

# Clinical research under threat



According to **GLYN V. THOMAS, GRAHAM TURPIN** and **CAROLINE MEYER**, training clinical psychologists to doctoral standards has not prevented a decline in research.

It has been accepted for many years that clinical psychology courses should include training in clinically relevant research: the evidence-based 'scientist-practitioner' model remains central to clinical psychology in the UK (Kennedy & Llewelyn, 2001). The relatively recent move from two to three years of training was accompanied by the introduction of a doctoral qualification for clinical psychology. This development increased the relative importance of the research component: most British universities have long regarded a doctoral qualification as a research degree, so it was expected that training clinical psychologists to doctoral standards would increase the amount and quality of research they carried out.

But it seems that the transition to doctoral training has coincided with a decline in UK research in clinical psychology, and increasing difficulties in the delivery of good training in clinical research. Clinical psychology training courses and university psychology departments now find it ever harder to recruit clinically qualified staff with sufficiently strong research records to supervise doctoral research, and to contribute to the profession's future research base. It is also becoming difficult

for many clinical psychologists to meet the criteria for inclusion as 'research active' in the Higher Education Funding Council's Research Assessment Exercises (RAEs). This is a serious matter, given the enormous pressure on university psychology departments to gain the best possible research ratings and associated funding. The outcome may well be that clinical psychology research and training

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are no longer situated within mainstream academic psychology departments.

Another consequence of these difficulties could be that other clinical professions will come to surpass clinical psychology in their research skills and productivity. If clinical psychology does not reassert its own research credentials, its evidence base in the future may be constructed more by psychiatrists, physicians and nurses than by clinical psychologists.

It also seems to us that there are intellectual, educational and pragmatic reasons why psychology as a whole has a stake in the maintenance of high-quality clinical psychology research. In particular, there is value in promoting links between academic and professional psychology. The obvious intellectual benefits include the exchange of ideas, concepts and research expertise. Laboratory research has produced theories of cognition and behaviour that have been productively applied to mental health problems. In turn,

the clinical realities of promoting effective therapy and care have been an important stimulus to the development and refinement of these theories.

Furthermore, the continuation of a strong academic discipline depends ultimately on its meeting two conditions – its evident usefulness to society, and its ability to attract students. Clinical psychology services are certainly important for psychology to meet the first of these conditions. Student interest in clinical psychology is in a large part responsible for the continuing popularity of psychology as a first degree course. In the long run it is hard to imagine that psychology would maintain its present position were intellectual research leadership in clinical psychology to decline significantly. Consequently, the problems that we have identified should concern *all* psychologists, not just those with particular interests in clinical psychology.

## How has this predicament come about?

One obvious contributory factor has been the well-known national shortage of clinical psychologists. Unfilled NHS vacancies have provided those having clinical psychology qualifications with rapid career progression, and remuneration that looks generous compared with that for their academic colleagues. At the same time, however, the very same shortage has imposed considerable burdens on those employed as clinical psychologists – they carry workloads exacerbated by unfilled posts, and meet ever increasing organisational and service demands.

It is therefore understandable that clinical psychologists have had to make hard choices between the various claims on their professional time. It is also

This article arose from a meeting at the University of Birmingham. In addition to the named authors, the following were present, contributed to the discussion and commented on drafts of the article: Michael Berger (Royal Holloway, University of London), Mary Boyle (University of East London), Stephen Morley (University of Leeds), Chris Oliver (University of Birmingham), Peter Salmon (University of Liverpool) and Glenn Waller (St George's Hospital Medical School, London).

understandable that the claims of management and the needs of clients can often seem more pressing than the more abstract and intellectual demands of research. Producing research of a national and international standard is exceptionally demanding, and it will not be achieved in the evenings or on occasional research afternoons by overworked staff whose energies and attention are mostly taken up with other professional concerns.

Arguably, it is also becoming harder for young researchers to obtain funding for their research. Some traditional sources of support (such as the MRC and Wellcome) have become more difficult to access for individual clinical researchers because of the growing emphasis on programmatic research teams, and an evident shift away from clinical psychology research towards neuroscience. At the same time NHS research funds that were previously administered by the former regional health authorities have become more focused in their targeting of new research following the Culyer Report (1994). Furthermore, even when research output has been achieved, it is rigorously – and often critically – evaluated through peer review. Consequently, it is quite likely that a research novice will experience evaluation stress and disappointment.

Another pressure to be reckoned with is the recent focus on health services research and service evaluation (Turpin, 1994). Much of this research is directed at demonstrating treatment effectiveness, economic evaluation and service improvement. Although these are valuable goals in their own right, they seldom directly address psychological processes.

The findings are usually specific to a particular service or location, and disseminated through local reports, presentations and training workshops, as opposed to publication in peer-reviewed journals. Even if such publication does arise, it tends to have little national or international impact. Consequently, clinical psychologists employed in the NHS who are expected to prioritise service audit may find it difficult to develop strong research profiles.

There are some interesting comparisons to be drawn between research productivity in clinical psychology and that in other areas of the discipline. Generally speaking, most non-clinical psychology research is produced within academic departments of psychology that exist primarily to deliver undergraduate training and research productivity. Although there are specialised research institutes for psychology, these are relatively few. In contrast, although it is sometimes assumed that much clinical psychology research originates from postgraduate clinical psychology training courses, the majority of good-quality clinical psychology research in the UK is carried out in independently funded research units. Such units are frequently led by research chairs in clinical psychology, and usually only distantly related to clinical psychology training courses.

There are two interrelated explanations for the relative lack of impact of courses on clinical research productivity. The first is funding. Most staff are funded directly or indirectly by an NHS training consortium, whose managers often want to pay for training but not research. The second is the recent expansion in training, with

consequent understaffing and pressure upon course teams. Not surprisingly, there is then insufficient time for either publication or the writing and submission of research grants.

So what can be done to ward off these various threats to clinical research?

### **Building an infrastructure**

Of the external factors the most important is that of ensuring an adequate infrastructure for clinical psychology research. It is encouraging that research has recently taken on a more pivotal role within the NHS. The emergence of the doctrine of evidence-based practice (see, for example, Milne & Paxton, 1998; Reynolds, 2000), together with the demands of clinical governance, has repositioned NHS research within the government's priorities. There has been recent recognition that insufficient attention has been paid to the funding of research in nursing and professions allied to medicine (Department of Health, 2000) and in the negotiation of training contracts generally for the health professions (National Audit Office, 2001).

If NHS research and development priorities are to be met, it will be important to persuade NHS purchasers of clinical psychology training of the fundamental role that training courses could play in setting and supporting the research and development agenda. Accordingly, support for research ought to be a component of the clinical psychology training contracts agreed between the universities and NHS purchasers. Similarly, it is also important that the Higher Education Funding Council recognises the contribution of research-active clinical staff and provides for research support, as it does for other medical and health professions. Until recently, various anomalies existed in the research funding of clinical psychology staff, depending on whether they were based in departments of psychology or elsewhere (e.g. medical faculties), but fortunately these have now been addressed by HEFCE.

It is also a mistake to equate clinical psychology research productivity with output of trained psychologists. Members of course teams funded via NHS clinical psychology training contracts should be expected, and should have sufficient time and resources, to pursue their own personal research with grants and publications. Recent changes in the organisation of NHS research support following the Hunt Report (2000) may make it easier to establish partnerships between the NHS and universities. In addition, the greater emphasis by the NHS on high-quality

research brings its research agenda into closer alignment with the more rigorous requirements of the RAE. At the same time, there has also been a narrowing of the gap between applied and fundamental research in the RAE by including the views of users of research.

To sum up, if research and training within clinical psychology are not to become irredeemably split, it will be necessary that the funding and strategic aims of clinical courses embrace both activities. Similarly, if courses are to remain positioned in research-active, high-grade RAE departments – whether they are in psychology or in health sciences – it is also essential for research to be maintained as an important strategic goal for those courses.

### Unlocking student potential

There do seem to be tensions for many clinical psychology trainees around the research requirements of their courses. Some students are attracted by clinical rather than research roles; some are poorly prepared for research by their undergraduate programmes; and doing research can indeed be difficult and demanding. What can be done to resolve these issues?

The selection criteria for clinical psychology courses should perhaps be considered. On some courses these criteria weight maturity and ‘relevant’ clinical experience, which may often count against younger applicants with strong recent research backgrounds. Can we afford not to select candidates with good research credentials, particularly when the assessment of ‘maturity of approach’ or ‘personal suitability’ is seen by some as worryingly subjective? In any case, it is important that the selection criteria require a basic minimum level of competence in research design and analysis.

In relation to the selection of research topics, one solution is to actively guide trainees into areas in which there are established, ongoing programmes of research. This suggestion merely extends the strategy used in clinical training for selecting clinical placement supervisors. Trainees on placement carry out work in the same area as experienced supervisors, and the role of modelling and teaching appropriate clinical skills via an expert supervisor is generally not questioned.

Applying this model to research training will entail some loss of independence for trainees, but it has considerable benefits. First, trainees will find it easier to identify research questions that will be likely to lead to success in the thesis examination, to

outcomes of value to the service and to the participants, and to publications. Second, many of the practicalities (such as gaining access to participants) will have been previously resolved. Third, it will ensure that trainees have expert research mentors, who are fully aware of the relevant literature, the practicalities of clinical research in that area, and possible pitfalls in the methodology. Finally, a close match between a trainee’s research and the personal research interests of the supervisor should make the whole research experience more enjoyable, and encourage continued collaboration and joint publications even after the course is completed. One might hope that early success in publishing their doctoral work will encourage newly qualified clinical psychologists to remain active in research.

### Staff recruitment, retention and development

The final problem, that of recruitment and retention of clinical staff with strong research records, is probably the most intractable of all. It was perhaps inevitable that there would be a shortage of appropriately research-qualified teachers

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and supervisors as the entire profession in the UK made the transition from a master’s level to a doctoral level of clinical psychology qualification. One worrying possibility is that while the DClin enterprise has increased the minimum amount of research training received by all trainee clinical psychologists, it has reduced the incentives for a smaller number of clinical psychologists to pursue extended research training such as that offered by the traditional PhD. A long-term consequence of the introduction of a clinical doctorate may therefore be a reduction in the pool of well-qualified researchers in clinical and abnormal psychology.

Nevertheless, the existence of top-up doctorates might offset some of these effects by providing more realistic research training opportunities for practising clinicians than the traditional part-time PhD. Moreover, it remains to be seen

whether recent doctoral clinical graduates will be more research-active than their master’s degree predecessors.

It also bears repeating that the workloads of staff on training courses leave little time for research. To some extent, heavy course workloads are a product of the increasing trend to accountability and demonstrated value for money. With so many stakeholders, however, clinical psychology training is in danger of being audited to death. Many courses are subject to internal audit by their department or university, and to multiple external audits by the BPS (for accreditation), funding NHS Trusts (contract monitoring) and the Quality Assurance Agency. Furthermore, the expectation that different (and possibly all) stakeholders will be consulted on changes to a course’s structure and operation means that even uncontroversial developments may consume large amounts of everybody’s time.

A final twist to the story is the lack of a recognised structure to encourage more newly qualified clinical psychologists to build a research component into their career development. It would help, we think, if some basic-grade posts had sufficient protected research time (up to 50 per cent) to allow those who want to continue in research to do so. Because a supportive research environment is normally essential for research success it is likely, but not necessary, that such posts would be linked to a university department. Even though now in possession of a doctorate, individuals choosing to follow this research track would almost certainly benefit from a research mentor. Research achievement, not just activity, would have to be built into the job description of the post, and monitored via staff appraisal.

### Time to act

We recognise that not all these suggestions will seem acceptable to everyone, and many may be regarded as highly controversial. Certainly, it would be understandable if there were objections to the costs that some of our proposals would entail.

An alternative to the steps we have outlined would be to debate whether it is in fact necessary for all clinical psychologists to be trained at a doctoral level to continue to be research-active in their subsequent careers. The NHS workforce-planning agenda is moving much more towards identifying key skills and competencies that are considered important for the workforce, rather than relying on

professionally accredited qualifications. It is likely that the BPS criteria for someone to become a Chartered Clinical Psychologist will need to be related to a set of agreed occupational standards rather than to any specific type or level of qualification. These changes may also coincide with greater flexibility around levels of provision of psychological health care. The government has already indicated its desire to see graduate psychologists working within primary care. It may be that issues of cost and efficiency in training might be addressed by the creation of several levels of qualification and service provision.

Where will that leave the criteria for Chartered Psychologist status and university doctorate degrees? Greater flexibility around psychological qualifications and services might actually help ensure that the appropriateness of the doctoral standard for clinical psychology is upheld. However, there also needs to be careful consideration of a possible distinction between research and taught doctorates. Within the next five years higher education institutions will need to demonstrate that all degrees fit with the new QAA framework (QAA, 2001). Clinical

psychology training courses are inevitably moving in different directions, and some courses are explicitly reducing their research components. Questions arise, therefore, as to whether or how external examiners should maintain a common standard across different types of doctoral course.

Because of the far-reaching implications of such developments, we hope that this problem within training and the profession will be debated not just by clinical psychologists, but also by the wider psychology community. We would also hope that these issues are addressed urgently, because at present we can scarcely recruit enough clinical

psychologists with sufficient research experience to teach and supervise clinical psychology trainees to the level of a doctorate as currently defined.

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