psychology, including the expansion and development of the profession (Hall, Pilgrim & Turpin, 2015).

The participants' decisions to come into clinical psychology arose from a combination of personal, intellectual, political and spiritual motivations. Writers have discussed the interconnectedness of individual and collective values and aspirations (Sandel, 1996; Samuels, 2015) which can underpin professional action. Prilleltensky (2001) refers to this as a 'value-based praxis', using one's theories and

values to move into action. Regardless of participants' interests in the field, they tended to increasingly view psychological distress in socio-political contexts and the narrowness of what micro-level interventions such as individual therapy could offer. In particular, participants who were drawn to areas where social change had migrated towards fields where social action was a central tenet, such as community psychology (Burton, Kagan, Boyle & Harris, 2007; Orford, 2008) and learning disabilities (Mittler, 2010).

As participants navigated various clinical and academic positions they were pro-active with a 'propensity for change'. They saw opportunities and critically analysed each one based on the level of wider impact they could have (Crunt & Bateman, 2000). Organisational psychologists are interested in the pro-active component of organisational behaviour, which offers to understand the interaction between personality factors and the organisational culture (Bateman & Crant, 2004; Judge & Zapata, 2015). Furthermore, as participants built their professional profile, networks and areas of expertise, they were also approached and invited to advise and contribute to policy work.

5.2 Being There

Having reached a position to have a wider influence, participants engaged in a vast array of different policy work. It highlighted that clinical psychologists role in policy can involve, such as changing it, writing it, researching it, reframing it, challenging it, contributing to it or commenting on it. An insider perspective was offered by some participants who were part of ameliorative policy development, at the heart of government systems such as the NHS Trusts, Department of Health and Public Health (Michie, 2008; Richardson, 2015). Other participants offered an

outsider perceptive on transformative policy change, attempting to challenge the status quo and power structures, developing campaigns, and giving a voice to marginalised groups affected by policy (Holland, 1992; Nelson, 2013).

However, working within wider socio-political environments often came with challenges, personally and professionally. Working at the interface with policy makers and politicians exposed the 'cultural differences' of the two professional communities (Caplan, 1979; Shinn, 2007; Solarez, 2001), working to different timeframes and priorities. The wider power structures and political climate determined the scope, remit and outcomes of the work, and highlighted the potential tension of being both 'in and against' systems and policy (Burton, 2013; Burton & Kagan, 2013). The participants reflected on challenges concerning the narrow remit, identity and structure of the profession and BPS (Burton & Kagan, 2003; Newnes, 2013). Nevertheless, there was a sense there had been some positive changes, particularly from the 2015 BPS President and they suggested helpful recommendations (Presidential Blog, http://www.bps.org.uk/blog/presidential). It takes years to see the effects of changes in policy, not least because of the scale of population-level health, but the processes involved in large scale policy change. Therefore amount of time, resource and emotional investment in the work placed participants at risk of burnout, frustration and difficulties with maintaining a healthy work-life balance.

Many participants stressed the limited impact an individual can have on their own, not taking credit for the outcomes. The ability to form trusting relationships with those in power and draw on broad networks across disciplines, form political allies and develop informal networks of friends and mentors to guide and advise them. A degree of confidence was described as both necessary and facilitative in

having a clear message and standing up to power; it is open to debate how such confidence is acquired. One hypothesis is that such confidence comes from a 'just do it' attitude, or feeling supported to taking risks and make mistakes.

5.3 Macro-level Skills and Knowledge

In the main participants drew on existing clinical skills and knowledge in a more broad and flexible manner, such as formulating wider organisational systems or policy contexts rather than individuals and families. The doctoral training provides clinical psychologists with the ability to rigorously produce, understand and present research for evidence-based policy making. However, there was more to having an impact on policy than good evidence alone and evidence-based policy comes with its own challenges for academics and policy makers, which has been written about extensively (Humphreys & Piot, 2012; Stevenson, 2011; Oliver, Innvar, Lorenc, Woodman, & Thomas, 2014). To be influential in policy also required a human element, with opportunities for clinical psychologists to draw on their interpersonal skills and knowledge, particularly the ability to understand the perspectives and motivations of others. The chain of decision-making in policy involves a wide range of people, therefore communication lay at the heart of all of their recommendations: the ability to consult, build consensus, facilitate, negotiate and bring people on board. Furthermore, practitioners can draw on their clinical knowledge working with service users to ensure the psychological impact of social and political structures are communicated to the wider public and policy makers (Afuape, 2016; Patel, 2003).

There were skills and knowledge that participants drew upon which were more about their social, organisational and political understanding, as well as the advocacy required in the work (Mallinckrodt, Miles & Jacob, 2014). However, there

was not a definitive line between new and existing skills, nor between what was acquired through training or through experience. Participants had learnt about policy 'on the job' but suggested training could bridge this 'policy-knowledge gap' (Hosticka, Hibbard & Sundberg, 1983). In particular, this involves knowledge of strategy, and having a clear vision, goals and targets. This work also requires clinical psychologists to adopt a "no health without mental health" public health approach (Prince et al., 2007; WHO, 2005), drawing on epidemiology, understanding of population-level mental health and preventative approaches.

5.4 The Ecology of Macro-Level Work

There were a number of personal skills and attributes that participants saw as helping them in their work such as passion, perseverance and confidence. A theme running throughout the research was "Who should be doing this work?". Is macro-level work reserved for mavericks who have always been 'rebels', deeply politically engaged and with an innate confidence to stand up to power (Camus, 1951; Samuels, 2015)?. While it is important to acknowledge these attributes, it is also important not to re-inforce traditional indivualistic views of clinical psychology and instead view these individuals within the complex ecology of social, economic and political influences (Rappaport, 1977) which they described as enabling the work. By their own admission, the culmination of these influences has placed them in the 'right place at the right time', with political backing, resources, support and allies to work with effectively. Furthermore, participants highlighted the danger associated with viewing this work as on the fringe of psychology, and instead as a valid, legitimate use of clinical psychologists' knowledge and skill set, and something everyone was able to engage with. Their journeys can be conceptualised within an ecological framework (Bronfenbrenner, 1979; Nelson & Prilleltensky, 2010). However the

framework will be used somewhat differently, to conceptualise the factors that have enabled the work in oppose to the various levels of intervention.

5. **Micro-level**: e.g. personal values and life experiences, theories and ideologies, world view, propensity for change, passion and perseverance, interpersonal skills.
6. **Meso-level**: e.g. relationships (allies, mentors, inspirational professionals, networks, partnerships) and collaboration.
7. **Exo-level**: e.g. professional training, role and structure, facilitative organisations, opportunities and positions of influence.
8. **Macro-level**: e.g. policy context, power and politics, public health.

Using this framework, in order to work effectively at a policy level, one needs to consider the interplay between micro-, meso-, exo- and macro-levels. Whilst this is not an exclusive or exhaustive list, it offers a preliminary insight into how the themes from the research can be conceptualised. The aim would be that recommendations would also touch on all levels of the system.

5.6 Limitations

Several limitations of this study should be considered. Firstly, the sampling method may have produced a non-random sample as it began with identifying clinical psychologists, particularly, but not exclusively engaged in community psychology, that were known to the researchers. However, using snowball sampling the achieved sample of clinical psychologists was from a broad spread of clinical psychology and senior positions within the government.

This study reports findings based on semi-structured interviews with clinical psychologists in the UK. Therefore their experiences may be difficult to generalise to

professional and training contexts outside of the UK. The sample size is considered satisfactory for a qualitative study (Braun & Clarke, 2013; Guest et al., 2006). However, it was a relatively homogeneous sample, of White British professionals, with only three participants identifying as from BME backgrounds. This limited the findings on how race, culture and ethnicity impact on clinical psychologists working at this level. An adequate mix of gender was also achieved and some women spoke about their views on 'gendered psychology'. However, this was outside the scope of this project but it would be interesting for future analysis of the data. The majority of participants trained in the early 1980s and at the time of the study they were mostly older (50-60 years old). Therefore this may limit how generalizable the findings are to current training and professional climates. As many participants reflected, the opportunities that were available to them for innovation and leadership are scarcer now and this may bring very different challenges and opportunities.

The experiences that participants described could be positively skewed for a number of reasons. Firstly, the psychologists had high profiles in the profession and this may have meant they were not able to be as open or critical as they would have liked. Interviews were ideally conducted face to face, however due to time and resources, a number of interviews were conducted on Skype, potentially impacting on the richness and quality of the data collected. A few participants commented after the interviews that they might have liked the space to discuss their experiences in a group as they felt their reflections would have been richer. This could be a consideration in the dissemination process of the research.

5.7 The Future of the Profession

One of the aims of the study was to develop recommendations for the profession on macro-level work. The final recommendations will be made based upon the themes from the analysis and their recommendations. They will be considered under four headings: training implications, professional implications, clinical implications and research implications.

5.7.1 Training Implications

An aim of the study was to use the experiences of these clinical psychologists to develop macro-level competencies, following suit from North America (Beven, 1980; Singh et al., 2010; Burnes & Singh, 2010; Nilsson & Schmidt 2005). However, the participants had mixed views on whether competencies were helpful or not in training. On the one hand, competencies can provide a framework for assessment in training and enable a profession to communicate the skills they have. They are also widely used in clinical practice (Roth & Pilling, 2008). Therefore, there is the question of whether macro-level competencies should be as rigorously evaluated and implemented, if this work is to be viewed as an important part of the role. On the other hand, some participants expressed concerns that competencies and guidelines could serve to disempower an already 'unconfident' profession. They may also confuse the message that clinical psychologists are already well placed and skilled to do to policy work. This poses a dilemma, therefore these recommendations are suggested tentatively in the hope that they can continue to spark debate and discussion within the training community. If we were to develop additional competencies, how could they be both assessed and then communicated to a wider audience? Would they form a part of all training programs or additional CPD

workshops? This could mean that individuals with a particular interest could take up these opportunities.

Regardless of how these skills are captured, training providers need to support the development of existing clinical skills and knowledge to be used in macro-level forums and systems. This requires a re-conceptualisation of the clinical psychologist's role and requires teaching from other social and applied disciplines, including clinical placements in policy-orientated settings. Firstly, the areas of core clinical and research skills that need developing are:

- Clinical skills and knowledge applied to macro-level systems e.g. formulation of organisations.
- The ability to communicate, and writing for wider audiences.
- Communicating the research evidence base to policy makers.
- Researching the impact of local, national and international policies on mental health.
- Work alongside marginalised groups in society.
- Consultation and collaboration with a broad spectrum of professional and non-professionals.
- Influencing skills, such as understanding the perspectives of others and building consensus.

Secondly, training providers need to consider introducing new areas of knowledge and skills:

- Teaching on epidemiology and public mental health, with the ability to build closer partnerships in the future.
- Knowledge of policy and policy analysis.

- Developing effective strategy for policy work.
- Media training.
- Teaching on community psychology action and research at undergraduate and post-graduate levels.

Policy and public health placements offer the opportunity to develop a greater awareness of this kind of work and to develop skills such as communicating science to non-scientists (Brown, 2002). Much like in the USA, some UK DClinPsy courses, such as at University of East London and Salomons, have begun these developments (http://www.bps.org.uk/events/group-trainers-public-health-public-mental-health-and-clinical-psychology-training). Hopefully the evaluation and dissemination of the experiences of trainees on such placements will contribute to these recommendations.

5.7.2. Clinical Implications

Qualified clinical psychologists who would like to further their journey towards macro-level work could further develop their skills in both clinical practice and research. As the findings suggested, a starting point for clinical psychologists is to become more aware and critically appraise the policy context and how it impacts on their clients. Secondly, they can work alongside service users and careers from the grassroots of policy development. Given the importance of meso-and exo-level contexts, clinical psychologists should join with others and engage with the multiple organisation and political systems around them. The following recommendations arise from the findings:

- Clinical psychologists need to be aware of population-level health issues and data in their field and how it can be applied to their work (Emerson, 2012).

- Clinical psychologists should consider alternative tools to formulate the impact of socio-political issues e.g. Societal Case Formulation (Burton, 2008).
- Clinical psychologists need to consider different ways of working that incorporate social action into their work (Holland, 1992). An example is MAC-UK (www.mac-uk.org.uk), a community psychology informed organisation that aim to transform mental health services and policy; with and for excluded young people (Allen, 2013; Zlotowitz, Alcock & Barker, 2010; Zlotowitz, Barker, Maloney & Howard, 2016).
- Clinical psychologists need to consider different ways to mobilise psychological knowledge about the impact of policy on their clients. An example of this is the campaign by Psychologists Against Austerity (https://psychagainstausterity.wordpress.com), which is open for clinical psychologists to get involved in.
- Clinical psychologists can be at the forefront of policy making by making links with their local MPs, commissioners and policy makers. An example is the first clinical psychologist MP Lisa Cameron (Cameron, 2015).
- Clinical psychologists should think about the impact of their research on policy and draw on a wider range of research methods including social action research (Williams & Zlotowitz, 2013).

The recommendations could be developed into a tool, such as a set of questions that can orientate clinical psychologists to macro-level work and opportunities available to them. Examples of questions include:

Where do I work? What is the scope of my role? What are the constraints on

the setting? What do I know about the system? How could I find out more?

How does current policy impact on the clients I work with? In what ways?

What skills do I have as a clinical psychologist? How can I sell these? How can these skills be used in a different way?

What opportunities are there to get more involved in policy? Who do I know with similar interests? How much time can I commit? What is sustainable and realistic?

5.7.3 Professional Implications

Professional recommendations relate to the exo-levels of the Bronfenbrenner (1979) model. They involve the wider systemic factors relating to the structures that can facilitate clinical psychologists in policy work. Firstly, leadership, although defined and adopted by participants in different ways, was clearly important. These participants demonstrated strong examples of clinical, academic and political leadership and these recommendations are to ensure that other clinical psychologists can continue to thrive in this domain.

1. The BPS should survey the profession to gather up to date knowledge on where clinical psychologists are working, what activities they are undertaking. This will help to further highlight the macro-level work that clinical psychologists are engaged in.
2. Policy makers, commissioners and employers of clinical psychologists need to consider ways to ensure policy work, where valued and expected, is part of the clinical psychologist's role.

2. The BPS should consider what structures are in place to support clinical psychologists working at a macro-level. This will include systems such as supervision structures for policy work, CPD workshops and media training, as well as continuing to develop interest groups and task forces in social policy areas. This will also ensure the mental wellbeing of clinical psychologists engaged in such challenging and complex work will be supported.

3. The BPS Leadership and Management Faculty should consider how the study fits within their agenda. This could include leadership opportunities and career pathways, within government and public health departments.

4. The BPS should consider setting up a Psychology and Policy section, much like SPSSI in the American Psychological Association (https://www.spssi.org). This would ensure that any policy work, both transformative and ameliorative, that is taking place within the profession has a clear home within the professional body. Furthermore it can facilitate more opportunities for those with an interest in the work.

5.7.4 Research Implications

Future research is needed to expand on these findings. This study has highlighted the number of clinical psychologists working at a policy level, who may not have been visible before. Further research could survey the profession, building on existing data (Norcross, Brust & Dryden, 1992) to find out more about where and how clinical psychologists who work at both micro and macro-levels are employed. Careful consideration would be required to ensure social action or policy work that is often in addition to their main roles was captured.

Further research could evaluate the implementation and impact of a set of recommendations from this study, particularly in how to develop and measure trainees' sense of agency and confidence in this work. As the sample in the study is largely from late career clinical psychologists, it would be interesting to carry out a qualitative study on early career clinical psychologists and their experiences earlier in their professional journeys. This would highlight some of the challenges of working more at a meso-level of systems change, within organisational settings.

The issue of measuring impact and outcomes posed a challenge. Clinical psychologists are well placed to consider tools to evaluate and measure, and to continue to develop new and innovative ways to measure impact. This could build on work on how to measure 'transformative' change (Prilleltensky, 2011). Manchester community psychologists have a number of tools they use as frameworks to ensure they maintain a critical stance when working in policy, including a way of analysing the ameliorative-transformative balance (Kagan, Burton, Duckett, Lawthom & Siddiquee, 2011).

The remit of this study was clinical psychologists, however, it was at the expense of more marginalised voices in policy such as service users and carers, whose priorities and experiences of policy may be very different (Richardson, 2015). Whilst clinical psychologists can mobilise these voices from practice to policy through research and social action, interviewing service users would have offered a rich insight into other perspectives. The 'top down' and 'bottom-up' approaches to policy development have not been explored in this study and would make for a rich contribution to the field.

5.8 **Conclusion**

The depth and breadth of the experiences shared by such prominent clinical psychologists has allowed for striking insights into the professional journeys from practice to policy, with the potential to inspire and enable other clinical psychologists to work in this way. There is a multitude of ways in which other clinical psychologists can move between ameliorative and transformative practice in their careers, depending on their interest. Clinical psychology is a broad profession and the training equips clinical psychologists with the skills and knowledge to work at multiple levels within the system, from micro-level practice to macro-level policy change. Raising awareness on so many levels, about what is beyond therapeutic endeavours, has the potential to motivate and inspire new clinical psychologists, just as many of the participants in the study had been in early parts of their careers.

However, the ideas from this study are not new. Clinical psychologists have been advocating the use of psychology in the fields of social justice and policy since its origins (Albee, 1986; Sarason, 1981). Furthermore, critical and community psychologists have written extensively on working at a wider systems level, although macro-level intervention has received much less attention. Therefore hopefully it can contribute to a much broader agendas that already exist, such as within clinical and community psychology, the BPS and the NHS (BPS Clinical Leadership Development Framework; Skinner et al., 2010).

The study has provided a unique grouping of clinical psychologists, working on a continuum of both ameliorative and transformative policy work. Through their own admission, they are a group of psychologists who may not have conceptualised their work in a similar vein before. This further highlights the distinct contribution

this research offers to the profession. An unintended consequence of the interviews was the participants' historical reflections on clinical psychology, practice and policy, in what has been a relatively short yet transforming time for the profession. The participants in this study were central in some of the most significant policy decisions in the profession e.g. closing long stay institutions, the Mental Health Act, the White Paper, Agenda for Change, IAPT and the development of psychology guidelines, as well as developing British critical and community psychology. It is both poignant and imperative that the next generation of clinical psychologists be facilitated to follow in their footsteps.

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Part 3

Critical Appraisal

1. Introduction

This paper offers some critical considerations and reflections on the empirical study. It draws on a reflective journal that I kept over the two and half years during which the research was undertaken. I will begin by reflecting on my own professional journey, which echoes the structure of the results. I will then discuss the advantages and disadvantages of my position as a trainee clinical psychologist and an 'insider' researcher interviewing eminent professionals, and consider the impact of the study on both researcher and participants. I will also address sampling issues and will conclude with reflections on terminology used in the study, particularly the term "activist practitioner."

2. My Own Professional Journey

Much like the participants, my decision to pursue this research was inevitably linked to my own experiences, interests and professional journey toward macro-level interests. Like them, I had wondered how far back to go when considering my early influences on this topic, but here I will go right back to my earliest influences in order to provide the background context to the study. I have had a lifelong involvement in socio-political issues; my parents both held strong values of equality and social justice which they put at the centre of my upbringing. My mother, an active feminist, worked in social policy and housing, and my father, a linguist, worked in the immigration and human rights field with refugees. As a young child I was immersed in cultural diversity through travel and growing up in London, and activism was a normal part of my growing up. I internalised this connectedness to the macro-level systems around me almost as a moral or ethical duty. I firmly believed it was impossible to disentangle the psychological, social and political and was

fascinated by where they met. By the age of 15, I had decided I wanted to be a psychologist.

However, like many of the participants, I found the next 20 years, 1995 to 2015, to be full of political and professional anguish. Very early on, I became disillusioned with approaches to understanding and treating mental health difficulties and I read began to increasingly read critical psychiatry (e.g., Bentall, 2004, 2006; Esher & Romme, 2012; Moncrieff, 2006; Newnes, Holmes & Dunn, 2001; Watkins, 2006). I realise, on reflection about my role in this research, that I too very quickly moved between micro- and macro-level systems and my own first experience of policy engagement was in my very first job, supporting service users to have a voice in policy via a documentary we made about their lived experiences and impact of cuts to funding of programmes helping vulnerable people in England to live independently (Supporting People Programme; Griffiths, 2000). In subsequent years I took roles in mental health services that were trying to change systems and offer alternatives ways of using psychology alongside service users, discovering Community Psychology in Australia in 2006 (Thomas & Veno, 1996). I feel that it encapsulated the theoretical, political and collective values that made sense to me and legitimised both my professional journey and identity, giving me a framework for working and joining with others. Opportunities for transformative work in my career snowballed (VTPU, 2006;Clark & Women, 2007; Stolk, Minas, & Klimidis, 2008) and whilst I took an active role in trying to find my place within mental health services, my professional experiences were very much enabled by being in 'facilitative environments' and around 'inspirational individuals'.

However, I would not have eventually come full circle into clinical psychology training without the support of my supervisor and manager John Cape, a

nationally prominent clinical psychologist, who held the view that clinical psychologists should have a broader view of health care delivery and enabled me to work almost entirely in community settings. I now realise the significance of his putting me in touch with Chris Barker at UCL, a clinical-community psychologist, who invited me to attend a community psychology conference. From that point, my network and allies in the field began slowly to develop. Therefore, by the time I decided to apply for clinical psychology training and gained a place at the age of 32, I had a strong idea that I wanted to carry out research that bridged clinical and community psychology, building on my interests, not denying them. I was fortunate that my supervisors, Chris Barker, Kat Alcock and Sally Zlotowitz, all shared views about the broader contribution that clinical psychology could make beyond therapeutic endeavours and finding other ways to make a difference in society. Sally suggested the research topic based on her experiences in leading the London Community Psychology Network, and we were all equally excited by it.

3. Personal Reflexivity

The process of declaring and reflecting on one's epistemological and personal beliefs is central incredible qualitative research, as the researcher shapes the process and outcome (Dowling, 2006; Finlay, 2002; Willig, 2008). The qualitative research process is a bidirectional one (Hofmann & Barker, 2016). Participants will share the stories and narratives based on the context and who they are telling (Josselson, 2013). The key concept of the reflexivity of qualitative research addresses this notion of a bidirectional influence. Finlay (2003), describes the reflexivity process as "the project of examining how the researcher and intersubjective elements impact on and transform research" (Finlay, 2003, p.4). For this reason, I offer some reflections on being an 'insider' researcher, having experiential knowledge of a subject and being

closely aligned with the participants, as they were from the same profession (Berger, 2015).

There are advantages and disadvantages to being an insider researcher (Berger, 2015; Hofmann & Barker, 2016) which will be discussed. The advantage was the ease with which the participants were recruited and the familiarity of settings and networks that gained me access to them. I was able to understand with ease their experiences of training, working within the NHS and the psychological knowledge they discussed. Towards the end of the data collection phase my familiarity with the data increased, in that I had become acquainted with the names of prominent figures in the profession, theories and significant historical developments. In some cases I had worked with the participants, and I then observed that I could easily adopt a more relaxed position, which opened up the interviews possibly in a way that was helpful. I was able to pay more attention to the process of the interview, as the content appeared more familiar (Josselson, 2013).

The potential disadvantage of being an insider was the risk of "false assumed similarity" (Hofmann & Barker; 2016), making assumptions about the experiences and presuming to understand. This was particularly difficult when discussing clinical psychology training, given how involved I was in the process. This effect was bidirectional, as many of the participants were interested in my own career goals and experiences of training and suggested ways I could personally get involved in policy. Whilst I embraced these conversations at the end of the interview, it highlighted the conflicted roles I had as trainee clinical psychologist and researcher in a small profession (Josselson, 2013).

The risk of over identifying with one's participants can be helped by bracketing (Ahern, 1999; Fischer, 2009; Gearing, 2004). Bracketing is the process by

which the researcher holds their previous experiences and beliefs in brackets, in order for them not to impact on the collection and interpretation of data. Bracketing was used in supervision, to discuss how interpretations and beliefs were behind the data without it being misinterpreted. However, my supervisors were also insiders and this did mean that as a team we had to pay particular attention to possible taken-for-granted assumptions and reflect on this.

The interview process was personally transformative in a number of ways. I would often felt inspired and motivated both during and after the interviews, and it was challenging at times to remain impartial. The reflective diary helped as I would record feelings and thoughts that came to me during the interview, also attempting to bracket them. Many of the participants I had followed in print or at conferences for years, never imagining the opportunity would arise to meet them.

An important reflection is that this experience strongly contrasted with my experience of clinical training. I had anticipated I might struggle to integrate into training, leaving behind a senior position and team I loved, a senior position and being slightly older. My experience of training chimed with many of the participants, as they had felt disempowered, with little opportunity for systems change work. I was increasingly despondent by the incongruence of theories and models presented on training, and those that I was being exposed to in the research process. It brought the socio-political context to the forefront of my consciousness and I became acutely aware that it was infrequently discussed and thought about, which was disheartening. Therefore, the impact of the research was career-affirming and motivated me to persevere, it transformed by experience of training and it was a privilege to be 'immersed' in such data at a pivotal and difficult point in my professional development. Furthermore, this experience of the research connected me to the

potential impact of the research on others, especially clinical psychologists with similar interests and wanting to work in this way.

There were other personal and professional consequences of the research process. Professionally, I became more engaged in professional issues, joining the BPS and contributing and organising lectures at UCL on topics closely related to the research. Personal consequences were that I questioned myself more and noticed when I was taking a passive position on issues important to me, prompting me to join the Labour Party and engage more in conversations about current affairs. I was able to see the benefits of branching out and connecting with others much as my participants had done. These apparently small changes in my life are a direct result of the research.

The experiences that are shared in data collection are affected by how the interviewer and interviewees are positioned (Josselon, 2013; Mishler 1986). Despite the experiential knowledge discussed, there was a stark power differential between the researcher and participants. They were eminent psychologists with significant profiles in the profession and with that came professional anxiety. This impacted on the research in several ways. Firstly, I lacked the confidence to interrupt them or move them when talking about their careers. Therefore interviews sometimes went on for longer and I may not have been active enough in my style for fear of cutting people off. Secondly, the research also appeared to have consequences for the participants. Their responses to the interview were overwhelmingly positive. It became apparent that, in the most part, they had not been asked these questions before or been given the opportunity to reflect on these policy-level experiences. They were both interested and engaged with the topic and the fact I was a current trainee who could also offer reflections on where this sat within course curriculums.

Some participants remarked that they had been speaking to one another about the research, sharing reflections on the interview and the profession as a result. One participant said:

> *"This is great – well done for developing a sense of unity and purpose about this work…I think we are rather poor at all this and I do like your enthusiasm for something a bit radical" (P2)*

4. The Scale of the Research

The sample size of 37 ended up being much larger than anticipated. The scale of the research happened organically, through the process of snowballing, but was far greater than originally planned. The number of clinical psychologists involved in policy work was an exciting development and interesting data in itself. This was the reason for having such a large sample, as it presented an opportunity to bring together a unique grouping of professionals, many of whom were in the latter parts of their careers. Furthermore, there was a risk that the original sample was biased towards community psychologists. This occurred not only because of the interests I and my supervisors declared, but the professional network we were drawing from. The idea to survey academics at UCL to get a broader sample came from a peer reviewer of the proposal who also highlighted the potential bias of the sample towards adult mental health. The range and variety of the final sample hopefully addresses these initial concerns.

As the sample grew, there was increasing concern in both the data collection and analysis phases that participants' rich experiences might be underrepresented. Thematic Analysis requires a number of choices to be made and requires the researcher to be decisive in their judgements (Braun & Clark, 2013). However, the

more that I revisited the data to 'refine and define' the more lost and immersed I became in the detail. Whilst this period of disorientation is an important part of qualitative analysis (Holloway & Wheeler, 2010), it lasted much longer than I anticipated. The professional pressure as an 'insider' researcher was heightened by seeing and speaking to participants at various events, and the potential for them to waive anonymity in the dissemination.

The dilemma of whether I had reached 'saturation' was present after about 15 interviews. Both supervisors and participants regularly asked me if I had reached this stage and I was not sure what they meant. I had noticed I was hearing patterns and themes in the data, yet still observed differences among participants. There is no actual description of how saturation is determined, nor are there guidelines for estimating it (Morses, 1995; Guest, Brunce & Johnson, 2006). 'Theoretical saturation' (Glaser & Strauss, 1976) is when no additional data is being found that can help the research, and the researcher starts to feel "empirically confident that a category is saturated". My experience was that the data was still interesting, even when saturation on the main themes may have occurred.

Using NVivo software in the data analysis process is arguably more rigorous (Richards & Richards, 1991). It was helpful in managing a large data set, although initially time consuming as the programme was unfamiliar. However, the initial stages of analysis were done by hand. This allowed the software to be used mostly as an organization tool once the main themes began to emerge (Smith & Hesse-Biber, 1996).

During the research period the professional climate was also changing. It coincided with the 50th Anniversary of the Department of Clinical Psychology, established in 1966, and the launch of the book *Clinical Psychology in Britain* (Hall,

Turpin & Pilgrim, 2015), generating much interest in historical reflection on the evolving role of clinical psychologists. Psychologists Against Austerity had gained significant momentum (PAA, 2015), and the BPS was committed to growing the policy department, increasing their impact on social justice issues (The Psychologist, May 2015). There was increased dissemination of macro-level work, including the 'Beyond the Therapy Room' conference (Harper, 2015) and the inspiring campaign 'Walk the Talk' (http://www.walkthetalk2015.org) which involved clinical psychologists raising awareness of the impact of benefits, homelessness and food poverty. The University of East London had also developed a third year policy placement and they were keen to work in partnership. This changing landscape meant that there was significant interest in the research and an ideal platform for its dissemination.

As a result, it seemed important and necessary to present the research when opportunities arose, including at the DCP Pre-qualification conference on Community Psychology in March 2016. The work in progress was written up in The Psychologist ('Be the Grit in the Oyster', May 2016). A number of clinical psychologists contacted me by email and on Twitter after the event to share that they found the research inspiring, again connecting me to how the study would be received by others.

Another challenge in managing a large sample was how to best to keep in touch with the participants over the period of the study. I informally bumped into many of them at conferences, some of them contacted me offering to meet for a coffee when they were in London or emailed to hear about how the study was progressing. Participants were enthused by the subject and it seemed important to keep them engaged and up to date, especially given the climate in the profession as

mentioned. I decided to write a participant newsletter (Appendix E) which updated them on the progress and time scale of the project and some of the developments, such as conferences. It was well received and I plan to continue to keep in touch with them in this way.

5. Terminology

There have been various attempts to define a term to label clinical psychologists working at a societal or macro-level of systems change. One of the research aims was to scope participants' views on the term 'activist-practitioner' (Zlotowitz, 2013), which was the term used in the original research proposal, in order to find out whether it was a term they would use to describe themselves. The first 20 participants were asked their views on the term. Based on their largely negative responses, the term was no longer used in the title of the project and 'Practice to Policy' was used instead.

The 'activist-practitioner' term conjured up vivid imagery of political activism for most participants, such as demonstrating on the picket line, using their voice in a loud way and activities they associated more with their personal rather than professional lives. Participants had sharply divided opinions on the term. Whilst some described activism in neutral terms as various degrees of action, there were just as many who feared that the term was too closely aligned with 'political activism' which the profession would struggle to adopt. Furthermore, many of the skills that participants described as important were 'softer' interpersonal skills, which was incongruent with the language of activism. As one participant put it:

> *It's possibly a bit narrow in the sense of it does sort of summon up the image of someone whose activism is like going on demonstrations, not that I haven't done that…of course there's other ways to change the world apart from that so maybe the concept of activism, but maybe it has that connotation to some*

people anyway. I do think of myself as an activist, I think. But in order to appeal to a broad range of clinical psychologists and encourage them to get involved in this kind of social action, I suppose, I'm not sure the word... I think it might put some people off. (P17)

There were also fears that it could be divisive within the profession, suggesting that other clinical psychologists were 'de-active'. Participants highlighted the danger associated with viewing this work as 'extra' or on the fringe, and instead as a valid, legitimate use of clinical psychologists' knowledge and skill set, a professional responsibility:

I guess my concern about it would be what it says about people that aren't in this group. Are they deactivated practitioners? Or inactive. So what would they be? It could be a bit divisive in that sense. I don't know. (P5)

A few participants liked the term, or acknowledged a need for an update to 'scientist-practitioner' which they felt did not capture the broad nature of their role:

This is not just about science, evidence and competency and management leadership and all that kind of stuff it's about anything that deals with human suffering it's about ethics, morals and values and if we take a values based ethical position then actually you look clearly at what you see. These are matters of social justice it's not a random group of people who end up mental health services it is people who end up at the bottom of the pile suffering from the highest level of deprivation to abuse and trauma and all the rest of it. So we cannot possibly see that through scientific practitioner or even a reflective practitioner lens we have to be activist in whatever we can there are lots and lots of ways we can do that. (P11)

Discussions around the term also highlighted the importance of discourse around macro-level work, such as 'activism' and 'politics'. One participant contacted me after I had informed the participants I was no longer using the term in the research. They offered some interesting reflection and hypothesis on why the term may have been unpopular, such as avoidance and fear relating to having political views within the profession. Participants who liked the idea of using an alternative term to define their role offered some alternatives.

We call ourselves 'Compassionate-warriors'. (P3)

I guess it's things like politically engaged or Influencing or Action focused? (P14)

I call myself a 'scholar activist' but that is what I am now you see because I am allowed to misbehave because I am not part of the bureaucracy anymore. (P1)

The use of 'skills' and 'competencies' in the interview schedule was criticised by some participants as reinforcing individualistic views within psychology. The questions were adapted to include resources, facilitative and enablers as well.

Terminology relating to policy was unfamiliar to me, which made conceptualising the work difficult at times. Policy work meant so many things and ways of working, it was necessary for me to seek out information relating to its development (Ham, 2009). As part of the process, I interviewed a policy maker, a civil servant in local government. This allowed me to ask questions about policy making and gain a much deeper understanding of their experiences of working with clinical psychologists. I decided to use this interview as a background learning experience, rather than to include it in the research, although it was an interesting perspective. I learned that policy makers valued clinical psychologists knowledge 'on the ground', which they can feel disconnected from and also their ability to critically appraise research. However, some of the concerns they raised echoed that of the participants, that clinical psychologists can be inflexible and unwilling to accept systems changes, they can be focussed on micro-level systems and struggle to think more broadly about issues relating to their clients. If I had had more time it would have been interesting to interview with other professionals, including epidemiologists such as Michael Marmot.

6. Conclusions

This study presented me with one of the richest learning opportunities in my career, which hopefully has contributed to the development of the project. I journeyed with the participants into a realm of their professional experiences that had gone largely unexplored and hopefully brought it to a captivated audience (Kvale, 1996). The study has gathered a unique data set of both current and historical importance. The experiences and views captured in the interviews are vital to the development of clinical psychology in the UK, and as many of their journeys are coming to an end I am thrilled that mine is just beginning.

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Appendix A: Recruitment Email

Practice to policy: clinical psychologists' experiences of macro-level work

Recruitment Email

Dear....

I am a clinical psychology doctoral student at UCL. My thesis research, supervised by Dr Kat Alcock, Prof Chris Barker and Dr Sally Zlotowitz, is on the experiences of clinical psychologists who are working at a 'macro level' to shape local or national policy. The purpose of the research is to understand the role of clinical psychologists in leadership and social change and aims to develop some guidance for clinical psychologists on how to work in this macro-level way. The study has received ethics approval from UCL.

I intend to interview around 20-30 such clinical psychologists. Your name has come up as someone who is involved in this kind of macro-level work. The formal inclusion criteria for my study are

(a) Qualified in clinical psychology to a masters or doctoral level (b) has worked in the UK (c) has engaged in macro-level policy work.

I'm writing to ask whether you feel you fit these criteria, and if so, whether you would be willing to be interviewed for my study. The study would be at a convenient time and location for you, or we could do it via Skype. The interview takes about an hour. The interviews would take place between now (my thesis is due to be completed in June 2016).

Please let me know whether or not you would be interested in taking part. If you are, I can send you further details. I would of course be happy to answer any questions about it.

Best wishes,

[Researcher details]

Appendix B: Participants Information Sheet

Practice to policy: clinical psychologists' experiences of macro-level work
Participant Information

What is the purpose of the study?

This study is being carried out by researchers at UCL. We would like to find out about clinical psychologists' experiences of engaging in social policy and activism. We hope that this study will help us to understand how they approached their work, the skills required and any barriers or facilitators they encountered. The study aims to develop a practical guide for other clinical psychologists working in this way.

Why have I been invited to take part?

You have been invited to take part in this study because some aspect of your work as a clinical psychologist is concerned with social change. We hope that around 30 people will take part in the study.

What does taking part involve?

If you choose to participate you will meet with a researcher for an interview, lasting for approximately one hour. This can be face to face, on the phone or via Skype. You will be asked a series of questions to guide the interview. These will include questions about your career path and your experiences of engaging in social policy and activism. The interview will be audio-recorded and we will also invite you to provide feedback on our analysis of your interview. We will send you a written summary of the main themes in your interview and ask for any comments you may have.

Do I have to take part?

You are free to choose whether or not to take part and to withdraw at any point.

What are the risks and benefits of taking part?

We do not anticipate any risks from taking part in this study.

What will happen to the information I provide?

The interview recording will be transcribed to help us analyse the data. The analysis will be carried out by the research team and will identify the main ideas expressed by everyone who participated. The results of the study will be written up as part of a doctoral thesis, which may also be published in a journal. In addition, we hope that the findings will be useful to other professionals.

Will my taking part in this study be kept confidential?

Anything you say during the interview will be kept confidential. All data will be collected and stored in accordance with the Data Protection Act 1998. Audio recordings will be stored on a password-protected computer and will be deleted once transcripts have been made. Names and other personally identifiable information will be removed from transcripts to ensure anonymity. We may include direct quotations from interviews in the published report, but we will not include names of participants (unless agreed) and we will make sure that any quotations we use cannot be linked to individuals.

However, given the nature of the research, the option of non-anonymity will be offered to you at the end of the interview.

Contacts:

For more information please contact the Nina Browne or one of the supervisors to the study:

[insert researcher and supervisor details]

Appendix C Consent Form

Informed Consent Form for Participants

Title of Project: **Practice to Policy: Clinical psychologists' experiences of macro-level work**

This study has been approved by UCL Research Department's Ethics Chair

Participant's Statement

I ……..agree that:

□ I have read the notes written above and the Information Sheet and understand what the study involves.

□ I understand that my participation in this study is voluntary and that I am free to withdraw at any point, without giving a reason, and without my care being affected in any way.

□ I understand that my interview will be audio-recorded and transcribed and I consent to the use of the recording and transcription for the purpose of the study.

□ I understand that the information I give may be used in a published report and I will be sent a copy. Confidentiality and anonymity will be maintained and it will not be possible to identify me from any publications. It will be possible to waive anonymity if I so wish.

□ I consent to the processing of my personal information for the purposes of this research study. I understand that such information will be treated as confidential and handled in accordance with the provisions of the Data Protection Act 1998.

□ I agree that the research project named above has been explained to me to my satisfaction and I agree to take part in this study.

Signed: Date:

Investigator's Statement

I ……..

confirm that I have carefully explained the purpose of the study to the participant and outlined any reasonably foreseeable risks or benefits (where applicable).

Signed: Date:

Appendix D: Ethics Approval

Ethics Approval Email:

From: [UCL Ethics]
Sent: 26 March 2015 12:00
To: [supervisors]
Subject: Ethics Approved CEHP 2015/532

Dear X,

I am writing to let you know that we have approved your recent ethics application, "Clinical Psychologist's experiences of their role in social change."

The approval reference number is **CEHP/2015/532**. I have attached a copy of your application form.

Please note I have approved for five years as is our normal practice for departmental programmes.

I will keep the approved forms on file, and a copy has been lodged with the UCL Research Ethics Committee. Please notify us of any amendments, in line with guidance on the PaLS Intranet.

Best Wishes,

John King
Chair of Ethics, CEHP

--
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Appendix E: Interview Schedule

Practice to Policy

Interview Schedule

Thank you for agreeing to take part in this study, which aims to understand clinical psychologists' involvement in macro-level policy work. By this I mean work that moves beyond the more dominant practice of working with individuals to take a broader focus on health and social issues and public health. The study aims to address the knowledge gap between theory and practice, to understand the steps clinical psychologists in the UK have taken in their work. I hope to be able to produce some practical guidelines for psychologists as activist practitioners.

The interview will last approximately an hour. It begins by briefly mapping your career in clinical psychology to provide some context for your current work. It will then ask about one piece of macro-level work you have done, the steps you took and some of the things that helped or got in the way. It will also ask about the skills and competencies that you used in a piece of work. It concludes with your recommendations for the profession and ideas about the term "activist practitioner".

1. Mapping career paths

I would like to start by outlining your career path in clinical psychology. I am particularly interested in how your training and the jobs you have had have influenced your decision to adopt a transformative focus in your work.

1.1. Could you tell me how you got into clinical psychology?

1.1.1. What influenced your decision to train as a clinical psychologist? Any things that stand out? E.g. something you read, people you met, your experiences?

1.1.2. Where did you train? Did the training have any influence on your career?

1.1.3. What was your first job once you qualified?

1.1.4. What influenced that decision?

1.1.5. Where and when was your next job?

1.1.6. What was your first experience of working in a transformative way?

1.1.7. Did you encounter any influential people in your training or later e.g. supervisors, fellow trainees, clients, colleagues etc.

2. Policy Work

I would like you to talk about a piece of your work in detail in order to map the steps that you took.

2.1Can you describe one piece of macro-level transformative work (past or present) that you have been involved in? Start with how you how you framed the problems

2.1.1 What in your view needed to change?

2.1.2 How did you first put these ideas into action? Or where exactly did you start?

2.1.3 How did you begin to identify mechanisms for addressing these issues?

2.1.4 What was the first step you took to address the issues?

2.1.5 What alliances, partnerships and collaborations did you make?

2.1.6 Any skills you drew on in particular to do this?

2.1.7 What were the outcomes (positive and negative)?

2.1.8 What proportion of your time did you devote to this work, and how did you balance it with other parts of your job?

2.1.9 Any other skills you drew on that we haven't discussed? How they map onto your training?

4. Barriers and facilitators

I am interested in the some of the successes and challenges you faced in this piece of work.

3.1 What aspects went well?

4.1.1. Who and what has helped you in this work?

4.1.2. What did you do to get the most from the situation/person?

4.1.3. What personal or professionals skills did you draw on?

4.1.4. What were some of the things that got in the way of your work?

4.1.5. How prepared were you for these?

4.1.6. How did you deal with them?

4.1.7. Where there any skills you found you needed that you did not have?

4.1.8. Are there any other aspects of this work you would like to mention?

3. Competencies and training

I'm interested in the role of the clinical psychologist and what the profession might need in order to work in this way. I would like to know more about the general skills, competencies and training required in transformative work.

4.1.9. What do you think are the core competencies you draw on in this work?

4.1.10. Do you see these competencies as part of your role as a clinical psychologist?

4.1.11. How well did your clinical psychology training prepare you for this work?

4.1.12. What aspects of your training did you use?

4.1.13. What additional training have you undertaken? How did this help?

4.1.14. What have you read that you have found helpful? E.g. inside or outside psychology

4.1.15. Do you think any of these things would be helpful; on training course?

4. Recommendations

I would like to develop some guidance for the profession and I am interested in your recommendations

5.1 What recommendations would you make for the profession about engaging in transformative work?

5.1.1 What additional training might be needed?

5.1.2 How would you disseminate these recommendations?

5.1.3 What does the term "activist practitioner" mean to you?

5.1.4 Do you identify with it?

5.1.5 How would you define it?

5.1.6 Do you have an alternative term?

5.1.7 How could this term be adopted by clinical psychology?

6 Closing Section

That's all of my questions

6.1 Do you have any other thoughts about this topic?

6.2 How did the interview feel for you?

6.3 Can you identify any other potential interviewees?

Thank you very much for taking part in this interview. You are welcome to contact me at any time in the future if you have any additional thoughts. I may send you a summary of the themes I extract from you interview in order to check their accuracy. Would this be OK? Finally, I will send all interviewees a summary of the main findings of the study in the summer of 2016 when it is finished. Thanks again.

Appendix F: Participants Newsletter

PRACTICE TO POLICY

NEWSLETTER FOR RESEARCH PARTICIPANTS

FEBRUARY 2016

Happy New Year! The last six months have been incredibly busy on the research front. A number of you have asked for updates so I am trying out sending you all a newsletter. It has been great to bump into a number of you at conferences or network meetings and I have been pleased that there is a lot of interest in how the research is progressing.

RESEARCH TIMETABLE

June 2016 – submit doctoral thesis to UCL

September 2016- Viva

TITLE

I have dropped the term 'Activist Practitioners' from the study as several people objected, sometimes strongly. I am currently using the title 'Practice to policy: Clinical psychologists' experiences of macro-level work'. I hope this title captures the broad range of policy work that you are all involved in, not just activism. I welcome further feedback or comments.

RECRUITMENT AND INTERVIEWS

I have completed 34 interviews with clinical psychologists from across the UK. I have four final participants who are due to be interviewed in the next month. This is a significantly larger sample than originally anticipated but the uptake has been extremely high and we felt that it was important to hear from as many as you as possible and adding value to the research. I have interviewed clinical psychologists from a broad spectrum of areas including learning disabilities, child and adult mental health, neuro, substance abuse and addictions and health psychology. Participants have been engaged in regional and national policy (NHS, BPS and private health care), social action and international development work.

ANALYSIS

I am using Thematic Analysis to analyse the data. I have started the analysis and will have completed this by March 2016. I will contact you all with the themes from your interviews to ensure their validity.

CONSENT

As mentioned at the interview stage, you have the option to waive anonymity in the study. I will send you an additional consent form in March once you have agreed to the themes and quotes from your interview.

DISSEMINATION

Thank you for all of your helpful disseminations suggestions, we are in the process of thinking about how to take them forward. I am presenting the research at the DCP Pre-Qualification group conference on Community Psychology on the 11th March in Birmingham along with Dr. Kat Alcock (research supervisor and UCL DClinPsy). We will be presenting very general themes at this stage and it will be anonymised. I look forward to seeing a number of you there!

We are also in the middle of organizing a half day conference based as many of you suggested, on macro-level policy work in clinical psychology. We hope this will be a great platform to present themes from the study but also to have as many of you involved as we can. It will be in December 2016 at UCL and most likely be London based participants. Details to follow.

I also wanted to take this opportunity to thank you all for your time, enthusiasm and support. Please keep in touch and contact me if you have any further questions.

All the best,

Nina

For more information please contact Nina Browne (Principal researcher) or one of the supervisors to the study:

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