

Practice to Policy: Clinical Psychologists' Experiences of Macro-Level Work

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This paper derives from the first author's Doctorate in Clinical Psychology at University College London. It has been presented at several conferences in various forms.

Thanks to our participants for taking time out of their busy schedules to relate their fascinating professional journeys. Length constraints of this paper meant that we could do scant justice to the richness of their ideas.

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Abstract

Aims: Many clinical psychologists have ventured beyond therapeutic and assessment roles to undertake public policy work. However, little research has systematically examined clinical psychologists' roles in policy work and the implications of such work for the profession. This qualitative study examined the influences, processes, skills and knowledge underpinning policy work by clinical psychologists, and the challenges and facilitators encountered.

Method: Participants were 37 UK clinical psychologists, from a broad spectrum of specialties, who had engaged in public policy 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 analyzed using Thematic Analysis.

Results: The analysis yielded six themes, grouped into two domains: (1) 'Getting There', describing participants' professional journeys to policy work, including early influences and career paths, and (2) 'Being There' describing their experiences of working in this way, the challenges and facilitators in the process, and the skills and knowledge upon which they drew.

Conclusions: Clinical psychologists already possess core clinical and research skills that may potentially be adapted to work within broader political systems. However, they need to learn to use their existing skills in a different context, and also acquire some additional skills unique to policy-level work.

Public Significance Statement

This study investigates the experiences of 37 clinical psychologists who had moved from a purely clinical role to undertaking policy work. It examines their various professional journeys, and describes some of the challenges and facilitators involved in doing policy work.

Keywords: policy, social action, clinical psychology, psychologists' roles, qualitative

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

Clinical psychology professionals primarily work with individual clients in clinical settings (Hall, Turpin & Pilgrim, 2015). But it was not ever thus: Witmer (1907), the founder of US clinical psychology, conceptualized the role as extending beyond clinical settings, drawing on psychological knowledge in order to engage in preventative social action. However, the profession developed along different lines (Humphreys, 1996). Following the Second World War, psychological therapy started to become its core activity, and, although its theoretical models changed, from behaviorism through to the cognitive revolution, they remained focused on intra-psychic phenomena (Humphreys, 1996; Pilgrim & Treacher, 1992). Comparative analyses of the roles of clinical psychologists in the USA, the UK (Pilgrim & Treacher, 1992), and Ireland (Doren & Carr, 1996) confirm the predominance of intra-psychic approaches (Norcross, Brust & Dryden, 1992; Norcross & Karpiak, 2012; Norcross, Karpiak, & Santoro, 2005; Richards, 2015).

Progress has recently been made in understanding the impact of socio-economic factors, such as inequality, on health and mental wellbeing (Marmot, 2015; Pickett & Wilkinson, 2010; Prilleltensky 2012). The World Health Organization proposed that “A focus on social justice may provide an important corrective to what has been seen as a growing over-emphasis on individual pathology” (Friedli, 2009, p.7). However, unlike medicine, clinical psychology does not have a public health arm, and historically clinical psychologists have had limited involvement in health and social policy (Simon, 1970), in contrast to other professional groups. The American Counseling Association has developed the role of ‘social justice counselors’ (Ratts, 2009; Ratts, Toporek & Lewis, 2010; Toporek, Lewis & Crethar, 2009), and 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). The Public

Psychology Doctoral training model also provides a leadership community based framework (Chu et al., 2012) and application in community mental health settings (Carr & Miller, 2017). In psychology in general, there is a longer history of public policy involvement, with an increasing number of psychologists in US government positions and advocacy engagement (Garrison, DeLeon, & Smedley, 2017).

Clinical psychologists have, however, become aware of the distress that the social and economic environment causes to their clients (Barr, Kinderman & Whitehead, 2015; Harper, 2015; Harris, 2014; McGrath, Walker, & Jones, 2016). Many have been influenced by community psychology, which views psychological distress as arising within a social, cultural, historical and political context (Levine, Perkins, & Perkins, 2005; Orford, 2008), and some have drawn on these ideas in order to move 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 to conceptualize the complex systems that may impact on an individual's wellbeing. Originally proposed in a developmental context, it is now used more broadly (Harris, 2014; Nelson, Kloos, & Ornelas, 2014; Phillips, 2000), and can usefully be applied to the possible roles of the clinical psychologist:

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. interventions in partnership with a local community group
4. Macro-level: e.g. working to change state or 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. Nelson and Prilleltensky (2005) describe two main approaches to macro-level intervention: ameliorative and transformative. Ameliorative interventions work to

change policies relating to the treatment of individuals, such as by developing and disseminating more effective forms of therapy (e.g., Clark et al., 2009), whereas transformative interventions strive to change policies relating to broader social issues, for example, focusing on changing power relationships and oppressive structures (Jason, 2013; Nelson, 2013). However, identifying problems and then implementing remedial policy changes is not easily done. Multiple factors determine whether any given issue even registers on the political agenda (Kingdon, 2003), and then applying research findings to public policy is a complex, challenging, and time consuming process (Humphreys & Piot, 2012; Shinn, 2007).

Clinical psychologists working at a macro-level face a number of barriers. These are linked to the dominance of micro- and meso-level interventions in clinical training, as well as the structure and positioning of clinical psychologists within employing organizations. Hosticka, Hibbard, and Sundberg (1983) use the term ‘policy-knowledge gap’ to describe the lack of knowledge about policy within psychology. They found that clinical psychologists feared that policy work was ‘overly social’ and engagement with it might result in a loss of political neutrality. Researchers and policy makers also have different agendas and professional cultures (Caplan, 1979; Humphreys & Piot, 2012; Maton, Humphreys, Jason & Shinn, 2016; Shinn, 2007), which may make working together more challenging.

Much of the literature on psychologists’ roles in policy is theoretically based (Hage & Kenny, 2009; Schmidt & Nilsson, 2005) and we know little about the experiences of clinical psychologists who have worked at this level. Three exceptions are the volumes by Maton (2016), and by Kelley and Song (2016) focusing on community psychologists in the US, and by Sternberg, Fiske, and Foss (2016), focusing on eminent psychological scientists generally. These case studies present illuminating accounts of individuals who have succeeded in ‘making a

difference' (Sternberg et al., 2016); however, they do not attempt a systematic thematic analysis of their material.

Present Study

The present, UK-based study investigated the experiences of clinical psychologists who had engaged in macro-level work, particularly policy work. An exploratory qualitative approach, using thematic analysis (Braun & Clarke, 2006), was chosen, since little is known about this topic (Barker, Pistrang, & Elliott, 2016). The study examined how these clinical psychologists had moved beyond individualized approaches to engage with a range of policy issues: what processes were involved, what competencies were required, and what barriers and facilitators were encountered. It aimed to map their career paths from practice to policy, in order to better understand the role that clinical psychology can play in policy development.

Method

Recruitment Procedure

Participants were eligible if they were clinical psychologists qualified to masters or doctoral level who had engaged in macro-level policy work in the UK. They were recruited using purposive sampling and snowballing, in four phases:

1. Identifying well known clinical psychologists in the field. Initially, we identified clinical psychologists who had a high profile in macro-level policy work, using their publications, activity on professional networks, or their general reputation.

2. Informal survey of local psychologists. We asked the clinical psychology faculty on our university to identify clinical psychologists in their specialty areas who met the inclusion criteria. This helped to ensure that the final sample was drawn from a range of sub-specialties (e.g., intellectual disabilities, child and adolescent mental health).

3. *Snowballing*. Once interviewing had begun, a snowballing procedure was used, asking initial participants to identify other psychologists who met the inclusion criteria.

4. *Monitoring the emerging sample*. The emerging sample was regularly monitored to maximize its demographic diversity, on gender, ethnicity and age. Recruitment ceased when we had a substantial, broadly representative sample.

Potentially eligible participants were emailed about the study. Those who expressed interest were sent an information sheet and consent form. Signed consent was obtained on the day of the interview.

The study was approved by the University research ethics committee.

Participants

We invited 43 psychologists to take part; 37 (16 women, 21 men) were interviewed (two declined, three could not be interviewed within the time frame, and one withdrew after arranging the interview). Participants were between 30 and 84 years old, median 61.5 (the ages of four participants were not recorded.) They had been qualified in clinical psychology, mostly to doctoral level (the majority with PhDs), for between 1 and 48 years, median 34, but, in terms of macro-level skills beyond the purview of clinical training, they were largely self-taught. They had worked in a range of clinical populations, the most common being adult mental health, child and adolescent mental health, and intellectual disabilities. Most participants held senior positions in organizations that employed them or that they had started themselves, either in academia, in charities or social enterprises, in the National Health Service, or the Civil Service. Most were carrying out their policy work in addition to their main jobs. Many were responsible for initiating far-reaching policy changes or establishing new ways of delivering services.

Interview

The semi-structured interview schedule covered six areas: (1) career path and influences, (2) example of policy work, (3) barriers and facilitators, (4) skills and competencies, (5) training and recommendations, and (6) dissemination. Twenty-two interviews were completed face-to-face, twelve by video call, and three by telephone only. All were audio-recorded, with the participant's consent, using an encrypted electronic recording device. On average they lasted about an hour. They were transcribed using Express Scribe (NCH Software, Canberra, Australia); transcripts were password protected.

Data Analysis

Transcripts were analyzed using Braun and Clarke's (2006) approach to thematic analysis, which has a six-stage procedure: (1) familiarization of the data through repeated reading, (2) generating initial codes, (3) organizing 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. The NVivo software (QSR International) was used to support the analysis.

Researchers' Background

All authors are white British clinical psychologists, who take a pluralistic stance to their work and sympathize with community psychology values and the desirability of psychologists being involved in policy. The first author conducted this study as her doctoral thesis, under the supervision of the other three authors. In line with standard qualitative research procedures, we attempted to 'bracket' our preconceptions during the analysis and interpretation of the data (Fischer, 2009).

Results

The 37 participants provided vivid accounts of their individual journeys from practice to policy. The analysis yielded six themes (Table 1), 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. Participants had uniformly embarked on a professional journey, starting from standard clinical psychology practice and ending in positions with the potential to have a wider impact in society (see Box 1 for three specific examples). Their journeys involved forming collectives and collaborating with other professionals, policy makers, and service users to create rich learning experiences.

Box 1. Three illustrative professional journeys

Throughout his career, P9 has worked in positions that combine work in a university department with practice in the UK National Health service. He has been an influential advocate for a community psychology approach. His work has focused on the addictions, particularly gambling addiction, which he views as a political problem, highlighting the deleterious impact of the gambling industry. He has made frequent media appearances, and has given evidence to several government committees.

P31 is an early-career clinical psychologist who founded a social enterprise that pioneered a model of co-producing services with socially excluded young people. In addition to working at a community level, she has also been influential in shaping policy, acting as a mental health advisor and consultant to a number of agencies across central and local government, the UK National Health Service, police and the voluntary sector.

P36 started out working in the UK National Health Service and in university-based psychological therapy trials. She has had a longstanding interest in the application of research to clinical practice, and has led or contributed to a number of UK Department of Health policy initiatives. She has also been a longstanding activist for homosexual equality, highlighting aspects of gay identity and mental health.

In the following presentation of the thematic analysis, theme labels are italicized headings, sub-theme labels are in bold in the text, and P denotes the participant code number. Ellipses (...) indicate editorial omissions; square brackets [] indicate editorial comments.

Domain 1: Getting There

1.1 Early influences

Participants' decisions to enter clinical psychology arose from early influences, comprising **social and political ideologies**, and **personal values**

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)

Many were drawn to areas which emphasized social change and where social action was a central tenet, such as community psychology and intellectual disabilities. Regardless of their professional identification, they tended to view psychological distress in socio-political contexts and were keenly aware of the **limitations of individual therapy**.

I'd sit in the GP surgery [general practitioner's office building], 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)

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

1.2 Professional journey

As participants navigated their various clinical and academic positions they were proactive with a **propensity for change** that kept them motivated personally and professionally. They described developing a skill in **seeing opportunities and taking risks**. It kept their careers exciting while 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.

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. (P33)

Participants highlighted the importance of critically analyzing opportunities based on the level of wider impact they could have. Organizations' contexts facilitated their professional journeys. The majority described **facilitative organizations** 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. (P34)

In a similar vein, participants had been influenced by **inspirational individuals** whose work they admired and had direct or indirect contact with at pivotal points in their early career. 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)

Moving beyond individual practice to policy-level activities was a gradual and dynamic process of doing 'bits and pieces', often over the course of many years. This transition often began by putting oneself in **positions to influence**, e.g. sitting on committees, health boards, and becoming increasingly involved with professional bodies.

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)

Furthermore, as they began to **build a professional profile**, networks and areas of expertise, they were also invited to advise and contribute to policy work. Their careers had incorporated the dissemination of their clinical or academic work which made them more visible within and outside of psychology.

Domain 2: Being There

2.1 Facilitators: policy lessons learned

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

The importance of trusted relationships was fundamental. Unlike clinical practice, much of this work was unsupervised so it was vital to find allies in the form of mentors or informal supervisors who helped navigate the challenges. Participants stressed the importance of drawing on contacts, existing relationships and networks, formal and informal, when they needed a favor.

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 organizer]." So I said, "Can you set up a meeting?" (P31)

The policy work itself was not done in isolation, but relied on **collaboration**, the ability to bring people together, working in partnership. This enables participants to draw on expertise outside of their own skill set and knowledge base to have more power and influence. Defining one stand-out policy success was difficult when psychologists worked in teams.

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)

Participants saw a number of personal skills and attributes as helping them in their work.

Passion and perseverance appeared to create a 'perfect storm' within enabling contexts.

You want people who've got passion and a bit of humor 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)

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)

A degree of **confidence** was described as both necessary and facilitative in having a clear message and standing up to power.

It is a legitimate use of clinical psychologists' skills...I think mainly what stops people is not lack of competence, it's lack of confidence. (P17)

2.2 Challenges: Policy Lessons Learned

The policy context was described as difficult to navigate and understand when it did not form part of the professional training participants received. Working at the interface with policy makers and politicians exposed the differences between the professions, such as working to different timeframes and priorities. Policy makers often required brief and accessible information.

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)

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

Because it could take years to see the effects of changes in policy, participants found it hard to **measure the impact** of their work. The scale of the 'problems' being addressed in policy are distinctively different to clients in therapy, where outcomes are clearly defined and measured, even though that also brings challenges.

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 wider **power and politics** at play determined the scope, remit and outcomes of the work, and highlighted the potential tension of being both 'in and against' systems and policy.

It's very hard to do that [policy work] 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. (P15)

Competing for funding or research grants was described as challenging, as was the power of corporate industries and lobbying organizations 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 behavior. 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)

Professional constraints were experienced as a barrier to this work, such as the narrow remit, identity and structure of the professional bodies. Some participants said that being called a clinical psychologist was a hindrance, and did not use or identify with their professional title.

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)

Therefore, policy work came with **personal impact**, such as the 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.

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)

2.3 Developing Existing Skills and Knowledge

Participants drew on a large repertoire of skills and knowledge in order to have influence at a macro-level. They were mixed in their opinions on whether their clinical training had helped or hindered their work, but uniformly agreed that they had existing core skills that could be developed and oriented to be used differently. In the main, participants drew on existing **clinical skills and knowledge** in a broader and more flexible manner, such as formulating wider organizational systems or policy contexts rather than individuals and families.

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 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)

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 psychologist it almost comes naturally in a way. (P20)

It's important to use the methods we've been taught, accurate observation and description as you can judge by people's behavior 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. (P36)

Furthermore, they drew on their clinical knowledge to ensure the psychological impact of social and political structures were communicated to the wider public and policy makers. They also drew on their **research** skills, to produce, understand, and present research for evidence-based policy making. The ability to draw on research skills flexibly was crucial.

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)

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 other perspectives** and motivations of others.

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)

Participants emphasized the importance of needing to refine their ability to adapt their **communication** effectively, in a jargon-free way. This allowed them to be clear and concise to and reach 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)

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

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. Yet so much of clinical psychology is not part of the community. It's clinical. It's an hour a week. (P14)

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

The ability to put yourself in other people's shoes was seen as central in **consensus building**: the ability to hold a line, keeping in mind the change participants were trying to effect whilst respecting the range of views held by others.

If you want to be influential in policy, it's extremely important that you understand the etymology 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)

Consultation was also the skill of redressing power and deciding whose voices to privilege. Some participants emphasized the importance of grass roots policy change, and therefore shared experiences of putting marginalized voices at the center of the consultation process.

I remember he [colleague] 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)

2.4 Developing New Skills and Knowledge

Participants also drew upon skills and knowledge concerning their social, organizational and political understanding, as well as the advocacy required in the work. However, there was not a clear line between skills that did feature as a core part of clinical training and those already discussed. Participants had learned about **systems change** and policy 'on the job', and referred to needing skills in **strategy**, such as how to develop a clear vision, and set goals and targets. There were suggestions that training could bridge this 'policy-knowledge gap' (Hosticka et al., 1983).

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)

Population-level thinking, as opposed to a focus on individuals and families, led participants into **public health**. With additional knowledge on epidemiology, they could reframe issues in a way that required 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 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)

Discussion

These prominent clinical psychologists gave varied accounts of their professional journeys from practice to policy. One central message was that clinical psychologists already possess many of the skills needed to work at a macro-level: they just need to learn to use their existing skills differently, and also acquire some additional skills unique to macro-level work.

In clinical training, psychologists learn to formulate an individual's difficulties; macro-level work required extending this process to formulating an organization, or a policy context. A degree of self-belief also helped many participants: the importance of confidence as well as competence. However, all acknowledged the importance of sound preparation and hard work, so that their confidence was built on solid foundations. Exactly how confidence is acquired is unclear, but it appeared to come from a 'just do it' attitude, combined with feeling supported by one's professional network to take risks and make mistakes. The importance of developing and

nurturing trusting relationships with colleagues seemed fundamental (Jason, 2013; Maton et al., 2016; Shinn, 2007; Tseng, 2012).

Is macro-level work reserved for mavericks who have always been rebels, politically engaged, with the confidence to stand up to power? Although it is important to acknowledge these attributes, it is also important not to reinforce an individualistic view of clinical psychology, instead to 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 accounts, the culmination of these influences 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 being on the fringe of psychology, and instead regarded it as a valid, legitimate use of clinical psychologists' knowledge and skill set, and something everyone could be able to engage with.

Macro-level work can be conducted either from an ameliorative, or insider, position, or from a transformative, outsider, position (Nelson & Prilleltensky, 2005). The insider perspective was offered by some participants who were part of ameliorative policy development, at the heart of government systems such as the UK National Health Service and public health departments (Michie, 2008; Richardson, 2015). Other participants offered an outsider perspective on transformative policy change, attempting to challenge the status quo and power structures, developing campaigns, and giving a voice to marginalized groups affected by policy (Allen, 2013; Burton, 2013; Holland, 2006; Nelson, 2013; Zlotowitz, Barker, Maloney, & Howard, 2016). Maton (2016) refers to these as varying 'vantage points' from which psychologists choose to influence policy, working with different stakeholder groups to achieve the same outcome. These perspectives are both equally advantageous and are not mutually exclusive.

Limitations

The sampling procedure may have produced an unrepresentative sample, because it began with identifying clinical psychologists known to the researchers. We attempted to mitigate this problem by using a snowballing procedure and informal surveys of colleagues, which yielded a more diverse final sample in terms of both demographics and clinical specialties. However, it was a largely white sample, with only three ethnic minority participants; this limited the examination of the impact of race, culture, and ethnicity. The sample was predominately although not exclusively from late career clinical psychologists. Many participants had trained in the early 1980s and at the time of the study were 50-60 years old, which may limit how generalizable the findings are to contemporary training and practice. As many reflected, the opportunities that were available to them for innovation and leadership are scarcer now and this may bring different challenges and opportunities. Finally, the study was UK-based, and it is unclear how much its findings can be generalized to other countries and cultures.

Implications

The study aimed to use the experiences of these clinical psychologists to contribute to the development of macro-level competencies (Bronfenbrenner, 1979; Bevan, 1980; Burnes & Singh, 2010; Schmidt & Nilsson 2005; Singh et al., 2010).

Participants had mixed views on whether or not lists of competencies were helpful. 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 argument that macro-level competencies should be rigorously implemented and evaluated, if such work is viewed as a potential part of the clinical role. On the other hand, some participants were concerned 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 policy work.

Macro-level work does, however, call for a reconceptualization of the clinical psychologist's role, plus the acquisition of additional skills. Teaching from other social and applied disciplines, such as organizational psychology (e.g., Jex, & Britt, 2014), epidemiology and public health medicine (e.g., Berkman, Kawachi, & Glymour, 2014), community psychology (e.g., Orford, 2008) and political science (e.g., Kingdon, 2003) would be valuable. Clinical psychologists should also be educated about how their own power and privilege interacts with their research, practice, and policy work. Clinical placements in policy-orientated settings would provide useful practical experience. Box 2 outlines a possible syllabus for preparing clinical psychologists for undertaking policy work.

Box 2. A syllabus for preparing psychologists for policy work

Developing a toolkit for policy work

A workshop approach that builds on trainees' existing skills and knowledge will give them an opportunity to apply theoretical ideas to a practical policy-level problem. Asking them to focus on a policy impacting on the work they do in clinical placements or for their doctoral research will make this most relevant. This syllabus should be incorporated throughout training, rather than just as a stand-alone lecture, embedding this way of thinking and working into the curriculum.

Example exercises:

- Role of the psychologist: a reflective exercise that enables trainees to think about the profession's role in social change and whom this social change work should benefit.

- Formulation beyond individual practice: 'assessment' of a particular policy challenge, using the ecological systems level analysis.
- Working within and outside of public systems: planning the 'intervention' and methods that would be most helpful.
- Co-production: taking a non-expert position and facilitating other more marginalized voices impacted by the policy.
- Communication: summarizing research findings succinctly and clearly for journalists and policy makers, e.g., via press releases.
- Communication: practicing talking to a policy maker or journalist using a two-minute 'elevator pitch' task.
- Power and privilege training: understanding how social and economic inequalities, colonization and other oppressive structural forces affect our practices, services and policies.

Areas for additional teaching

- Public health and epidemiology, particularly focused on mental health inequalities.
- Political science, particularly focused on agenda setting and policy formation.
- Organizational psychology, particularly focused on leadership, strategy, innovation and scaling.
- Community psychology and its approach to systems change, particularly focused on working in partnership with communities and other agencies.

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. Some UK and US clinical psychology doctoral programs have started to offer such placements. Hopefully the evaluation and dissemination of the experiences of trainees on policy placements will contribute to developing the training recommendations.

Qualified clinical psychologists who wish to move towards macro-level work could further develop their practice and research skills by joining others outside of the profession. The findings suggest that a starting point is to critically appraise how the policy context impacts on their clients, e.g., in terms of health, housing, welfare, or social inequality (Burton, 2008; Jason, 2013; Marmot 2015). Certain contexts lend themselves more to policy work, such as, historically, in intellectual disabilities (Mittler, 2010). Clinical psychologists could also work alongside service users and carers from the grassroots of policy development. Given the importance of meso-and exo-level contexts, they could join with others to engage with the surrounding organizational and political systems.

There are also implications for professional bodies, who 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, professional development workshops and media training, as well as developing interest groups and task forces in areas of social policy. The American Psychological Association's Congressional Fellowships (<https://www.apa.org/about/awards/congress-fellow>) are an excellent exemplar of what can be offered. Such systems will ensure that the wellbeing of clinical psychologists engaged in challenging and complex policy work will be supported.

This study has highlighted around forty 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. It is important to ensure social action or policy work that is in addition to psychologists' main roles be captured.

Researchers could also develop ways to measure the impact of macro-level work, building on work on how to measure 'transformative' change (Kagan, Burton, Duckett, Lawthom & Siddiquee, 2011; Prilleltensky, 2012).

Conclusion

The ideas animating 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) and continue to do so (McGrath et al., 2016). Furthermore, community psychologists have written extensively on working at a wider systems level (Humphreys, 1996; Jason, 2013; Maton, et al., 2017; Orford, 2008), although macro-level intervention has received less attention. However, the present study provides a useful focus on the variety of individual journeys, complementing the extensive collection of US narratives assembled by Maton (2016).

The study sampled a unique grouping of clinical psychologists. Many had influenced the changing landscape of British clinical psychology and the UK National Health Service, including the expansion and development of the profession (Hall, Pilgrim & Turpin, 2015). They were central to some of the most significant policy decisions in the profession e.g. closing long-stay institutions (Mental Health Act, 1983), the Increasing Access to Psychological Therapies (IAPT: Clark et al., 2009), and the development of British community psychology (Burton, 2003; Orford, 1992, 2008). An unintended benefit of the study was the assemblage of a fascinating oral history archive of the development of UK clinical psychology, practice and policy, in what has been a relatively short yet transforming time for the profession. We plan to make this archive publicly available, subject to the necessary permissions. It is poignant that this cohort is now

making way for another generation of psychologists, so it is important that their accounts be preserved. We hope that their voices will inspire this next generation, who are currently setting out on their own professional journeys.

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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. Limitations of psychology and psychiatry
	1.2 Professional journey	1.2.1. Propensity for change 1.2.2 Seeing opportunities and taking risks 1.2.3 Facilitative organizations 1.2.4 Inspirational individuals 1.2.5 Positions to influence 1.2.6 Building a professional profile
2. Being there	2.1 Facilitators	2.1.1 Relationships 2.1.2 Collaboration 2.1.3 Passion and perseverance 2.1.4 Confidence
	2.2 Challenges	2.2.1 Measuring impact 2.2.2 Power and politics 2.2.3 Professional constraints 2.2.4 Personal impact
	2.3 Developing existing skills and knowledge	2.3.1 Clinical skills and knowledge 2.3.2 Research 2.3.3 Understanding others' perspectives 2.3.4 Communication 2.4.5 Consensus building 2.4.6 Consultation
	2.4 Developing new skills and knowledge	2.4.1 Understanding systems 2.4.2 Strategy 2.4.3 Public health