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The past, present and future of clinical psychology training

Abigail Methley, Francesca Sawer, James Randall-James & Joanne K. Persson

This article reflects on the past and present of the clinical psychology doctorate training programme, and looks ahead to the future in the context of the changes within the wider NHS.

THE NHS is changing; caring for an increasing population during funding cuts to services and widening disparities in access to care (Psychologists Against Austerity, 2015). Society's mounting recognition of psychological wellbeing has transformed clinical psychologists' roles and responsibilities from a reflective-practitioner model towards a reflexive approach to evidence and clinical practice (Hosking & Pluut, 2010). Trainees contribute to the NHS in many ways, providing new knowledge, skills and resources (Croft et al., 2013). As clinical trainees, we provide some reflections on the history of clinical psychology training, current training experiences and possible future directions.

The past

When clinical psychology was coined in America by Witmer in 1896, the first training course focused on educational psychology. W.H.R. Rivers is credited with bringing experimental psychology to England in the 1890s, and applied psychology in England reached new prominence in the first and second world wars through the need for explanations and treatment of 'shell shock' (Shepard, 2015). The history of clinical psychology after the Second World War has been summarised as comprising: application of psychometric techniques (1950–1958); behaviour therapy (1960s–1970s); and eclecticism (1970s onwards; Cheshire and Pilgrim, 2004).

The push for an empirical evidence base for psychology is by no means new; the first issue of the *British Journal of Psychology* emphasised the need for psychology to be a discipline based on 'facts' and 'positive science' (Ward & Rivers, 1904). In the emerging field of clinical psychology there was a tension between the 'healing' role of psychologists and the empirical role of psychologists as applied researchers, which still exists in clinical psychology training and practice today (Cheshire & Pilgrim, 2004).

Postgraduate clinical psychology training developed in three sites: the Tavistock Clinic and Institute of Psychiatry in London, and the Crichton Royal Hospital in Dumfries. In the 1960s and 1970s, training awarded master's level degrees before the introduction of a professional doctorate in the 1990s, which reflected the growing role of the profession of clinical psychology in the NHS (Cheshire & Pilgrim, 2004).

Applicants at this time looked to join a profession characterised by an integration of deductive and inductive approaches (Korchin, 1976). The use of general principles of psychological functioning to understand individualised client experiences, and vice versa, continues to be central to formulation in current practice (DCP, 2011).

The Trethowan report (1977) investigated the role of clinical psychology at a time when the profession was under scrutiny in the NHS. It stated that clinical psychology should be viewed as a distinct profession, with a structured career pathway focusing on clinical skills, research and teaching. Its recommendation

that psychologists work within local districts facilitated the movement of psychological care from hospitals to the community. It also questioned the role of psychology as a subsidiary of psychiatry, whilst clarifying that psychiatrists or other medical doctors would retain medical responsibility for patients (Barraclough, 1984).

The Department of Health requested a review of clinical psychology services in 1989, recognising that there was a need to increase the number of clinical psychology training positions (Management Advisory Service, 1989). It also provided an operationalised definition of the 'levels' of psychology practice ranging from Level 1 (providing basic psychological techniques) to Level 3 (specialist interventions requiring sophisticated understanding of theory), highlighting that clinical psychologists were the only clinicians to work across all three levels.

Agenda for Change (Department of Health, 2004) evaluated the roles of professionals in the NHS against a set of weighted criteria. Due to the doctorate level of training (and subsequent knowledge required for the role) clinical psychologists were allocated to higher pay bands than some other professions within the NHS, reportedly causing tensions between professionals (Wright, 2012). This quantification of skill set allowed managers to investigate less costly 'alternatives' to clinical psychology by using professionals with qualifications below doctoral level to deliver discrete areas of psychological intervention such as cognitive behavioural therapy.

…exposure to applied psychological services using alternatives to westernised or Eurocentric models…

The present

Since its gradual introduction from 2008, the Improving Access to Psychological Therapies programme has changed the delivery of mental health services, increasing access to evidence-based interventions for psychological distress in the wider population.

In Scotland, the increasing demand for access to psychological therapies led to the development of a new master's programme for Clinical Associates in Applied Psychology (CAAPs) in 2005. Similar to the doctoral level training, this postgraduate qualification prepares CAAPs to utilise a range of psychological models and theories to promote wellbeing and reduce distress. In contrast with clinical psychologists, however, CAAPs are trained to work within circumscribed areas of practice (e.g. adult or child) and with individuals presenting with mild-moderate levels of distress within primary care services (Quality Assurance Agency, 2006). Many current trainees gained experience and further education working within Improving Access to Psychological Therapies delivering low and high-intensity interventions and developing skills in the implementation of outcome measures (Turner et al., 2012).

To ensure a professional role beyond manualised therapeutic approaches (ensuring that the Level 3 criteria described in 1989 are still retained), current trainees develop skills in leadership, consultation, research and supervision (BPS, 2010) in addition to a repertoire of traditional (typically didactic) therapeutic competencies. Clinical neuropsychology is also an important aspect of clinical psychology training, with an emphasis on teaching trainees to choose, use and interpret neuropsychological tests (BPS, 2014). It constitutes a specialist skill and a relatively unique and protected selling point for clinical psychologists. However, where services focus on testing (at the exclusion of broader therapeutic skills and competencies), it may echo a time where clinical psychologists where employed primarily in a psychometric testing role, led by psychiatry.

Whilst clinical psychology has always had the unique skills to incorporate culture into formulations, some training courses have been progressing in recent years to include a greater focus on cultural models (e.g. African-centred psychology; McInnis & Moukam, 2013). This appreciates the diverse cultures of both clients and professionals by incorporating this context into formulation, intervention, evaluation and broader service provision, opening up dialogue and stimulating debate. The inclusion of elective placements abroad and exposure to applied psychological services using alterna-

tives to westernised or Eurocentric models has also increased opportunities for trainees to develop culturally sensitive competencies.

Social networking has transformed the experience of training (Coiffait et al., 2013), facilitating nationwide networking and presenting both challenges and benefits in negotiating the interface of trainees' personal and professional identities. It facilitates engagement in real-world and real-time debates regarding socio-political changes and policy, champions new ways of public and service user involvement, and increases dissemination of perspectives, experiences and research. This has encouraged trainees to become more creative in using different mediums to communicate complex ideas in clear, concise and engaging ways to the public and peers.

The recent decline in assistant psychologist positions suggests a change in the once traditional route of working as an assistant psychologist pre-training. Many psychology graduates perceive honorary assistant posts as a prerequisite for successful training applications, amid controversy regarding these posts potentially making clinical psychology more elite (Stuart et al., 2014).

> *Minorities in Clinical Psychology Training Group are essential for ensuring equitable access to training…*

Changing demographics of successful candidates may represent the increasingly competitive journey to training. For example, in 2014, candidates aged 25–29 years old had greater success in securing a place in training (57 per cent) compared to their younger peers (< 24 yrs; 24 per cent), in contrast to 44 per cent and 39 per cent respectively in 2005.

The future

There are many challenges and opportunities for the future delivery of clinical psychology training. There are an increasing number of non-funded places offered by some training providers in England (Clearing House, 2015). Projected reductions in funding for mental health services may affect commissioning of future training places (including the ratio of funded to non-funded places), potentially influencing cohort dynamics and increasing the perceived elitism of the profession that training courses have tried to reduce in recent years. This counters the recommendations from the Wells report (Scottish Government Health and Social Care Integration Directorate, 2011), which called for increasing the number of Applied Psychologists within Scotland. Moving to a bursary funded model of training instead of salaried posts may also discourage potential applicants with caregiving duties, and potentially raise issues regarding employee rights.

There is increasing recognition of the need to encourage applicants from minority groups. Initiatives like the DCP BME Mentoring Scheme (led by Alcock, 2014) and the DCP Minorities in Clinical Psychology Training Group are essential for ensuring equitable access to training, a diverse workforce reflective of all aspects of society, and potentially, increasing innovation (Kinouani et al., 2015). Indeed, the future of clinical training needs more initiatives like these, to support individuals from all under-represented groups (e.g. people from families/communities with low socio-economic status, and people who identify as lesbian, gay, bisexual or transgender). Likewise, providing support to mature applicants changing career paths may contribute to changing the landscape of psychology in novel and useful ways.

The introduction of the Health and Social Care Act (2012) in England, and subsequent tendering and competition for services that were once NHS provided, has increased awareness of clinical psychologists' role as independent practitioners. Working in the private sector has been suggested to have multiple benefits for people in the pre-qualification stage (see Gilligan & Methley, 2015), and will surely raise social, political and potentially ethical debates about maintaining a cohesive professional identity in the face of such heterogeneity. An increase of private sector training placements highlights contrasts in ethos, approaches to psychological wellbeing and requisite skill set to traditional NHS-based placements, providing opportunities to develop and test trainees' abilities to work flexibly across multiple service

providers. However, it will be a new approach for a profession so historically embedded within the NHS.

A possible impact of clinical psychology in non-NHS settings could be that it may allow greater dialogue of debates regarding political issues affecting communities and services users. Historically, employment by the NHS may have prevented widespread public criticism of governmental reforms. Clinical training and clinical trainees will need to address the role of psychologists in lobbying, commissioning and becoming more politicised in order to shape the future of clinical training and clinical psychology services.

The 2012 consultation process between the Society and the Health and Care Professions Council addressed the need for service user integration into educational programmes, including clinical training. The Group of Clinical Trainers' Annual Conference 2014 included talks on involving service users and carers not only in teaching but also in various roles in relation to placements, highlighting the increasingly appreciated benefits of service user involvement in training. Some courses now employ a service user representative (or committee) to fully integrate service users' perspectives within teaching and training, whilst others facilitate mentoring schemes pairing trainees with a service user representative to further develop their understanding of people's lived experiences and hopes for services. In the future, we believe (and hope) that services will be co-produced by those with the lived experience and that all training courses will involve service users.

Conclusion

In recognising the development of clinical psychology as both a scientific discipline and unique professional group, it is clear how the issues facing current and future training (e.g. evidencing practice, maintaining a clearly defined and autonomous identity), have been recurring themes throughout the history of clinical psychology training. At the 2014 DCP Annual Conference, the Pre-Qualification Group discussed their vision to 'build a platform for pre-qualified members [to voice] the challenges and possibilities' of their work. Clearly, the near future of clinical training presents multiple challenges for pre-qualified members, but also many more opportunities to become strong candidates for the qualified arena. As the Society President-Elect Peter Kinderman stated in 2013, 'the future for my profession is bright and positive… And I think that, in 2023, we'll see a robust, effective, [and] authoritative profession'. The challenge for clinical psychology training then, is to learn from the previous successes of clinical psychology and operationalise the skills of current and prospective trainees to build upon this future.

Authors

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