
Working effectively with clinical psychologists

John N. Hall

Most clinical psychologists and psychiatrists already work together constructively and cooperatively, although guerrilla warfare may describe the situation in some areas. This outline of issues affecting work with clinical psychologists, looking not only at a mutual awareness of each others' profession-specific knowledge and clinical skills, but also at an understanding of mind-sets and value systems, is aimed at further improving working effectively together, while not glossing over actual and potential areas of role-confusion and conflict between the professions.

Who are clinical psychologists, and what do they do?

Thirty years ago, when I began my training as a clinical psychologist, no-one could have foreseen either the major changes in the shape of the mental health services, or the developments in numbers and in treatment skills within the profession of clinical psychology over that period (Hall, 1993). Since psychiatrists work with flesh-and-blood psychologists, it is more practical to speak of their attributes and work, rather than finely hone an abstract definition of clinical psychology as a discipline. The number of clinical psychologists working in Britain has grown rapidly over the past 25 years – in 1970 there were 362 full members of the Division of Clinical Psychology of the British Psychological Society (BPS), and in 1996 there were 2982 members, most of whom work in the National Health Service in Britain. Despite this growth, there remains a serious national shortage, currently running at about 25% of all posts – although current personnel procedures make it difficult to establish accurate vacancy figures.

Within the NHS, three specialities – adult mental

health, children and young people, and learning disability – account for about 80% of all clinical psychology posts. Within the mental health field clinical psychologists may also work, for example, in the field of substance misuse – possibly associated with specialised services to HIV-positive patients – or in the growing field of forensic psychology. In all specialities, psychologists may be working in a community team, in a specialised unit or service, or in a 'central' service accepting GP referrals. In smaller Health Districts organisational patterns for services to smaller specialities vary quite markedly, so an incoming consultant needs to clarify exactly how psychological staff time is assigned to these specialities. One feature of the growth of clinical psychology has been the increased proportion of posts outside psychiatry, most obviously in the fields of neurology, physical disability, and general medicine (such as pain management, and oncology), so psychiatrists should be aware of any local clinical psychologists working outside the mental health services who may be a useful resource.

Training and career paths

Training structures for clinical psychologists have changed very rapidly in the past few years. Entry to postgraduate training courses is highly competitive, so that the majority of trainees bring with them several years experience either as nursing or care assistants or as assistant psychologists, and a significant proportion have postgraduate degrees or another professional qualification. Since 1990 three year courses have become mandatory, and in the last two years most courses have moved towards a 'practitioner doctorate' qualification – typically Doctor of Clinical Psychology. Special

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'lateral transfer' training arrangements exist for British professional psychologists experienced in another field of applied psychology who wish to transfer to clinical psychology, many of whom have previously been educational psychologists, typically with an excellent knowledge both of children and of the educational system. A 'statement of equivalence' is also issued to foreign clinical psychologists when they have satisfied training requirements: a Trust may not employ an overseas clinical psychologist in a qualified capacity who does not hold such a statement.

After initial qualification many psychologists will acquire additional qualifications, either academic (usually a part-time PhD on a clinical topic, or a part-time masters degree), or clinical (usually an advanced training in a specific therapeutic approach, such as the Oxford Cognitive Therapy Course). Given this range of backgrounds, it is well worth psychiatrists finding out what prior experience any new psychological colleagues have had, as they may possess skills or experience of value to the service, over and above that required within a particular post. The grading system for psychologists usually follows the nationally agreed 1990 Whitley Council procedures (DoH, 1990). There are no nationally agreed grade titles to correspond with a specific set of spine points, so a particular grade title – such as senior or principal – does not currently give a clear idea of the level of experience of the post holder.

Clinical psychologists as applied psychologists

An important issue in understanding the way in which clinical psychologists function is to understand the 'world-view' from which they start. Unusually among health-care professions, bachelors level degrees in psychology are non-vocational, so that unlike medical and occupational therapy students, psychology graduates have not been socialised into the health-care world. An explicit assumption in psychology is that explanations should first be sought from 'normal psychology', before looking for explanations assuming abnormality – a good example is the controversy about the nature of psychotic experience, as expounded by Bentall *et al* (1988). The knowledge base to which clinical psychologists appeal encourages cross-fertilisation with the worlds of developmental, social, occupational, and physiological psychology, as well as other disciplines such as sociology or physiology. Some

psychological theories lead to explanations of disordered behaviour which use language and practice concepts not found in medicine – an example being the Personal Construct Theory of George Kelly (1955), which views clinical interventions as mutual problem-solving between a research supervisor and a student, rather than as treatment by a therapist upon a patient.

An associated issue is the nature of psychological institutions, notably the British Psychological Society (BPS), which is the major British academic and professional body for all psychologists, and the professional body recognised by the Department of Health. Drawing on early philosophical, medical, and educational roots, it was originally, and remains, a learned society, with internal structures that reflect this as well as a professional institute. Within the BPS there are interest-based 'Sections' open to all members, such as the psychotherapy, and history and philosophy of psychology sections. There are also a number of professional 'Divisions', other than the Clinical Division – including the Occupational, Criminological & Legal, Counselling, and Educational & Child Psychology Divisions, for which there is no parallel within the Royal College of Psychiatrists. While these structures – themselves under review – can lead to difficulties in identifying which BPS and College subsystems should interact on particular issues, they also further contribute to the range of practice assumptions and applied knowledge from which clinical psychologists draw. This range of orientations and backgrounds of clinical psychologists may sometimes be uncomfortable, but it has certainly transformed important areas of psychiatric practice, and continues to offer creative potential for new forms of clinical understanding and interventions.

Roles of clinical psychologists in psychiatry

Clinical psychologists can occupy a number of role relationships with psychiatrists: as clinical colleagues, as management colleagues, as teachers and trainers, and as researchers and evaluators (see Manpower Planning Advisory Group 1990).

Clinical colleagues

For most psychiatrists the role of clinical psychologist as clinical colleague will be the most familiar, where they are seeing the same patients and

working in the same team, offering both direct clinical services and 'consulting' together. Most aspects of their work together will be guided by local unwritten precedent and practice, tacitly negotiated informally and implicitly over particular cases and incidents, often over a number of years. These relationships usually work well when staffing is stable and when workload is containable, but may come under pressure when new colleagues take up posts, or when workload and the associated stress become unacceptably high. It is always helpful for a team to put down on paper their working assumptions, consulting together to produce clear and succinct clinical protocols, available to providers and users of services alike. Key issues to clarify are referral procedures, communication guidelines, clear assignment of responsibility for action, and agreement about who should see which category of patient – this obviously depends on good communication about the clinical skills and interests of each team member.

What patient groups do they see?

Within each major patient group, clinical psychologists will typically see a subset of patients, which should reflect those conditions most amenable to a psychological intervention. Thus within the 'acute' adult mental health field, clinical psychologists are likely to see those with serious anxiety-related conditions, such as obsessive-compulsive disorder and phobias, for example. Within the learning disability field, they are likely to be involved with both high-need patients, who may present with highly demanding challenging behaviour, as well as with a community team, working with staff in residential and day settings as well as with patients and their carers in their own homes. Many clinical psychologists and psychiatrists develop special interests in less common conditions, such as compulsive gambling, and it is often helpful for a patient to see someone with special expertise in their problem, who may not be in the team where the patient has presented.

What treatments and interventions do they offer?

Over the past 20 years or so there has been a rapid growth in the range of available psychological interventions, and newly-qualified clinical psychologists will typically be trained in a number of these. Characteristically psychological interventions have developed from the classical-conditioning and operant-conditioning models of learning underlying, for example, token economies, passing through social-skills approaches and personal

construct theory approaches to the present dominant cognitive-behavioural orientation (CBT) (Hawton *et al*, 1989). CBT encompasses a very broad range of procedures, including, for example, problem solving and anger management, and subdivides into, for example, schema-focused approaches, and is being integrated with dynamic approaches, an example being Cognitive Analytic Therapy (Ryle, 1989).

Many clinical psychologists have interests in family or group methods or in a creative therapy, such as drama therapy, and a proportion pursue further training as dynamic therapists. Particularly in smaller Health Districts, away from a teaching centre, the clinical psychology service may contain the only staff with an advanced training in psychological therapies. In such circumstances the psychology service may become the natural base for clinical nurse specialists and counsellors, so that it becomes in effect a multidisciplinary psychological therapy service.

It is a matter of concern that the present emphasis on community services means that insufficient attention may be paid to the milieu in which patients pass their waking day, and there is considerable scope for psychologists to work in residential care settings, and to offer a range of services in day settings, as well as work with individual patients in these settings. Clinical psychologists may also be a resource for particular tasks. Thus clinical psychologists may be skilled in carrying out large-scale surveys of populations of patients to identify their needs; they may be skilled at designing treatment manuals and information booklets that are readable and user-friendly; or skilled at designing assessment methods, such as rating scales and questionnaires. There are many pitfalls in designing these measures, and from bitter experience I know that even experienced psychiatrists can design measures which are difficult to use in practice.

Management colleagues

Until the advent of general management within the NHS some 10 years ago, it was not possible for a clinical psychologist to venture into the higher reaches of NHS administration, although a small number achieved substantial influence locally by virtue of their clinical skill and sapiential authority. Since then a small number of psychologists have become full-time general managers, including a number of NHS Trust Chief Executives. More commonly, senior psychologists act part-time as locality managers or team leaders, in a planning capacity, as clinical directors, or hold responsibility

for Trust-wide functions, such as audit or quality. The senior psychologist in a Trust may also act as manager for other professions, such as occupational therapists. In all of these roles, it is important that general managers, psychologists, psychiatrists, and others alike, agree clearly the lead tasks to be performed, obtain the time and resources to do a decent job, ensure that professional lines of advice and accountability are clear, and communicate clearly with others. This in turn assumes that managers are sensitive to clinical issues, and of course are around for long enough to implement changes properly.

Teachers, trainers and supervisors

Most qualified clinical psychologists are to some extent trainers and educators. A clinical psychologist who has been qualified for two years is eligible to supervise trainee clinical psychologists, so trainees are often encountered while on placement. A good experience in a placement is itself one of the best recruiting aids, so psychiatrists have every incentive to be nice to trainees, particularly where recruitment is difficult! SHOs and registrars should have some direct contact with psychologists during basic training, which may include direct clinical supervision of cases by a psychologist.

Clinical psychologists may also have a formally agreed time commitment to formal post-basic courses – such as family therapy – or to the training and supervision of other health-care professions, such as community psychiatric nurses or counsellors. More experienced psychologists – usually at B grade – and consultant psychiatrists are an important resource for both their own and each others' continuing professional development after initial training. It is unfortunate that there is often little shared teaching between trainees of both professions, and most continuing professional training is usually pursued through the profession of origin. Multidisciplinary continuing education is an excellent means of bringing minds together, although psychiatrists may not realise the often pathetically small amounts of money available to non-medical staff for continuing professional development.

Researchers and evaluators

A glance at either the *British Journal of Psychiatry* or *Psychological Medicine*, quite apart from journals such as *Behavioural and Cognitive Psychotherapy* or the *British Journal of Clinical Psychology*, shows how much published research in the mental health field is done by psychologists. Published research is not

much use if no-one reads or applies it, so creating research-awareness within a service is valuable so that research can be critically evaluated for its relevance to local problems.

As far as conducting research is concerned, much can be carried out collaboratively, so the conceptual, clinical, design, and statistical skills of both professions are brought together. Collaboration can take place in every aspect of study, so both professions are mutual resources to each other. The recently introduced changes in the training of clinical psychologists mean that those now qualifying have more experience of clinical research and so should become a more useful resource in this field. Apart from traditional clinical research, which will itself become more necessary with the emphasis towards demonstrating good outcome and establishing 'clinical effectiveness', there is likely to be more pressure towards what used to be called 'Health Services Research', now subsumed under such titles as quality, audit, and evaluation. Far more sophistication locally in developing Trust 'R & D' policies will be required, where again a clinical psychologist may be a useful resource.

Clinical psychologists and you

An underlying theme of this article is that clinical psychologists and psychiatrists – and all other professional colleagues – should be a resource for each other. Our knowledge and experience should be available to each other, and our necessarily limited personal range of specific skills should be able to complement each other, so that we can offer a patient the person best equipped to help them. This requires space for non-competitive conversation and to explore issues of mutual concern. This cannot happen without time and places being given to it, whether it is within team meetings, or via pub lunches and snatched cups of coffee!

Areas of tension

Despite major improvements in relationships between psychiatrists and clinical psychologists, there remain areas of tension, and it would be idle to assume these do not exist.

Statutory responsibilities and protection

Clinical psychologists do not carry major responsibilities under the 1983 Mental Health Act (MHA).

While my own view is that many B grade clinical psychologists could accept responsibilities under the Act, and while some act as Mental Health Act Commissioners, they do not have to carry the burden of MHA duties, with all that means in terms of emergency assessments and on-call rotas. It is then easy for some psychiatrists to say that clinical psychologists do not know what life is really like, and for 'I am the RMO' to be produced as a trump card in a clinical discussion, and easy for some clinical psychologists to attack psychiatrists for responsibilities imposed on them by Parliament. The present Chartering arrangements for clinical psychologists (under the terms of the BPS Royal Charter of 1965) offer a high standard of protection for the public, although the BPS is currently preparing an outline Parliamentary Bill for statutory registration of all professional psychologists. There is little incentive for psychologists to additionally register as psychotherapists with the UK Council for Psychotherapy, unless they practice privately.

Coping with managerial and organisational boundaries

Until very recently, medical staff were responsible to an often remote District Medical Officer, usually drowning under paperwork, so that it was extremely difficult to find a common administrative point at which inter-professional issues could be discussed. The advent of Trusts means that medical staff are now employed by, and budgeted within, the Trust in which they work, so that both psychologists and psychiatrists are now usually subject to the same Trust Board, although some odd managerial arrangements exist, sometimes because local managers are aware of 'bad blood' between services. There is bound to be some variation in managerial arrangements, but they should all offer a clear route for negotiating assignment of staff and clinical time, perhaps through a formal service agreement.

The emergence of NHS Trusts, and new patterns of within Trust management, mean that organisational boundaries between specialities may have changed, not always with an improvement in continuity of care for users, and should be reviewed from time to time. Points of transition in care are often of high risk to the patient, so it must be clear how transfer of clinical responsibility is effected, and it is essential that psychologists and psychiatrists alike are clear about who is responsible for what managerially, and understand the local planning and contracting cycles and associated

deadlines. Some psychologists and psychiatrists have not fully absorbed the implications of the new-look NHS – whatever its merits and demerits – and do not seem to realise the damage they do to their own credibility by continuing to fight personalised battles against reasonable changes agreed by Trust Boards and local purchasers.

Who is responsible for what?

The hoary old chestnut of consultant responsibility for everything still comes up again and again. There is still a need to unpack the overlapping concepts of medical, clinical, professional, and consultant responsibility, and duty of care, and concede that members of individual professions will be sued according to the extent to which they are responsible for any negligence. The fact that in some districts there is, for example, no medical input into substance misuse teams, or no specialist consultant input into learning disability services, indicates that Trusts consider that some services can be run without a responsible medical consultant, and that other professions can exercise full responsibility for such services. This is not to say that this necessarily offers the best service to the population; simply that the old principle that there must be a consultant responsible for all clinical services is no longer tenable.

A specific issue relates to patterns of leadership within community teams. Hidden under vague and usually unarticulated phrases such as 'consultant-led CMHTs', and concepts such as team-leader and team coordinator are a range of arrangements for coping with different aspects of team-work, such as liaison with GPs, monitoring clinical activity within contracts, communication with the host NHS Trust, and budgetary control. Given that some teams are teams in name only, and would be better described as networks, there are bound to be a number of workable patterns of team leadership, so to advocate one model of leadership simply denies reality.

A subterranean tension partly justified by issues of clinical responsibility is that of salary differentials. A conundrum: consultant psychiatrists (especially those with merit awards) are paid more than clinical psychologists; clinical psychologists are paid more than clinical nurse specialists; a nurse specialist may be working autonomously and may be more skilled in an area than a consultant: justify this state of affairs. This issue is becoming real in deciding how to provide psychological therapies, and maybe should be more openly discussed?

Coordinating psychological therapies

A contentious issue is that of responsibility for psychotherapy within a Trust. Given the burden of general psychiatry, specialised work in the psychological therapies area is appealing, and seeing attractive areas of work being hijacked by other professions cannot be welcome. The length of time it took for the BPS and the College to produce the joint 1995 statement on psychological therapies suggests that it was not all plain sailing. That statement, while welcome as a statement of service standards, does not address the very obvious issue of direct inter-professional competition in this area, compounded by the growing numbers of counsellors, some of whom are very well-trained, attached to GP practices. It would appear that clinical psychologists and psychotherapists occupy the same space (in terms of a two-dimensional analysis) by severity of and the broad nature of presented problems, but differ in terms of the range of interventions they offer and the specific problems for which those interventions are most effective.

I suspect that patients want a skilled therapist, and are not too bothered about the profession of origin of the therapist. Given that advanced training in most therapies can be undertaken by both clinical psychologists and psychiatrists, it is hard to see the justification for a highly qualified psychologist being clinically responsible automatically to a possibly less experienced consultant psychiatrist, although there is clearly a need for meaningful coordination of services and assignment of resources. What patients want, and certainly what GPs want, is clear and honest information on therapies available and waiting times, and skilled therapists, and what they do not want is local sniping and point-scoring between professions.

Coping with high demand

Almost universally, psychiatrists and clinical psychologists face a high level of demand for their services. In both in-patient and day settings this results in high occupancy figures, which may in turn result in worrying difficulties in maintaining a safe environment and an active therapeutic milieu. For out-patient and community team work this results in very long waiting lists for clinical psychologists, possibly compounded by the proportion of patients who refuse psychotropic medication, which can become a cause of conflict.

Some head-on discussion of these issues, particularly relating to agreed clinical prioritising criteria, could defuse what some psychiatrists see as psychologists opting-out of this pressure by allegedly unilaterally choosing their own clinical criteria. Various other stratagems may help, such as early assessment before going on the waiting list or carefully considered negotiation with referring GPs on how to use any counsellors attached to their practice; but there is no easy or quick solution to increasing demand for an inadequate resource.

Summary

Have clinical psychologists been cuckoos in the psychiatric nest? They now certainly exist in the NHS in numbers and at a level of experience and competence which means that psychiatrists in all specialities must positively address how to relate to them, when they have not yet done so. The two professions have to accept different mind sets, and work to create open communication. We have to contribute to the creation of practice agreements rooted in the foreseeable reality of high demand, formal contracting for services, prioritisation of high-need cases, and demand for good outcomes and effective interventions by patient, referrer, and purchaser. We are capable of together offering a range and choice of services from a communality of interest and mutual respect.

References and reading

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The Division of Clinical Psychology of the BPS publishes *Clinical Psychology Forum* monthly, which is received by all clinical psychologists who are members of the Division. This journal is similar in style to the *Psychiatric Bulletin*, and contains both brief technical articles on matters of clinical practice, and also opinion pieces on controversial topics, including those covered in this article.

Multiple choice questions

- 1 How many clinical psychologists are members of the Division of Clinical Psychology?
 - a about 2000
 - b about 5000
 - c about 7000
 - d about 3000
 - e about 6000
- 2 What is the current dominant conceptual orientation of clinical psychologists?
 - b behavioural
 - a cognitive-behavioural
 - c cognitive-analytic
 - d psychodynamic
 - e family systemic
- 3 What is the current procedure for the professional registration of clinical psychologists?
 - a registration under the terms of a Royal Charter
 - b registration under the terms of an Act of Parliament
 - c registration under the terms of the Council for Professions Supplementary to Medicine
 - d registration by the Whitley Council
 - e registration by the United Kingdom Council for Psychotherapy (UKCP)
- 4 What postgraduate training is required for a psychology graduate to be employed as a qualified clinical psychologist in the NHS?
 - a any clinical psychology training in Europe
 - b any doctoral-level clinical psychology training in the world
 - c any British training as an applied psychologist
 - d three years supervised probationary experience
 - e clinical psychology training approved in Britain
- 5 What is one consequence of recent changes in the training of clinical psychologists?
 - a more emphasis on management
 - b more emphasis on specific therapies
 - c more emphasis on teaching
 - d more emphasis on clinical research
 - e more emphasis on non-psychiatric areas of work

MCQ answers

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| 1 | 2 | 3 | 4 | 5 |
| a F | a F | a T | a F | a F |
| b F | b T | b F | b F | b F |
| c F | c F | c F | c F | c F |
| d T | d F | d F | d F | d T |
| e F | e F | e F | e T | e F |