TOM PARSLOE BSc Hons

CLINICAL PSYCHOLOGISTS' BELIEFS ABOUT THE PURPOSE OF THEIR PROFESSION IN RELATION TO THE WIDER MENTAL HEALTH SYSTEM: A CASE STUDY OF VIEWS ON NEW POWERS OF COMPULSION.

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Summary of the Project

Section A reviews literature regarding clinical psychologists' beliefs about their profession's role in relation to mental health services. It observes that such literature is surprisingly scant for a profession which promotes reflective practice in its training programmes, but that a debate about recently acquired powers of compulsion prompts some to articulate underlying beliefs about their profession and thus may provide a window into this under-researched area.

Section B takes as a case study clinical psychologists' beliefs about new powers of compulsion, and examines these in order to theorise their implied beliefs about their profession. Grounded Theory is used to analyse responses from a questionnaire survey and a focus group. The model explains beliefs about the powers as reflecting two underlying and opposing beliefs about clinical psychology's role within mental health services: belief in either the profession's transformative power or its vulnerability to assimilation by the discipline of Psychiatry. Strengths and weaknesses are examined. Implied beliefs about professional self-identity and organisational change, as well as possible explanations regarding ambivalence and motivation, are examined with reference to theoretical literature, before discussing clinical and research implications.

Section C examines lessons learned from the study, implications for clinical practice and areas for further research.

Section A: Literature Review Paper Contents

Section B: Empirical Paper Contents

Section C: Critical Appraisal Contents

Tables and Figures

Appendices

TOM PARSLOE BSc Hons

CLINICAL PSYCHOLOGISTS' BELIEFS ABOUT THE NATURE AND PURPOSE OF THEIR PROFESSION AND ITS RELATIONSHIP TO WIDER MENTAL HEALTH SERVICES

Section A: Literature Review Paper

Abstract

This review outlines the historical context of the British clinical psychology profession and its relationship with wider mental health services. Given current political developments which are pulling the profession in different directions, it examines and critically analyses the literature theorising and debating the role of the profession in relation to services.

The review first examines the view from leadership (e.g. Division of Clinical Psychology officers) and then the beliefs of others within the profession. The latter are organised into four conceptual continua, namely clinical psychology as: a separate psychosocial paradigm versus one which is compatible with that of wider services; separate from, versus implicated in a coercive system; a client-advocate role versus an expert role and a therapist role versus a consultant/leader role. The review then examines sociological theory which has been applied to clinical psychology.

A relative dearth of literature and debate in the profession is noted and possible explanations are considered. It is observed that a debate about the profession's recent assumption of statutory powers appeared to prompt many clinical psychologists to articulate their view of the profession. It is suggested that said debate could provide a useful window through which to further investigate the review area.

2.0 Introduction

This review will outline the historical context of the British Clinical Psychology (CP) profession and its relationship with mental health services. In view of current political developments which appear to be pulling CP in different directions, it will examine and critically analyse the literature theorising and debating the nature and purpose of the profession in relation to services. It will observe a dearth of theoretical literature and debate within and without CP before considering possible explanations and implications. It will conclude by observing that a debate about CP's recent assumption of statutory powers, which prompted a number of CPs to articulate their views about the profession, could provide a useful window into these beliefs.

3.0 Context

3.1 The Historical Development of British CP within Mental Health Services

British CP has been much influenced by its relationship with the National Health Service (NHS), its main employer, and in particular with Psychiatry (Lavender & Hope, 2011; Liddell, 1983; Pilgrim & Treacher, 1992). Its development has paralleled that of the state mental health system, where a medical perspective has often predominated (Pilgrim & Rogers, 2009). A biomedical perspective usually understands mental disorder as related to intracellular or synaptic processes, implicating dysregulated neurotransmitter functioning and therefore implying biological treatment i.e. targeting synaptic neurotransmitters (Kinderman, 2005a). Some (e.g. Pilgrim & Rogers, 2009) see the State as privileging a medical perspective in exchange for Psychiatry's statutory duties.

During its sixty year history, CP has undergone various transformations. After initially performing psychometric tests for Psychiatrists, it has traversed behaviourism, therapeutic eclecticism and managerialism, gaining partial autonomy from medical control

along the way (Pilgrim & Treacher, 1992). It has also steadily developed an individual therapy role and presence in community and primary care settings (Cheshire & Pilgrim, 2004; Hall & Llewelyn, 2006; Pilgrim, 2010). Today, various other roles include: supervisor, researcher, teacher/trainer, consultant and manager (Cheshire & Pilgrim, 2004).

This path could be viewed in various ways: the development of a unique, valuable and independent identity in services (Llewelyn, Beinart, & Kennedy, 2009), an attempt to escape a junior relationship with the older, more established profession of Psychiatry (Hall, 2007; Harper, 2010a), or alignment with the perceived "ruling discourse of the times" e.g. scientific, managerial etc. (Midlands Psychology Group, 2011, p. 32). Recently, the psychiatric profession has also been experiencing change.

3.2 The Power of Psychiatry Curtailed

Since a policy shift in the 1980s characterised by deinstitutionalisation and managerialism, psychiatric dominance has undergone a slow decline (Samson, 1995). A number of changes have arguably eroded its authority: voluntary sector service provision, consumerism, psychosocial interventions (e.g. Improving Access to Psychological Interventions (IAPT) (Department of Health (DoH), 2008), workforce development policies (e.g. New Ways of Working (NWW) (British Psychological Society (BPS), 2007b), the service-user movement, and the substitution of 'recovery' for 'containment' (Craddock et al., 2008; Pilgrim & Rogers, 2009; Samson, 1995). By 2000, the then President of the Royal College of Psychiatrists was suggesting that, with time, Psychiatry might even become supplanted by CP (Kendell, 2000). A more recent plea to recapture its former ascendancy (Craddock et al., 2008) can be interpreted either as biological Psychiatry's last gasp or a restatement of dominance. At the same time, the medicalisation of services under the

auspices of the National Institute for Health and Clinical Excellence (NICE) is arguably still discernible (Mollon, 2009).

3.3 The Reform of the Mental Health Act (1983)

Amidst such change a reformed Mental Health Act (MHA) (2007) recently received royal assent. Such legislation has historically provided legitimation opportunities for rival mental health professions (Pilgrim & Rogers, 2009). For example, the 1959 Act made compulsory detention a medical decision and the 1983 Act introduced an Approved Social Worker (ASW) co-assessing statutory role. Similarly, these latest reforms granted CPs new powers. By adopting a Responsible Clinician (RC) role, they can now perform the majority of functions formerly reserved for Psychiatrists under the 1983 MHA's 'Responsible Medical Officer' (RMO) role, taking responsibility for organising care where clients are subject to compulsion. They can also adopt an 'Approved Mental Health Professional' (AMHP) role, entailing similar powers and responsibilities to the former ASW role. Both of these new roles confer upon CPs the power to compulsorily detain clients. In addition to CPs, other mental health professionals such as Nurses, Occupational Therapists and Social Workers may also now assume these roles.

Whilst divergent in opinions, commentators seem to agree that the potential effects are far-reaching. Some (e.g. Cattrall et al., 2001; Joseph, 2007) fear that as with Social Workers or Educational Psychologists, who now spend much of their time fulfilling such responsibilities, statutory duties could completely redefine CPs and their traditionally collaborative client-relationships. Alternatively, the most recent Chair of the Division of Clinical Psychology (DCP) regards the recent granting of Approved Clinician (AC) status (competence to act as RC) to the first CPs, as a breakthrough for psychological treatment,

which challenges the accepted idea that mental healthcare is a legitimate offshoot of medicine (Kinderman, as cited in BPS, 2010).

3.4 Concomitant Political Developments

Uptake of this new role has so far been limited (Gillmer & Taylor, 2011). However, as Kendell (2000) observes, "it is in the nature of professions to seek to expand both their membership and the territory covered by their expertise" (p. 9). Therefore the role may eventually reposition CP more centrally within services. At the same time, the profession has also been profoundly affected by the emergence of IAPT. The new initiative is steadily drawing CP towards individual therapy, with British Association of Behavioural Cognitive Psychotherapy (BABCP) accreditation becoming increasingly considered in relation to CP training (Haddock & McDonald, 2011; Mollon, 2008; Moore & Amoako, 2010). Moore and Amoako (2010) suggest that IAPT has the potential to narrow CP, making it synonymous with cognitive-behavioural therapy (CBT). Therefore, CP could become pitted against lower-cost competitors (e.g. Nurse-therapists, Social Workers, Psychotherapists) just as the Government is implementing fiscal austerity measures. Pulled in such different directions, there is now a need to either agree or lay out the positions within the profession regarding its role and purpose in relation to mental health services. In other words, what is CP for?

4.0 Results of the Literature Search

4.1 The Nature and Purpose of British CP within Mental Health Services

4.1.1 The View from Leadership: DCP and BPS Guidance

Scrutiny of the DCP's (2010) Core Purpose and Philosophy of the Profession reveals that CPs are regarded as "scientist-practitioners" whose core purpose is "to reduce

psychological distress and to enhance and promote psychological well-being by the systematic application of knowledge derived from psychological theory and data" (p. 2).

Acton and Sinclair (2008) reflect on this definition with reference to the only psychological therapy in which all trainees must be trained: CBT, and suggest that the definition lacks clarity. They claim that CPs' levels of competence at using CBT to 'reduce psychological distress' in comparison to other (e.g. BABCP-accredited) practitioners may be unclear to outsiders. Furthermore, citing patchy implementation of the 'well-being' agenda and limited explanatory literature, they question CP's ability to pursue the core aims 'systematically'. They believe it consequently struggles to convey its purpose to other professions, relying instead on "a proximity model of influence: people only know what a CP does when they work with one" (p. 50). Hence, they advocate the development of a more communicable model.

Elsewhere the DCP (2010) explains: CPs "treat all people – both clients (across the life span) and colleagues – with dignity and respect and will work with them collaboratively as equal partners towards the achievement of mutually agreed goals" (p. 2). Yet how the possession of compulsory detention powers is reconciled with working collaboratively is unclear. The BPS (2009a) Code of Ethics and Conduct emphasises the imperative for protecting the public and meeting the legal requirements of one's role, whilst acknowledging that legal obligations may contradict (unspecified) aspects of the code. Similarly, the amended BPS (2009b) Code of Practice MHA 1983 acknowledges competing duties of care between the RC and therapist roles, but neither of these documents seem to satisfactorily resolve these conflicting aims.

Regarding other mental health professions, "occupying leadership roles" (DCP, 2010, p. 4), enabling them "to develop psychologically-informed ways of thinking" (p. 4) and facilitating "organisational change" (p. 7) are all promoted. Wider applied psychologist

guidance encouraging effective team-working (BPS, 2007b) supports the idea of increased integration of CPs within teams, with a caveat about remaining critical of the medical model. The document avoids taking a clear position by advocating constructive conflict and explaining that the level of integration depends on the context.

Similarly, a DCP-commissioned project (BPS, 2007c) aiming to determine commissioners' and service-managers' needs so as to devise a CP marketing strategy, found that some of CP's main weaknesses were "a lack of clarity regarding roles and expectations as well as issues around integration into teams" (p. 29).

Given such opacity and the possibility that leadership rhetoric may not always reflect the range of views within the profession, individual CPs' published views will now be documented.

4.1.2 The View from Within the Profession: Individual CPs' Beliefs

Within the profession, there is a dearth of literature theorising or debating the nature or purpose of British CP in relation to services. Within the limited debate that has taken place, four continua appear to be discernible, regarding the extent to which CP is believed to be: compatible with vs. separate from the service paradigm; implicated in vs. separate from coercive practice; to have a therapist vs. a consultant/leader role and to have an advocate vs. an expert role.

Compatible with the Service Paradigm or a Separate Psychosocial Paradigm

Some authors (e.g. Bentall, 2009; Boyle, 2007; Harper, Cromby, Reavy, Cooke, & Anderson, 2007; Kinderman, 2005b; Slade, 2002) are critical of the biomedical model and/or psychiatric nosology, which they perceive as the predominant paradigm within services. They see CP's conceptualisation of mental disorder as an alternative to this. For example, Bentall

(2007, 2009) and Boyle (2002, 2007) believe research data is insufficiently reliable or valid to justify primary biological or genetic explanations of mental disorder or psychiatric diagnostic systems. Boyle (2007) argues that diagnosis distorts research by encouraging a focus on deviant individuals as the cause of disorders, ignoring socio-economic or circumstantial factors (e.g. BPS, 2009c; Lund et al., 2010) and limiting prevention. Psychiatric services justify coercively treating some of these individuals on the basis that they lack 'insight' regarding their condition. Rogers and Pilgrim (2010) see this concept as usually "defined in a circular way: that is, insight means that a patient agrees with their psychiatrist" (p. 171).

Furthermore, CPs normally formulate (integrate information and use psychological theory to generate frameworks for understanding problems) rather than diagnose (Hall & Llewelyn, 2006). They emphasise the importance of meaning-seeking, seeing distress as partly due to context and one's ability to understand it (Llewelyn et al., 2009). Some (e.g. Harper et al., 2007; Slade, 2002) observe that the bio-psychosocial model, a holistic model which understands mental health problems as resulting from interactions between physiological, social and psychological factors (Gilbert, 2002) is, in title, the dominant service model, but in practice, the biomedical model usually predominates and psycho-social factors are considered as secondary, if at all.

Miller, Morley and Shepherd (1987) claim that most CPs are critical of this state of affairs and Gelsthorpe (1999) suggests that CPs "are employed...to offer a different perspective; we are paid to disagree" (p. 16). Similarly, Newnes (2004) regards CP's role as opposing and critiquing the medicalisation of distress that occurs through diagnosis. Lavender and Hope (2011) argue that the surest means for reducing this diagnostic discourse is through the use of formulation.

Yet commentators (e.g. May, 2007; Pilgrim, 2011) observe that CPs still commonly use diagnostic categories e.g. 'schizophrenia' or 'depression', leading Newnes (2004) to criticise such behaviour as "compliance" (p. 374) and Boyle (2007) to entreat CPs to "abandon diagnosis" (p. 290). In contrast, certain other CPs (e.g. Congdon, 2007; Scott, 2007) voiced objection to a special issue of the BPS in-house publication The Psychologist which had critiqued psychiatric diagnosis. They argued, for example, that diagnosis enjoys practical advantages over formulation and that the evidence-base for CBT is diagnosis-specific, not generic. Such views might indicate a greater perception of compatibility with the service bio-psychosocial paradigm, presumably with acceptance of the need for coercion in cases of limited 'insight'. Alternatively, they could indicate pragmatism: challenges to the medical model are often simply rejected (Johnstone, 1993) and eschewing services' daily parlance of diagnosis for formulation can diminish credibility or impede inter-disciplinary communication (Pilgrim, 2008a).

Miller et al. (1987) elucidate a further dichotomy between the contrasting notions of 'treatment' (a short-term intervention reversing a malfunction) and ameliorative or rehabilitative intervention ("enabling functioning in important areas of life as satisfactorily as possible and, if necessary, despite the existence of the basic problem") (p. 241). This relates to a recovery model (Anthony, 1993), which stresses the importance of regaining valued roles rather than trying to 'get better'. Similarly, a positive psychology framework rejects concepts of illness and treatment in favour of enabling 'well-being' and building resilience or strengths as a social, educational and political intervention. This moves beyond services themselves by operating in community settings (Joseph, 2007; Linley, Joseph, Harrington, & Wood, 2006; Wood & Tarrier, 2010).

Some community or critical CPs (e.g. Coles, Diamond, & Keenan, 2009; Cox & Kelly, 2002; Diamond, 2008; Hassall & Clements, 2011a; Newnes, 2004; Smail, 1990)

criticise CP for focussing on individualistic explanations of distress at the expense of environmental / societal factors. They argue that this effectively helps Psychiatry maintain a status quo which marginalises people. Coles et al. (2009) dub CP "the magician's assistant" (p. 5), suggesting that it helps Psychiatry create an illusion by obscuring external causes of distress. Some believe CP to be intimidated by the political implications of targeting the latter (Hagan & Smail, 1997) and using threat avoidance strategies (Boyle, 2011).

Consequently, certain authors theorise CP as they believe it should be e.g. "an environmentalist psychology" (Smail, 1990, p. 8) or "a critical, questioning psychology" (Diamond, 2008, p. 13). For these CPs, psychological help is seen as ideally providing comfort, clarification and encouragement (Smail, 1993), developing more meaning in individuals' lives through linking with others and identifying personal strengths (Diamond, 2008) or power sources (e.g. family, social life, material and personal resources) (Hagan & Smail, 1997; Smail, 1990). CP is exhorted to help reduce distress at a personal, social and political level (Smail, 1990) and collaborate with communities according to societal rather than professional interests (Diamond, 2008).

Exactly how representative these critical views are is unclear. Certain authors acknowledge their significance, whilst pointing to resource constraints (Burns, 2011), regarding them as "voices in the wilderness" Emerson (2008, p. 14) or as offering inadequate explanations of how to intervene at a macro or societal level (Roy-Chowdhury, 1991). But as Smail (1995) correctly spells out, "What CP has not done...is develop a consistent theoretical position of its own, i.e. one which accurately reflects its practice within...a large, essentially free public health service." (p. 3). He fears that this will prove a tactical error as interdisciplinary competition grows.

Separate from versus Implicated in the Coercive System

Debate regarding the introduction of the RC role starkly illuminated internal disagreement as to whether CPs regarded themselves as separate from the system seen as coercive, or as implicated in the enforcement of a necessary social control function (e.g. Joseph, 2007; Markman, 2002; Pilgrim, 2005).

The first position is evident in assertions that CP is essentially collaborative and more effective if non-coercive (e.g. Cattrall et al, 2001; Holmes, 2002; Diamond, 2007) e.g. playing a counterbalancing 'critic' to Psychiatry's 'surveillance / enforcer' role (Diamond, 2007). Diamond (2007) believes that remoteness from coercive practices has allowed CP to serve a function of facilitating internal dialogue and independent questioning. A similar position is taken up by Smail (1995). He sees a lack of formal powers as the chief factor shaping CPs' NHS role, leaving them relying on persuasion skills rather than force. He also perceives them as distinctive in being trained not only to understand evidence but also to think more critically than doctors.

In contrast, Lucas (2003) argues that "implicitly, coercive power is present in all relationships between mental health workers and service-users, due to the very existence of the MHA" (p. 1). Some (e.g. Johnstone, 2006; Pilgrim, 2005; Taylor, Gilmer, & Robertson, 2003) see coercive practice as an undesirable but necessary task, which CPs should not leave to other professions to carry out.

These opposing views might partially reflect contrasting beliefs about the viability or effectiveness of compulsory treatment. On the one hand, Cattrall et al. (2001) and Holmes (2002) underline the importance of motivation and trusting relationships for successful intervention. Given this and the environmental nature of some causes of distress, they regard psychological therapy as unenforceable. On the other hand, whilst little mentioned in the

published debate, operant principles (Skinner, 1938) might suggest that some coercive treatments could be effective. Furthermore, many CPs do use psychological therapies in forensic services, prisons and with offenders on remand or probation.

However, coercive treatment (whether with psychotherapy or medication) has been largely uninvestigated empirically, presumably due to methodological and ethical problems (Sjostrom, 2006; Winick, 2008). Existing findings with different populations have been inconsistent (Durham & La Fond, 1988; Katsakou & Priebe, 2006; Molodynski, Rugkasa, & Burns, 2010; Opjordsmoen et al., 2010; Swartz et al., 1999; Steadman et al., 2001). Accordingly, commentators within British CP variously suggest that coerced treatment is: of unclear effectiveness (e.g. Holmes, 2002), ineffective (e.g. Cattrall et al., 2001), less likely to be effective than voluntary treatment (e.g. BPS, 2008), or that in the case of mandatory community treatment for intellectual disabilities, it can be effective (Gillmer & Taylor, 2008).

Polemics about CP's positioning regarding coercion may also reflect disagreement over the way mental health services are sometimes used. Of particular relevance here is the Government's use of legislation to preventatively detain people who have not necessarily committed an offence but have a diagnosis of 'personality disorder' and are considered dangerous. Some (e.g. Cooke, Harper, & Kinderman, 2001) contest the scientific basis for this diagnosis, express concern about professional ability to predict risk with sufficient accuracy to warrant detention (e.g. Cattrall et al., 2001; Holmes, 2002) and point out that others not subject to such discrimination are statistically as dangerous (Harper, 2004a). Various commentators (e.g. Cohen & Baldwin, 2000; Harper, 2006) regard this as enabling the transfer of responsibility for an aspect of social control to clinicians by bypassing Psychiatry, which has often considered such difficulties 'untreatable' (Pilgrim, 2005).

Parallel controversy has surrounded the Government's introduction of a conceptual, rather than diagnostic category for high risk individuals: 'dangerous and severe personality disorder' (Department of Health and Home Office, 1999). This has been criticised as a politically contrived medicalisation of violent behaviour (Pilgrim & Hewitt, 2001; Cooke et al., 2001) for resolving the 'prison or health service' dilemma (Rogers & Pilgrim, 2010), with limited effectiveness (Tyrer et al., 2010).

Furthermore, Psychiatry's statutory function has been accompanied by a higher status and salary within the system (Pilgrim, 2007a). Levenson (2001) notes positively, that statutory powers might also enhance these for CP. However, not all share this reaction. Diamond (2001, 2007) perceives CP as imitating Psychiatry, by gathering power through: discussion about minimum prescribing rights; the doctorate qualification; increased salaries under Agenda for Change and the AC role. He therefore fears that the profession may become more interested in self-aggrandisement, which he feels would undermine its critic role.

A Therapist Role versus a Leader/Consultant Role

Thirdly, some CPs may identify primarily with the role of therapist (Mollon, 1989; Hassall & Clements, 2011b) or "therapist/assessor" (Emerson, 2008, p. 13), whilst others might see their role more as promoting psychological thinking in services as team consultants (Dilks, Smith, Doherty, Lala, & Estall, 2009) or leaders (Bullock, Buffham, Coysh, & Nienaber, 2010; McCarron, 2001).

This tension has been described as "one of the key features of the profession" (Turpin, 2008, p. 9). Its traces can be seen in the Manpower Planning Advisory Group (MPAG) review of CP in the 1980s and in the IAPT (DoH, 2008) and NWW (BPS, 2007b) initiatives. MPAG argued that CPs were mostly used as therapists but would be more cost-effective

offering consultancy and training (Pilgrim, 2008b). Their view of CP as "a resource for other professions" has led to the consultancy model (Hall & Llewelyn, 2006, p. 13). Consultancy can be seen as distinct from an expert role as it aims to draw out the consultee's skills rather than advise them. However this could also be seen as a tactic for competing with other therapy professions (Lake, 2008).

Dilks et al. (2009) theorises some CPs' experiences of work in community mental health teams as managing "a tension between being a generic member of the team and preserving a unique contribution as a psychologist (balancing integration and separation with the team)" (p. 28), whilst broadening the perspectives available. This involves carrying out clinical work whilst also adopting a consultancy role and shifting a team's perspective away from a medical model towards a psychological perspective. Bullock et al. (2010) report that trainee CPs perceive CP as becoming more leadership-oriented (BPS, 2007a) and feel expected to embrace leadership roles, but perceive barriers to CP leadership of teams. These include: the medical profession's dominant position in teams, a lack of leadership / management training and a perception that other professions may not properly understand or respect CPs. CPs also still face managerial pressure to deliver therapy, as this can be monitored to measure performance (Hassall & Clements, 2011a) e.g. through payment by results.

This continuum between therapist and promoter of psychological perspectives was thrown into sharp relief, again, during the debate over the introduction of statutory powers. Many opposing the development cited a threat to therapeutic relationships (Cattrall et al., 2001; Diamond, 2002; Holmes, 2002), whereas those in favour consistently cited the potential for increasing the influence of psychological models and access to psychological therapy within the system as their chief reason (Black, 2001; Gillmer & Taylor, 2008; Taylor et al., 2003; Pilgrim, 2005).

A Subversive Client-Advocate versus an Authoritative Expert

Finally, some CPs emphasise an advocate role (e.g. Bell, 1989; Clements & Hassall, 2008; Markman, 2002) and others an authoritative 'expert' role (Cheshire & Pilgrim, 2004; Ussher, 1992). Accordingly, Smail (1995) defines CPs as "benign pro-patient scientist-practitioner(s)" (p. 4), who play a kindly, but subversive role within the system, obtaining solidarity with disempowered clients by helping them resist labelling, stigmatisation and oppression. Similarly, others (e.g. Diamond, 2007; Holmes, 2006; Kinderman, 2005b) seek to reduce the prevalence of electro-convulsive therapy, prevent poly-pharmacy or help clients control and make decisions about their medication.

Miller (1995) perceives the subversive / advocate role as often resulting from conflicting objectives for employers and CPs (e.g. managerial goals versus healthcare goals). He suggests that other mental health professions actually share this problem and that CPs should, rather than opposing them, be trying to stimulate collective action for restraining managerial power. Advocating for clients by campaigning for improved services therefore challenges the status quo, which can threaten individual career prospects (Clements & Hassall, 2008). Such considerations prompt Smail (1995) to wonder whether CP is a "liberatory practice or discourse of power?" (p. 3).

This power is perhaps most enshrined in the expert role, which is defined in different ways. MPAG identified CP's defining feature as 'Level III skills': a flexible, generic knowledge of psychology allowing the use of various theories for devising bespoke strategies to deal with complex difficulties (Huey & Britton, 2002). But whilst valuing Level III skills, Kinderman (2001) believes it is 'formulation' skills more specifically that distinguish CP from other professions. Alternatively, others observe that formulation is also referred to and

practiced in Psychiatry (Crellin, 1998; Lake, 2008) whilst Newnes (2004) comments: "formulation...seems to mean thinking about things" (p. 361).

CP is also seen as a 'scientific' expert: a scientist-practitioner (Llewelyn et al., 2009; Raimy, 1950) with a "clinical attitude" (Huey & Britton, 2002, p. 72). Echoing Lake (2008), some (e.g. Cheshire & Pilgrim, 2004; Pilgrim & Treacher, 1992) regard both scientific credentials and Level III skills as helping to justify superiority over competing professions.

However this expert role can effectively distance CPs from clients (Newnes, 2004) and some believe that CPs seek refuge in this role due to insecure professional identities (Mollon, 1989; Soffe, 2004). Mollon (1989) theorises CP in intra-psychic terms: engaged in an Oedipal struggle with paternalistic Psychiatry and Psychoanalysis, in which the expert scientist role reflects both a delusion of omnipotence and an institutionalised defence against contact with clients' emotional pain.

A tension therefore exists between whether CPs are guided by (and exercise power on the basis of) their expert skill and knowledge or service-users' decisions (Hall & Llewelyn, 2006; Newnes, 2006; Soffe, 2004). Both perspectives have perhaps gained favour as the service-user movement and evidence-based approaches have grown (Hall & Llewelyn, 2006).

Furthermore, a tendency to take over is seen as often sabotaging CP's advocacy role (Newnes, 2004). Harper (2010b) regards CP as mistakenly conflating its interests and service-users', when these do not always coincide. Illustrating this, he argues that CP widened its roles in the MHA (2007) at the expense of the inclusion of an impaired judgment clause, when the latter was more in service-users' interests. Some (e.g. Kinderman, 2005b) believe CP's unique expertise justifies the adoption of statutory powers whereas others feel the powers may compromise CPs' advocacy role (Markman, 2002) or support of human rights (Pilgrim, 2003).

Some of this relatively thin debate from within CP has drawn on psychological or CPs' own theories. We will now turn to theory from without the profession.

4.1.3 The View from Without the Profession: Sociological Theory

From sociology, wider post-structuralist accounts (e.g. Foucault, 1965, 1977; Rose, 1990) of mental health services in 'disciplinary' terms are well known. Marxian and feminist critiques of British CP can also be located (Pilgrim & Treacher, 1992; Ussher & Nicolson, 1992). But broadly speaking, these tend to emphasise state, class or gender interests more than CP's relationship with services itself.

However, a Weberian perspective (e.g. Freidson, 1970; Saks, 1983) has a particular focus on relationships between professions. This framework views professions as implementing two status-enhancing strategies: social closure (denying other groups access using esoteric knowledge and monopoly) and professional dominance (enjoying a power-imbalance over dependent clients and assuming power from competing professions by: subordinating, excluding and limiting the powers of equal groups or arrogating roles from superiors) (Rogers & Pilgrim, 2010).

A neo-Weberian analysis has been applied to British CP (Pilgrim & Treacher, 1992; Rogers & Pilgrim, 2010) as follows. Regarding social closure, CP is seen as having used MPAG in 1987 by recommending that it conduct the review (in the hope that MPAG would define a special level of expertise for CP). Since the 1970s CP has also sought a State-sanctioned monopoly of psychological practice through a campaign for psychologists to be statutorily registered. With respect to professional dominance, it challenged Psychiatry's therapeutic monopoly regarding behaviour therapy in the 1950s by attempting to corner the treatment of neuroses; increased its autonomy from Psychiatry with the Trethowan Report

(Department of Health and Social Security, 1978) and assumed a psychiatric role with statutory powers in 2007 (Pilgrim & Treacher, 1992; Rogers & Pilgrim, 2010).

4.2 Possible Reasons for the Thin Debate and Lack of Theoretical Literature

From this Weberian perspective, CP could seem relatively opportunistic, meritocratic and self-serving. Whilst, understandably, professions attend to their own interests to an extent (Smail, 1995), this might be consistent with the absence of theoretical literature and the relatively thin debate. Indeed, some critical authors (e.g. Cox & Kelly, 2002; Newnes, 2004; Burton & Kagan, 2007) perceive CP as avoiding self-examination, whilst evincing: "remarkable concern with status", "extreme pragmatism", (Burton & Kagan, 2007, p. 34), undue concern "for its own professional self-aggrandisement" (Diamond, 2008, p. 3) and an apparent readiness to "serve the powers it (identifies) as essential to its survival" (Midlands Psychology Group, 2011, p. 32).

Alternatively the thin debate and absence of theoretical literature could indicate confusion over professional role and identity. For example, despite the scientist-practitioner model, there is a lack of available resources for research (Kennedy & Llewelyn, 2001) and most CPs fail to publish scientific work regularly (Orford, 1995; Pilgrim & Treacher, 1992). Furthermore, the increasing segmentation of CP, with its diasporic subdivisions, specialties, client groups, and theoretical orientations could produce identity confusion (Cheshire & Pilgrim, 2004). Mollon (1989) believes confusion has been caused by the widening of CP beyond its original psychometrician role because this has removed any central function. He also believes that CPs have resisted having their role defined. Pilgrim and Treacher's (1992) description of some CPs' responses to the MPAG Review observes that some may perceive considerable political value in remaining inscrutable e.g. less accountability if their role and

expertise are difficult to define. Alternatively, entrepreneurial CPs could be seen as having developed multiple identities for CP by entering new areas.

One more possible explanation for the lack of literature is worth considering. CP can be seen as historically tending towards a non-critical naive realist position (Harper, 2008) for reasons of political expediency (e.g. bolstering its scientific legitimacy and status) (Atkin, 2010). A preference for empirical quantitative studies on clinical samples and a detached clinical stance (Pilgrim, 2008c, 2010) may therefore have impeded self-theorising in CP.

4.3 Problems with the Lack of Self-Reflection

However, such a detached stance can prevent critical thought about CP's societal function (Pilgrim & Treacher, 1992). Kidner (2001) argues that, like all professions, psychology has an unspoken political ideology and that denying this or maintaining awareness of it are both political acts. He points to the development of psychology in Nazi Germany as an example of how the detached neutral stance can become ethically problematic. Similarly, Pilgrim (2008c) argues that self-reflection is important for professions both to maintain shared ethical directions and survive. It also facilitates individual awareness of the influence of personal agendas or beliefs on client-interactions (Chinn, 2007).

Echoing this, a reflective-practitioner (Schön, 1987) training model, has emerged to jointly underpin CP training alongside the earlier, less critical scientist-practitioner model (Hall & Llewelyn, 2006; Harper, 2004b; Huey and Britton, 2002). But despite this, Pilgrim (2008c) highlights the absence of even a clear forum for self-reflection within British CP, criticising the British Journal of Clinical Psychology*'s* editorial policy of disallowing theoretical pieces on professional issues. He suggests that such limited reflexivity has resulted in, inter alia, insufficient awareness of CP's socio-historical context, inadequate criticism of the theoretical incoherence he sees within CBT, and engagement in research

based on psychiatric categories rather than psychological formulations (Pilgrim, 2010). This all suggests a need for greater self-theorising within CP.

5.0 Conclusion

This review has identified a paucity of theoretical literature and rigorous debate regarding CPs' beliefs about the role of their profession in relation to mental health services. There is no clear institutional recognition of this as a central issue and attempts by leadership to clarify such beliefs often use indistinct, abstract generalities which seem unhelpful when values clash. A number of belief continua include CPs as: compatible with or separate from the service paradigm; implicated in or separate from coercive practice; therapists or consultants/leaders and advocates or experts. Inter-disciplinary power relationships and professional self-interest have also been considered. However the debate appears thin in terms of the number of available forums, the number of contributors, the depth of contributions and the lack of clarity regarding their representativeness of ordinary CPs' views. Such limited self-examination is concerning in a profession which works with vulnerable client groups and purports to value self-reflection, as beliefs about the profession are likely to influence behaviour, whether with clients, teams or research. It is also especially problematic at the present time. With political developments pulling CP in different directions amidst declining health service funding, the ability to cogently articulate the current purpose and societal value of CP may prove critical.

One way of addressing such beliefs would be to look at a concrete example in a case study. Several participants in the debate locate the introduction of statutory powers in the context of broader views about CP's relationship with mental health services. Given CP's coterminous existence with the NHS, the latter could be said to have essentially been CP's raison d'être thus far. But various CPs appear to believe that statutory powers could

fundamentally change that relationship, either in positive or negative ways. Therefore, exploring views about this development as a case study could be highly revealing of CP's central concerns, revealing how its implicit beliefs, values or goals are actually expressed and enacted in practice. These could be used to contribute to the theoretical literature regarding CP by theorising CPs' beliefs about the purpose of their profession in relation to services. Developing such a theory could inform leadership decisions regarding action and policy, enabling clearer communication to straitened healthcare commissioners, services and the public of CP's societal value and purpose.

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Clinical Psychologists' Beliefs about the Purpose of Their Profession in Relation to the Wider Mental Health System: A Case Study of Views on New Powers of Compulsion.

Tom Parsloe

Canterbury Christ Church University

(For submission to Clinical Psychology & Psychotherapy)

Abstract

Despite the profession's putative reflexivity, little theoretical or empirical literature addresses British clinical psychologists' beliefs about the nature of their profession and its relationship with the wider mental health system. This study examined attitudes towards one new development – the adoption of compulsory powers – in order to discover the implicit beliefs that clinical psychologists draw upon in practice. Written comments from 292 clinical psychologists responding to an earlier questionnaire survey were analysed using Grounded Theory, together with data from a focus group.

Two contrasting constellations of belief emerged. Some clinical psychologists appeared to believe in the profession's ability to transform services from the inside by opportunistically accreting power. Others appeared to believe in a need to defend the profession against assimilation, by maintaining separate spaces for more collaborative relationships. These overarching beliefs were associated with different beliefs about specific issues, namely professional identity, its compatibility or otherwise with coercion, where power is located and what drives organisational change.

These findings suggest a need for greater professional self-examination. They are considered with reference to organisational, sociological and psychological literature. Limitations and areas for further research are discussed.

Key Practitioner Message:

- British clinical psychologists differ in their beliefs about the function of their profession in relation to wider mental health services.
- Some believe in clinical psychology's power to transform the wider system. Others believe that the profession is vulnerable to assimilation within a system that is sometimes antithetical to its values.
- The profession needs to articulate and debate these conflicting sets of beliefs further.

Keywords: Clinical psychology, Purpose, Mental health system

Clinical Psychologists' Beliefs about the Purpose of Their Profession in Relation to the Wider Mental Health System: A Case Study of Views on New Powers of Compulsion.

British Clinical Psychology (CP) has been much shaped by its relationships with the National Health Service (NHS) and Psychiatry (Pilgrim & Treacher, 1992), having developed concomitantly with the state health system, where a medical perspective frequently takes precedence and Psychiatrists hold statutory powers (Pilgrim & Rogers, 2009).

Since its initial ancillary role performing psychometric tests for Psychiatrists, it has undergone transitions through: behaviourism, therapeutic eclecticism and managerialism (Hall, 2007; Rogers & Pilgrim, 2010). Partially extricating itself from medical control, CP has developed an increasing individual therapy role and primary care presence, with additional roles now including: supervisor, teacher/trainer, manager, researcher and consultant (Cheshire & Pilgrim, 2004; Pilgrim & Treacher, 1992).

This trajectory might be variously explained as the emergence of a unique, independent identity in mental health services (Llewelyn, Beinart, & Kennedy, 2009), an unsuccessful attempt to escape a subordinate role to Psychiatry (Harper, 2010), or alignment with the perceived "ruling discourse of the times" e.g. scientific, managerial etc. (Midlands Psychology Group, 2011, p. 32).

Since the 1980s, Psychiatry has also experienced change. Its dominance within mental health services has arguably been weakened by deinstitutionalisation and the rise of: managerialism, voluntarism, consumerism, the service-user movement, psychosocial interventions e.g. Improving Access to Psychological Interventions (IAPT) (Department of Health (DoH), 2008), workforce development policies e.g. New Ways of Working (NWW) (British Psychological Society (BPS), 2007) and a move from 'containment' to

'recovery' (Craddock et al., 2008; Pilgrim & Rogers, 2009; Samson, 1995). This trend has prompted speculation that CP might someday supplant Psychiatry (Kendell, 2000) and more recently, a 'clarion call' to re-establish medical hegemony (Craddock et al., 2008). Yet arguably, the medicalisation of services still continues (Mollon, 2009).

Within this context a reformed Mental Health Act (MHA) (2007) was recently introduced. Such legislation has historically proffered opportunities for bids for power from competing mental health professions (Pilgrim & Rogers, 2009). Accordingly, the Reform has granted CPs and other professions new powers. By adopting a Responsible Clinician (RC) role, CPs can now perform the majority of functions formerly reserved for Psychiatrists as part of the previous 1983 Act's 'Responsible Medical Officer' (RMO) role, taking responsibility for implementing compulsory care plans. They can also adopt an 'Approved Mental Health Professional' (AMHP) role, entailing similar powers and responsibilities to the former Approved Social Worker (ASW) co-assessing role. Both new roles carry powers of compulsory detention.

This acquisition of statutory roles is a potentially significant development, which some (e.g. Cattrall et al., 2001; Joseph, 2007) fear could redefine CP. They worry that CP may become less collaborative and, as happened with Social Work, eventually spend much of its time fulfilling statutory responsibilities. Others view it differently, as an opportunity to challenge the notion that mental healthcare is a legitimate offshoot of medicine (e.g. Kinderman, as cited in BPS, 2010). These arguments appear to reflect slightly different underlying beliefs about the fundamental nature/purpose of CP. Therefore, examining CPs' beliefs about this issue might provide insights into an important, under-researched area, namely CPs' beliefs about the nature/purpose of their profession in relation to the wider mental health system.

This issue is perhaps particularly germane today when CP appears to be facing a number of changes or threats. The IAPT initiative appears to steadily pull it towards individual therapy, with training increasingly oriented towards British Association of Behavioural and Cognitive Psychotherapy (BABCP) accreditation (Haddock & McDonald, 2011). This risks narrowing the focus of the profession and synonymising CP with cognitive-behavioural therapy (CBT) (Moore & Amoako, 2010), when competitors for its provision e.g. Nurse-therapists, Psychotherapists, Social Workers are often cheaper. With ongoing fiscal austerity measures to boot, it would now behove CP to clarify its role and the way in which it can contribute to mental health services. In other words, what is it for?

The Nature and Purpose of British CP within Mental Health Services

In attempting to answer this question, we will now examine statements from leadership i.e. BPS/Division of Clinical Psychology (DCP) officers, before documenting the debate from within and without CP.

The view from leadership. The DCP (2010) describes CP's core purpose as "to reduce psychological distress and to enhance and promote psychological well-being by the systematic application of knowledge derived from psychological theory and data" (2010, p. 2). "Occupying leadership roles" (p. 4), enabling other professions "to develop psychologically-informed ways of thinking" (p. 4) and facilitating "organisational change" (p. 7) are all advocated.

CPs are also said to "work with [all people] collaboratively as equal partners towards the achievement of mutually agreed goals" (p. 2). However, it is unclear how collaboration is reconciled with statutory powers. The British Psychological Society

(BPS) Code of Ethics and Conduct (2009a) emphasises public protection considerations, whilst acknowledging potential contradictions between legal obligations and the code. The amended BPS MHA Code of Practice (2009b) acknowledges competing duties of care between the RC and therapist roles. But these documents do not appear to resolve satisfactorily how individuals might reconcile these contradictory roles.

The view from within CP. Elsewhere there appears to be a dearth of literature theorising British CPs' beliefs about their function within mental health services. From a thin field, one view is of "benign pro-patient scientist-practitioner(s)" (Smail, 1995, p. 4), kindly but subversive client-advocates who are distinctive in their critical ability, expert understanding of evidence and lack of formal power. Others see them as 'critics' counterbalancing Psychiatrists' 'surveillance / enforcer' role (Diamond, 2007), or authoritative 'experts' (Cheshire & Pilgrim, 2004), distinctive in their use of formulation skills (Kinderman, 2001). CPs are also seen as torn between therapist and consultant roles (Turpin, 2008) and theorised as balancing integration (generic membership) and separation (preservation of a unique contribution as a psychologist) with their teams, whilst broadening the teams' perspectives (Dilks, Smith, Doherty, Lala, & Estall, 2009). Some perceive themselves as increasingly expected to adopt leadership roles but facing barriers to these e.g. a dominant medical discourse within teams (Bullock, Buffham, Coysh, & Nienaber, 2010). Alternatively, Mollon (1989) theorises CP in terms of an Oedipal struggle with Psychiatry and Psychoanalysis.

Certain commentators (e.g. Coles, Diamond, & Keenan, 2009; Cox & Kelly, 2002; Hassall & Clements, 2011; Smail, 1990) believe that CP maintains the status quo with Psychiatry by focussing on individualistic explanations of distress, rather than

environmental/societal factors. Boyle (2011) perceives this is a threat-avoidance strategy and encourages CP to apply its own theories to itself i.e. through exposure. Others partially theorise CP as they believe it should be e.g. "an environmentalist clinical psychology" (Smail, 1990, p. 8), a counter to medicalisation (Newnes, 2004) or "a critical, questioning psychology" (Diamond, 2008, p. 13). But as Smail (1995) observes, in contrast to medicine, "What CP has not done...is develop a consistent theoretical position of its own, i.e. one which accurately reflects its practice within...a large, essentially free public health service." (p. 3, emphasis in the original).

The view from without CP. British CP has also been theorised using sociological theories of professions (Pilgrim, 2011). The neo-Weberian approach views professions as employing two status-enhancing strategies: social closure (denying other groups access by means of esoteric knowledge and monopoly) and professional dominance (enjoying a power-imbalance over dependent clients and wrestling power from competitors e.g. by arrogating roles from them) (Rogers & Pilgrim, 2010).

Regarding social closure, CP could be seen as having capitalised on the opportunity presented by the Manpower Planning Advisory Group in 1987 by recommending that it reviewed the profession, in the hope that a special expertise level would be defined for CP. From the 1970s until recently, CP also sought a state-sanctioned monopoly of psychological practice through a registration campaign. In professional dominance terms, it challenged Psychiatry's therapeutic monopoly by attempting to corner the treatment of neuroses in the 1950s, subsequently obtaining greater autonomy from Psychiatry with the Trethowan Report (Department of Health and Social Security, 1978) and assuming one of Psychiatry's roles with statutory powers in 2007 (Pilgrim & Treacher, 1992; Rogers & Pilgrim, 2010).

Explanations for the lack of theoretical literature and debate. This analysis could be regarded as indicating relatively self-interested behaviour. Indeed, critical views (e.g. Burton & Kagan, 2007; Diamond, 2008) and the thin debate/paucity of theoretical literature would be consistent with this. However, expansionary behaviour is quite natural in professions (Kendell, 2000) and additional factors e.g. the preferences of research commissioners (Harper, 2008) or scientific journals (Pilgrim, 2010) (empirical quantitative studies, clinical samples etc.) may inhibit CP's self-examination. Pilgrim (2008) suggests that CP lacks clear forums for self-reflection.

The Rationale for a Case Study

Self-reflection can be seen as facilitating a profession's ethical direction and survival (Pilgrim, 2008). Accordingly, a reflective-practitioner model (Schön, 1987) does underlie CP training (Hall & Llewellyn, 2006; Harper, 2004; Huey and Britton, 2002). Yet, surprisingly little theoretical/empirical literature exists regarding British CPs' beliefs about CP in relation to psychiatric services and the debate seems thin. Guidance documents appear contradictory and unclear, whilst political developments propel CP in different directions. As fiscal austerity measures unfold, the ability to articulately communicate the purpose/societal value of CP may prove pivotal. Theorising the profession better might enable this.

One potentially significant change to CP's role has recently taken place, namely the acquisition of statutory powers. In taking positions on this issue, CPs may be forced to articulate implicit beliefs that they draw upon in practice. Therefore, a case study examining CP's beliefs on this issue may help the profession to theorise and articulate its fundamental nature/purpose.

CPs' Beliefs Regarding the New Powers

During the proposal stage for the reforms, various authors debated the implications for CPs (e.g. Black, 2002; Cattrall et al., 2001; Diamond, 2002; Harper, 2006; Holmes, 2002; Kinderman, 2005; Levenson, 2001; Pilgrim, 2005; Taylor, Gillmer, & Robertson, 2003). Their articles covered three main areas: the extent to which the roles would lead to greater influence of psychological models in services; CP's positioning regarding social control and the extent to which accepting the role was motivated by desire to enhance status and salaries. However, a limited number of authors participated and few studies directly examined ordinary CPs' views.

In one attempt, Cooke, Kinderman and Harper (2002) surveyed CPs in 2001 using a questionnaire (Appendix IV) distributed with the DCP publication Clinical Psychology (now Clinical Psychology Forum), which is sent to all Division members. The circulation was 4160. Whilst definitive figures are rather difficult to obtain, a 2002 survey (Lavender, Gray, & Richardson, 2005) of NHS and Prison and Probationary service CPs suggested that the majority (57%) were DCP members. However a minority without membership could have been excluded. Two questions concerned 'CPs as Clinical Supervisors' (CS) (an earlier term for RC). The first question asked whether CP should: a) resist or b) be open to (the development of this role). The second asked whether respondents would: a) be willing to be a CS if offered appropriate training, b) be unlikely to volunteer if given the choice or c) refuse to be a CS even if pressurised.

Of 681 respondents, 71% (n=477) felt CP should be open to the role and 29% (n=191) favoured resisting it. Over half, 52% (n=349), were willing to be CSs, with 32% (n=210) unlikely to volunteer and 16% (n=104) prepared to refuse. Forensic CPs were slightly more in favour than non-forensic CPs. Limitations were a low response

rate (16.4%), ambiguous wording in some questionnaire items and no neutral response option for the first question.

A smaller questionnaire survey (Miller & Dickens, 2007) recruited 51 CPs from an independent mental healthcare organisation predominantly providing secure/locked facilities. Participants rated seven statements from DCP members about the CS on a Likert scale (with neutral response options in contrast to Cooke et al. (2002)) and provided qualitative data in a comments space.

The response rate was 63% (n=32), 66% of whom (n=21) were trainee/assistant psychologists. In contrast to Cooke et al.'s (2002) findings, Miller and Dickens (2007) found that only 34% (n=11) welcomed the role, 41% (n=13) did not and 25% (n=8) were neutral. Consultant psychologists (19% of respondents and those most likely to become CSs), were the least supportive, whilst 44% (n=14) feared a negative impact on the therapeutic alliance and 50% (n=16) anticipated hostility from clients. Although 75% (n=24) were frustrated at medical dominance within services, only 19% (n=6) believed CPs would behave "more philanthropically and benignly than psychiatrists" (p. 26) as CSs and 38% (n=12) thought they would "ask questions and make conclusions based on a more fundamentally humane system than psychiatrists" (p. 26).

Additional comments revealed concerns about risk-management displacing therapy as a central role and capacity to provide treatment being reduced. The authors concluded that CPs appeared reluctant to become RCs and proposed investigating their views further. The study's limitations were the small sample size, secure private-sector setting and high proportion of junior psychologists.

These contrasting findings may reflect methodological weaknesses, differences in sampling, data collection or context. Opinions may have altered in the interim

between the studies. The later study also took place closer to the date of reform, when details were presumably clearer. Many of its participants may have understood what the role might involve better, because of experience in settings where compulsion was commonly used. This all leaves ordinary CPs' beliefs regarding these developments, together with their more general underlying beliefs about CP, rather unclear.

The Present Study

This study investigated CPs' beliefs about statutory powers for CP, in order to theorise their implied beliefs about CP's role and relationship with mental health services. The research question was: what underlying beliefs about the role of CP in relation to the mental health system are implied by CPs' statements/beliefs about new statutory powers for their profession?

Method

Participants

The first participant group comprised 292 CPs from Cooke et al.'s (2002) survey who had provided additional written statements in two comments boxes (see Measures). These had not yet been analysed and were made available to the investigator. All participants were DCP members. The most heavily represented specialties (Appendix XI) were: Adult Mental Health: 21.3% (n=62); Child/Adolescent: 6.5% (n=19); Forensic: 9.9% (n=29); Learning Disabilities: 6.2% (n=18); Mixed: 20.2% (n=59); Neuropsychology: 3.8% (n=11); Older Adults: 5.1% (n=15) and Rehabilitation: 3.1% (n=9).

For reasons outlined below (see Design), an additional group was used: six CP members of the DCP Faculty of Psychosis and Complex Mental Health (FPCMH), a source chosen because the powers were of likely particular relevance to its members. All except one were Consultants. One was employed at grade 8A, four at 8C, and one at 8D. Three worked in Adult Mental Health, two in Recovery and Rehabilitation and one in a Forensic service. Exclusion criteria were: non-UK practitioners, Assistants/Trainees and CPs managed by another participant.

Ethics

The Salomons Ethics Panel granted full approval (Appendix VI).

Design

In order to investigate this under-theorised area and inductively construct a theory for conceptualising CPs' implicit beliefs about CP, an exploratory non-experimental qualitative design was chosen. This can enable theory generation and help understand how people explain their world (Willig, 200) or the reasoning underlying beliefs. To generate theory, the unstructured data regarding CPs' statements about statutory powers first needed to be analysed for patterns. Grounded Theory (GT) methodology (Glaser & Strauss,1967) informed by Charmaz's (2006) social constructivist approach, was therefore employed. GT is specifically designed to generate theory from unstructured data (Willig, 2001) where no theory exists, whereas alternative methodologies such as Interpretative Phenomenological Analysis and Discourse Analysis focus more on subjective experience or the use of language (Potter & Wetherell, 1994; Willig, 2001).

A very large, unanalysed qualitative data set from Cooke et al.'s (2002) survey was used, namely participants' statements regarding the reasoning behind their attitudes to compulsory powers. This was arguably uniquely important as the survey had been sent to the majority of the profession and the unanalysed statements were highly relevant to the research question.

However, this data was old and the proposed legislation to which it related had since been passed. Whilst fundamental beliefs/values seem less likely to change over time, some specific opinions may have. Therefore additional up-to-date data was required to ensure the validity of findings and enable any new themes to emerge. Repeating the survey would have been impractical: exceptional permission to circulate the earlier survey with Clinical Psychology had been granted owing to urgent need to inform policy at that time (A. Cooke, personal communication, February 21, 2012). However, a focus group interview method is practical and can also facilitate discovery of how opinions function within cultural contexts (Kitzinger, 1995; Willig, 2001) such as the CP community. Furthermore, this complements a questionnaire method by eliciting richer detail and facilitating exploration of views through group processes (Kitzinger, 1995). Correspondingly, where the presence of other group members might cause response bias, questionnaires offer anonymity. Therefore it seemed appropriate to combine these two methods.

Measures

Cooke et al. (2002) had used an unvalidated questionnaire with closed questions and comments spaces (Appendix IV), rapidly constructed to inform BPS policy during discussions with the DoH. It had been acknowledged as having methodological weaknesses e.g. leading questions designed to confirm whether members' views echoed

specific BPS policy statements. Questionnaire items consisted of 10 closed questions and four comments spaces. The written statements collected included approximately 9500 words in a comments space regarding two questions about the CS role and approximately 8000 words in a general comments space (many of which referred to the role).

Focus group interview topics were chosen by noting the main areas in the published debate. A combined interview guide and semi-structured interview (Appendix V) consisting of open and closed questions referring to opposing beliefs expressed during the debate was then developed in consultation with the research supervisor and a professional focus group facilitator. Ten potential questions were developed. Topics included: 'increasing the influence of psychological models in mental health', 'the therapeutic relationship and effectiveness of therapy'; 'the balance of roles'; 'supporting colleagues'; 'the corrupting influence of power' and 'status and salary'.

Procedure

In order to identify potential problems with this interview guide, two consultants experienced in the CP field (one trainee CP and one CP staff-member) were recruited (Appendix VII) from the Department of Applied Psychology at Canterbury Christ Church University. Two individual consultation meetings were held and amendments made.

FPCMH members received an e-mail (Appendix II) and information sheet (Appendix III) requesting focus group participants. Responders were sent a Consent Form (Appendix X) and six participants were recruited. J. MacLeod (personal communication, November 18, 2009) and Willig (2001) suggest using a maximum of six participants as larger groups can create transcription difficulties and reduce the depth

of contributions. The 75-minute focus group took place at the BPS London Office following a Faculty meeting. It was audio-taped and later transcribed. Participants were initially asked to state their general position regarding the statutory role. One expressed opposition, one was neutral and the remaining four were more in favour. Following the interview, they were debriefed and invited to reflect together on the experience.

Data Analysis

GT involves sampling and coding data and grouping codes into categories. Similarities and differences are constantly identified (constant comparative analysis) and cases which do not fit examined (negative case analysis) until new categories no longer emerge (theoretical saturation) (Willig, 2001).

'Full' GT requires multiple data collection points. As this study used a unique data set and only two data collection points, Willig's (2001) abbreviated version of GT, which involves using GT principles to analyse extant texts, was chosen instead. This was used with both data sets to ensure one consistent approach. Therefore, alongside practical reasons (e.g. the availability of participants) the focus group was conducted prior to the questionnaire data analysis. However, initial separate analyses of the data sets revealed more commonality than difference: themes, categories and most (i.e. 15/17) sub-categories were the same. Consequently, given the limited space and need to generate a parsimonious model, the decision was made to avoid repetition by collapsing the data. The differences were noted beforehand, so as to prevent undue emphasis being placed on either data set.

The study adopted a critical realist epistemological position. Willig (2001) sees this as one of the "less naive forms of realism" which "have much in common with social constructionist approaches because they recognise the subjective element in

knowledge production" (p. 145). This aimed to determine what CPs' expressed/implied beliefs were, whilst acknowledging that the language used by an individual mediates the way they construct their world. Similarly, the investigator could not conduct the study and interact with data without their own construction of reality influencing the outcome to some degree. Charmaz's (2006) GT approach which offers an interpretive understanding of the world, seemed consistent with this position.

GT requires the practice of reflexivity for evaluation purposes (Willig, 2001). A research diary (Appendix XVII) and memos (Appendix XVIII) were completed to document the research process. To reduce bias and enhance credibility, categories and coding were audited for suitability at different stages by research supervisors and alterations made. Focus group participants were asked to confirm that summaries of findings (Appendix XIX) authentically reflected their experiences. For triangulation, similarities between categories and topics in published articles regarding CP were noted, further increasing the credibility of the results.

Results

Initial coding generated 221codes, from which 53 focussed codes were refined and collated into 17 sub-categories. These sub-categories were then refined and combined into eight categories. Theoretical coding (Charmaz, 2006) was used to link categories to sub-categories, specify inter-relationships and determine themes, of which two were identified. These themes, categories and sub-categories are shown in Table 1 and were used to build the model shown in Figure 1.

Table 1

*CPs' Beliefs abo*ut Their Role Within Mental Health Services As Implied by Their Beliefs about New Statutory Powers by Theme, Category and Sub-Category

Theme	Category	Sub-category
Belief that CP can transform services from within by opportunistically accreting power	Compulsory treatment is compatible with CP's values	Compulsion is necessary and justifiable
		CP is implicated in the process of compulsion
	Greater power for CP will lead to more humane mental health services	Psychiatric dominance within mental health services is often harmful to clients
		CPs are sensitive, humane advocates with a more sophisticated understanding of some clients' needs
	Consequences will be positive for clients	Clients will receive better quality care
	The role will increase the power of CP	CP will be less dispensable
		The powers will increase the influence, status and credibility of CP within mental health services
		The powers are likely to result in an increase in pay
		The risks are limited
Belief that CP must defend against assimilation by maintaining separate spaces for collaborative work	Compulsory treatment is ethically problematic	The principle of compulsion is contestable
		Compulsion is incompatible with CP's values
	A collaborative CP is only possible if separate from compulsion	CP is distinctive and more autonomous because of its separation from the system of coercion
		Separation from the coercive system is valuable and enables collaboration
	Consequences will be negative for clients	The powers will compromise collaborative alliances with CPs and reduce the effectiveness of CP
	Consequences will be negative for CP	The powers will have a negative impact on the role and identity of CP
		The powers will not increase the influence or enhance the status of CP
		The powers will reduce the roles available to CPs

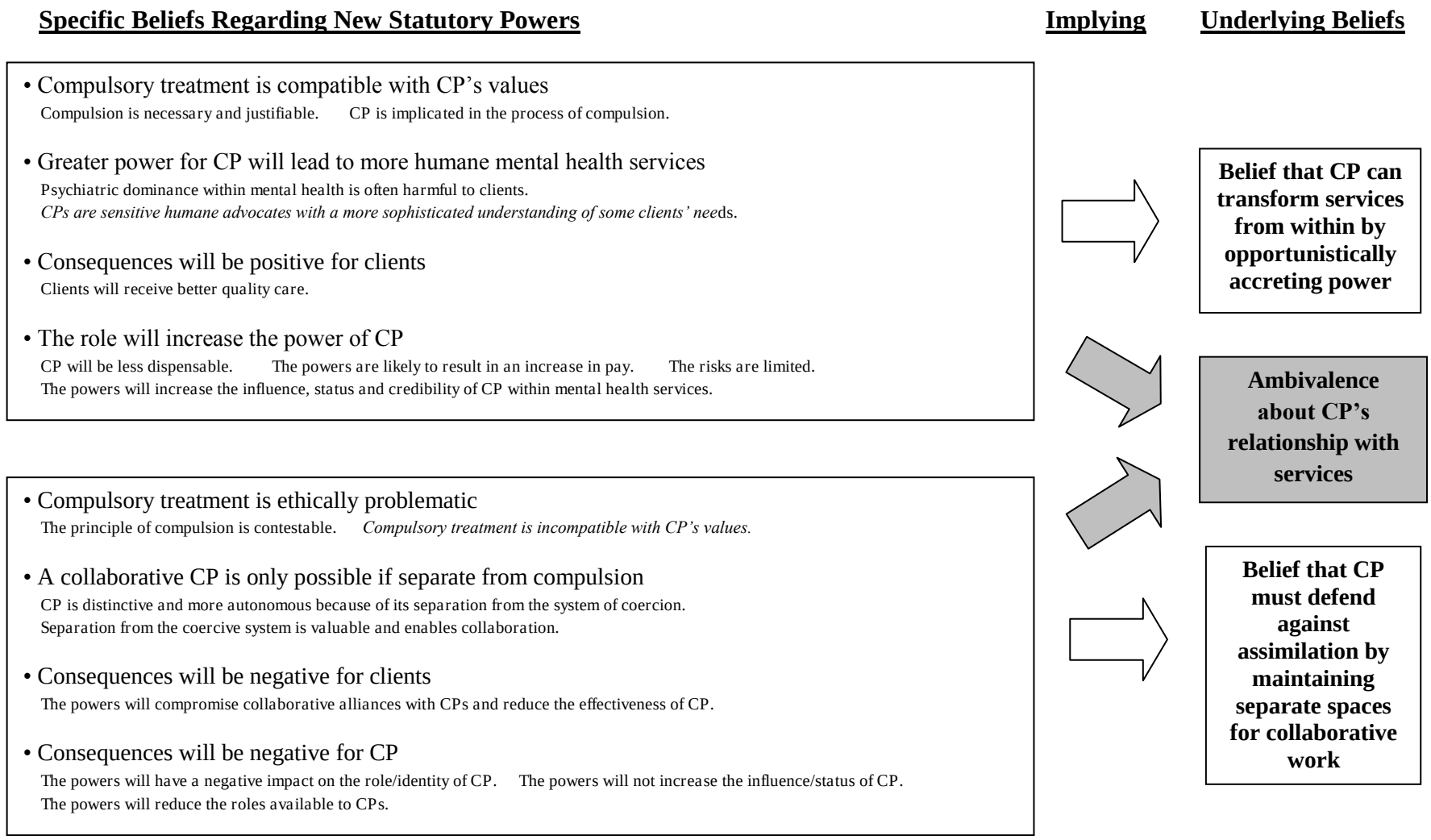

Figure 1. Model accounting for CPs' beliefs about new statutory powers for CP. This figure shows how these imply differing underlying beliefs about the nature/purpose of CP and its relationship with mental health services.

Model summary

The model suggests that views regarding the statutory powers imply two contrasting themes/beliefs about the nature and purpose of CP and its relationship with wider services: a 'belief that CP can transform services from within by opportunistically accreting power' and a 'belief that CP must defend against assimilation by maintaining separate spaces for collaborative work'. These were not mutually exclusive: some participants accepted certain views associated with the opposing theme, whilst a minority expressed ambivalence.

As few comments explicitly referred to the AMHP role, most were assumed to refer to the RC. Differences between participant groups mostly appeared contextual. For example, unlike questionnaire respondents, focus group participants (speaking after the legislation and in a harsher economic climate) perceived little managerial will to implement the powers (e.g. by offering training), perceived concerns about expendability as influencing views about the role, and were less critical of those with opposing views (which one might expect given that focus groups afford less anonymity than questionnaires).

Each theme will now be examined consecutively, using extensive quotations from participants to ensure the authenticity and groundedness of the data.

Belief That CP Can Transform Services from Within by Opportunistically Accreting Power

This was an overarching belief in CP's ability to opportunistically use power to change services from within using superior expertise. It comprised four categories of belief: that involvement in compulsion could be compatible with CP's values; that

greater power for CP would lead to more humane mental health services; that the consequences would be positive for clients and that the role would increase the power of CP. Each belief category will now be examined in turn.

Compulsory treatment is compatible with CP's values. In both groups more participants were broadly supportive of than opposed to the powers. Many emphasised the necessity of compulsion for protecting the public and helping clients: "Certain individuals pose a danger to themselves or society and need restraining" (Survey Respondent 164). They described feeling implicated in social control: "Psychologists are already to some degree agents of social pressure. Better to be clear when ambiguity exists" (Survey Respondent 341) and feeling that this difficult responsibility should be shared: "Our profession should [share] the responsibility for the MHA 1983" (Survey Respondent 613). Consequently, various questionnaire respondents perceived opposition as obstructive and understood it as fearfulness, immaturity or avoidance: "*Not engaging with these issues doesn't make them go away. Avoidance is no answer*" (Survey Respondent one).

Greater power for CP will lead to more humane mental health services. Many CPs appeared to believe that psychiatric dominance in services was harmful to clients. They felt that services were too bio-medically oriented, often increased client dependency and dysfunction and that CP lacked agency to reduce such harm: *"I have* seen many people over medicated and denied psychological treatment because we lack the influence to *prevent this"* (Survey Respondent 671).

In contrast they regarded CPs as sensitive, humane advocates with a more sophisticated understanding of some clients' (e.g. people with personality disorders or learning disabilities) needs than other disciplines:

- "[CPs] may be able to offer more sensitive and appropriate care" (Survey Respondent 665)
- "Clinical psychology offers a mu*ch better understanding of lots of... 'detainable' conditions"* (Survey Respondent 180)

Consequences will be positive for clients. Therefore many envisaged better quality care and adopted a generally positive discourse of advocacy, meeting needs and a more humanised process as consequences for clients:

- "A chance to put forward the views of our clients in a balanced and productive way" (Survey Respondent 452)
- "Some people...are much more in need of supervision by a psychologist than a psychiatrist" (Survey Respondent 235)

The role will increase the power of CP.

Many participants from both groups believed that influence would accompany the powers, allowing them to spread their specialist knowledge, broaden perspectives and impact on the concept and treatment of mental illness: "The role [is] a way of influencing the current construction of mental illness and subsequent treatment" (Survey Respondent 477). Medical dominance over other models/professions would

also be reduced: "Psychologists carp about the power and dominance of mental health *services by psychiatrists and others within the "medical model". This is a way to* redress the imbalance" (Survey Respondent 40).

Adopting the powers was also seen as enhancing credibility: "If we want psych*ologists' opinions to be listened to...we've got to take responsibility for weighty* issues" (Survey Respondent 53). Various participants believed that system change was more achievable from within: "Engineering change is easier from the inside" (Survey Respondent 610).

Some from both groups also believed that the powers could enhance status or increase salaries: "Clinical psychologists...whinge about...pay, professional status etc., yet...cower away from developments which could enhance both" (Survey Respondent 602). Questionnaire respondents' frequent comments about pay implied beliefs that: CP's should receive similar pay to Psychiatrists: e.g. "Equal recompense to psychiatrists" (Survey Respondent 23), CPs should not be exploited: e.g. "We should....ensu*re we don't get forced into working as cheaper psychiatrists*" (Survey Respondent 107) and that pay incentivised adoption of the role: e.g. "A substantial pay rise would make it a more attractive option" (Survey Respondent 235)

Participants perceived limited risks from the powers and restricted consequences for other roles e.g. the therapeutic relationship. Given limited alternatives for improving care, they argued that compromise was possible, although focus group participants saw this as dependent on context. A few participants dismissed fears that power might corrupt CPs, viewing power as inescapable, ever-present in client-therapist relationships and kept in check by protective mechanisms.

Some questionnaire respondents perceived opposition as impractical and potentially harmful to clients and CP and advocated a pragmatic rather than principled

response: "We must not pass up this opportunity of...contributing to an especially needy group of people because of political-moral concern" (Survey Respondent 454). Many questionnaire respondents believed that regulation could (and should) safeguard therapeutic relationships by ensuring that CPs could not adopt both a therapist role and role of compulsion for the same client. They also believed that the role could (and should) be optional.

With funding cuts looming, a small number of focus group participants believed the powers made 'expensive' CPs less dispensable: "We are going to be very exposed...if we had a vital function like that we would be much...less easy to get rid of" (Focus Group Participant five).

Belief That CP Must Defend Against Assimilation by Maintaining Separate Spaces for Collaborative Work

This was an overarching belief in CP's vulnerability to assimilation into a psychiatric system with antithetical values to its own and need to maintain separation from the system so as to preserve collaborative relationships. It comprised four categories of belief: that compulsory treatment was ethically problematic; that a collaborative CP was only possible if separate from compulsion, that the consequences would be negative for CP and that the consequences would be negative for clients. Each category of belief will now be examined consecutively.

Compulsory treatment is ethically problematic. Many participants expressed ethical concerns. For example, a small minority of questionnaire respondents questioned professional ability to predict behaviour accurately, challenging the need for mental health legislation and the practice of compulsion:

- "No individual...can exercise control and prediction over the behaviour of others *and to attempt to do so under the guise of "professionalism" is l*udicrous and a violation of...civil liberties" (Survey Respondent 629)
- "I would like to see a much wider debate on the...mental health act including whether it should even exist" (Survey Respondent 501)

Many participants believed that compulsion was incompatible with CP's values because involvement in coercion was antithetical to the nature of their profession: "Against all my principles and values as a CP" (Survey Respondent 501).

A minority of questionnaire respondents also believed the role was based on a model of mental disorder (i.e. medical) which conflicted with a psychological model. A small number of questionnaire respondents claimed a localised consensus of opposition or foresaw their departure from the profession / NHS should the role be introduced: "If this role is imposed on our profession I will feel unable to continue working for the NHS" (Survey Respondent 639).

A collaborative CP is only possible if separate from compulsion. A number of participants saw CP as distinctive and relatively autonomous in enjoying a degree of separation from the coercive system:

- "I believe Psychologists have served a valuable function not having to enforce the *system's rules,* and can usefully occupy a more neutral position than those bound *by their professions' responsibilities*" (Survey Respondent 660)

- "[The] autonomy we currently enjoy would be compromised" (Survey Respondent 604).

Many participants valued this separation. They believed that the mental health system needed a non-coercive profession, because a lack of powers enabled collaborative, empowering relationships:

- "Our principal therapeutic tools are persuasion and a...relationship untainted by statutory powers" (Survey Respondent 529)
- "A key advantage...*is that we do not have powers to 'do things' to [people]* against their will" (Survey Respondent 292)

Consequences will be negative for clients. Participants therefore foresaw negative consequences for clients. They viewed the powers as incompatible with therapeutic relationships, due to the unenforceability of therapy: "How can someone be forced to talk?" (Survey Respondent 431) and the effects on both collaboration: "Any involvement would compromise the possibility of collaborative...therapy relationships" (Survey Respondent 207) and clients' perceptions of CPs: "We would be feared rather than respected" (Survey Participant 604). Some also believed that advocating for clients might become harder: "Would seriously compromise and jeopardise our abilities to act as advocates" (Survey Respondent 287).

Consequences will be negative for CP. Participants believed that the powers negatively altered CP's role and identity: "Another step in the worrying trend for

clinical psychologists to play at being psychiatrists" (Survey Respondent 272), reducing its distinctiveness from Psychiatry.

They also believed that the powers would socialise CP into a system of social control: "The danger of becoming social police officers is one I would strongly resist" (Survey Respondent 281). Small numbers of participants also feared the corrupting influence of power: "I*t's*...conceivable that some people would be seduced by power" (Focus Group Participant four) and the powers leading to an excess of roles: "We have got too many strings to our bow as it is and we would be diluting our skills further" (Survey Respondent 328).

Many questionnaire respondents believed that accepting the powers was simply colluding with the system as it was unlikely to increase influence or enhance status:

- "This would involve unhealthy collusion and not healthy influencing" (Survey Respondent 496)
- "Engagement in the process of invoking [the] mental health act has not increased the status and power of social workers. Why would we assume it would for CPs?" (Survey Respondent 351)

Some also believed that support was motivated by envy of medical status and power-seeking:

- "To other professions it looks like we wish for the status of medics, and have *done so by effectively 'disguising' ourselves as medics*" (Survey Respondent 25)
- "*Those who want this role see it as a means of extending our power 'per. se'*" (Survey Respondent 272)

Some participants also believed that the powers would reduce the roles available to CPs. Should employers' expectations change, CPs' ability to prevent the role becoming obligatory might be limited "We all have job descriptions which...can be *changed almost without consultation can't they?*" (Focus Group Participant four).

Discussion

This initial model of beliefs about CP in relation to wider services might be crystallised as beliefs in its transformative power versus its vulnerability to assimilation. These imply contrasting beliefs about organisational change processes, professional identity and where power is located. I will now discuss these with relevant theory, before critiquing the study and examining its implications.

Beliefs about System Change

Participants appeared to have contrasting beliefs about whether systems are best changed from within or without. Some authors take issue with the former, challenging suggestions that organisations might be changed by altering individual members (Georgiades & Phillimore, 1975), that individual CPs might change mental health systems which have structures that prevent change (Praill & Baldwin 1988), or that therapeutic innovation might overcome entrenched systemic resistance in special hospitals (Pilgrim & Eisenberg, 1985). Instead, they see successful change as requiring corporate-level commitment that incorporates the whole system (Georgiades & Phillimore, 1975) by addressing each member's needs (Praill & Baldwin, 1988), or as

coming from outside, through media exposure, public concern and political will (Pilgrim & Eisenberg, 1985).

Conversely, perhaps suggesting that change from within is possible, Pettigrew, Ferlie and Mckee (1992) cite eight interlinked change factors within the NHS (e.g. key individuals leading change). However, as little research evidence regarding drivers of change within healthcare organisations exists, practitioners' views on change management are more likely to stem from experience (National Co-ordinating Centre for NHS Service Delivery and Organisation Research and Development, 2001).

Professional Self-identity

The model suggests a possible continuum of belief about professional identity, each end of which might reflect a distinct role/identity. Those opposing the powers ascribed a high value to collaboration and therapeutic relationships, perhaps indicating a perception of CPs as 'therapists'. This, together with a perception of CP as slightly separate from coercive practices might suggest a 'collaborative external ally' identity. Alternatively, those supporting the powers, who valued power, influence and the ability to transform services, might represent enduring managerialism: viewing CPs more as team leaders, dismantling Bullock et al.'s (2010) barriers to leadership (see p. 59). Together with a perception of CPs as part of the coercive 'system', and an emphasis on superior expertise, these beliefs might represent the other end of the continuum, perhaps suggesting a 'benign expert insider' identity, a profession 'allied to medicine' rather than representing a separate paradigm.

Psychological Theory

Psychological theories may be instructive here. Social identity theory (Tajfel & Turner, 1986) regards individuals as favourably distinguishing between their groups and out-groups to maintain positive self-concepts. This, and the concept of self-stereotyping (perceiving oneself as a prototypical group member) (Turner, 1987), might explain the beliefs about identity. The relative importance that membership of particular groups has for one's self-concept influences the degree to which one identifies with them (Jetten, Spears, & Manstead, 1997). This in turn, influences the degree to which one responds to threats to a group's status/distinctiveness by self-stereotyping and encouraging homogeneity/group cohesion (Spears, Doosje, & Ellemers, 1997).

Perceived distinctiveness enhances social identification (Ashforth & Mael, 1989). Therefore, 'collaborative external allies' may perceive distinctiveness in CP's collaborative nature, echoing Diamond (2007), whereas 'benign expert insiders' may perceive it in CP's expertise, echoing Kinderman (2001). High-identifiers with the first identity might perceive their status/distinctiveness as threatened by statutory powers. Consequently, they might adopt what they perceive as prototypical views (e.g. emphasising collaborative values), attempt to enhance group cohesion/homogeneity (e.g. claiming a localised consensus against) and support their organisation less (e.g. leaving) (Ashforth & Mael, 1989).

Conversely, within the second identity, perceiving CPs as part of the system might make statutory duties seem more proto-typical (e.g. sharing a difficult responsibility), less threatening and homogeneity therefore less important (e.g. emphasising that the RC role is optional). Having two such clashing identities within an

organization is likely to reduce cohesion (Ashforth & Mael, 1989), thus undermining CP's credibility.

Regarding the overarching beliefs, motivation theories linked to expectancy-value models (Eccles & Wigfield, 2002), focussing on beliefs, goals and values might be relevant. Participants wishing to transform services might have an expectancy belief that CPs can internally drive system change and a goal of increasing power/humanising services, which they value as an opportunity to demonstrate aspects of a benign insider expert/leader identity. Participants wishing to defend CP might have an expectancy belief that CPs cannot internally drive system change and a goal of preserving power/separation which they value as an opportunity to demonstrate aspects of the collaborative external ally/therapist identity.

Ambivalence about the beliefs may either reflect insufficient consideration of the issues, or Dilks et al.'s (2009) balancing of separation and integration in teams (see p. 59). Social identity theory suggests that individuals separate/buffer conflicting organisational identities, switching between them as required (Ashforth & Miel, 1989) and only recognise conflict when incongruities become conspicuous (Greene, 1978) e.g. with new statutory powers.

Alternatively, information processing, cognitive dissonance and impression management theories might explain ambivalence. Better informed individuals with a high need for cognition experience greater political ambivalence than individuals motivated by directional goals (Rudolph & Popp, 2007). Conflicting beliefs (adopting both therapeutic and social control roles) produce dissonance, and, depending on tolerance levels, attempts to reduce this (Festinger, 1957). External justification (e.g. power, exemption from unpleasant work) might reduce dissonance. Ambivalent participants may therefore have been better informed, had more need to consider issues

and higher dissonance tolerance than univalent participants, whose beliefs may represent dissonance reduction attempts aimed at conveying impressions of consistency (Tedeschi, Schlenker, & Bonoma, 1971).

Sociological Theory

Wider explanations for the overarching beliefs might include guild interests. Accreting power and wishing to 'reduce medical dominance' perhaps reflect a neo-Weberian professional dominance strategy: wrestling power from superiors. Likewise, maintaining separation from coercive practices might indicate a neo-Weberian social closure strategy: conserving a monopoly on 'collaboration'. Locating power within voluntary relationships also echoes post-structuralist literature regarding consensual social control: where regulators' and subjects' interests converge in a secular confessional (e.g. Miller & Rose, 1988; Pilgrim & Rogers, 1994; Rose, 1990).

Strengths and Weaknesses of the Model

The model provides a parsimonious, much needed preliminary theory for an under-theorised profession, illustrating how implicit values/beliefs are drawn upon in a specific concrete case. It fits real-world data and appears generalisable beyond a statutory powers context. However it requires further development and refinement before it can be considered a sufficient explanation. Ambivalence regarding beliefs is unexplained, the extent to which CPs are univalent is uncertain and relative weightings for beliefs are unclear. Furthermore, as it has an organisational focus, it offers no individual level of explanation e.g. underlying motivation for beliefs.

Methodological Limitations

This study suffered from several weaknesses. The data was mostly collected using a questionnaire with ambiguous wording and some leading questions. Those motivated to return questionnaires and/or comments may have held stronger views. Their views may also have changed since the survey. Nevertheless, this unique data set offered access to a very large sample's views on this key issue.

Furthermore, the study used data sets collected nine years apart, one pre-legislation and one post-legislation, using different populations, sample sizes and collection methods. Since the reforms new members had qualified, whilst CP had grown and altered demographically (Lavender et al., 2005; NHS Workforce Review Team, 2008). Mental health policy changes (e.g. using Community Treatment Orders) meant that focus group participants were more likely to understand what the powers might involve. IAPT may have increased perceptions of CPs as therapists whereas NWW may have reduced perceptions of clearly delineated inter-disciplinary roles. Funding cuts may have increased propensity to embrace new roles, or reluctance to jeopardise positions through dissent. However, no other clear technique was available for capitalising on the best data available for answering the research questions whilst ensuring that the findings were valid. Using this method and checking that similar themes emerged in both data sets seemed the best available compromise.

Despite its relevance to detention powers, the special interest group used for the focus group might not have widely represented CP. As participants held quite senior positions they may also have held different beliefs from junior CPs, who might have been less aware of the reported lack of managerial support.

Using different size samples also risked unduly emphasising one group. Whilst allowing a more parsimonious theory, collapsing the data sets, given the contextual differences, could have reduced the reliability of results. However, this decision was only made after observing that despite the different contexts, the results still contained more commonalities than differences. The fact that differences appeared largely contextually-driven (see Method) whilst the categories, range of views and greater proportion of supporting views were otherwise broadly consistent, suggests that the findings represent fundamental beliefs less likely to change over time.

The methodological choice could be criticised, because the first data set prevented use of the full version of GT. Ideally, one would have analysed this before interviewing the focus group, so as to allow theoretical sampling. However, practical considerations - accessing potential group participants and analysing data within the available time - prevented this.

Quality Evaluation

In line with Henwood and Pidgeon's (1992) quality evaluation guidelines, the research process documentation (Appendices XV & XVI) made integration of theory clear and verifiable, demonstrating good fit between categories. External auditing prompted revisions to themes/categories so as to increase groundedness in the data. Negative case analysis was also conducted.

The investigator initially felt more sceptical about CP's ability to transform services from within and also opposed the new powers, having previously experienced conflict between therapeutic and social control roles as a nurse. Therefore, such views could conceivably have been overemphasised. Appropriate safeguards implemented to

mitigate danger of this included: being transparent about his view in supervision, attempting to maintain consciousness of it throughout without overcompensating and to avoid bias, seeking consultation whilst developing the interview guide.

Focus group participants were sent summaries of findings but unfortunately none responded, possibly due to competing demands for their time. Triangulation showed similar themes (e.g. valuing collaboration versus expertise) in the published literature. Overall, the study appeared to offer a plausible, useful understanding of beliefs about CP's role.

Implications for Future Research

To test and refine the model, larger scale research might use theoretical sampling to determine its wider representativeness and whether the beliefs about identity/drivers of organisational change etc. fit the overarching beliefs. For example, a complementary case study might investigate beliefs about IAPT, by asking "Is IAPT the best way to change services?" Varying endorsement of the model's categories could be scored on a questionnaire and added to produce total scores on an overall continuum between the two beliefs, or an ambivalence-univalence continuum. A linear regression analysis could establish relative belief weightings. One could then determine where most CPs clustered and how ambivalent and univalent CPs differed.

Implications for Future Practice

The model is a good start towards conceptualising different beliefs about CP's role within mental health services, but greater self-reflection and a more detailed

framework are clearly needed. A refined version with cluster data could aid DCP decision-making, make CP more theory-driven and enhance the profession's credibility.

Conclusion

This investigation has examined CPs' beliefs regarding new statutory powers, analysing them as an enactment of underlying beliefs about CP's role within services. Two overarching, opposing beliefs were identified, namely belief in CP's transformative power versus its vulnerability to assimilation. The first emphasises compatibility with coercion and a need to opportunistically accrete power, so as to humanise the system through superior expertise. It implies a leadership role and belief in internally-driven organisational change. The second emphasises incompatibility with coercion and a need for separation from such practices to ensure collaborative client-relationships. It implies a therapist role and scepticism about internally-driven organisational change. The model implies future conflict, a need for greater self-examination and a clearer framework for understanding conflicting values. Prospects for further developments in this under-investigated field appear promising.

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TOM PARSLOE BSc Hons

CLINICAL PSYCHOLOGISTS' BELIEFS ABOUT THE PURPOSE OF THEIR PROFESSION IN RELATION TO THE WIDER MENTAL HEALTH SYSTEM: A CASE STUDY OF VIEWS ON NEW POWERS OF COMPULSION

Section C: Critical Appraisal

1.0 Introduction

This section will critically appraise my learning during the study, aspects which might be approached differently, likely effects on my clinical work and possibilities for further research.

2.0 What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

2.1 Epistemology

I learned about different epistemological positions and moved from a more positivist position to a critical realist perspective: a "third way" between social constructionism and positivism (Robson, 2002, p. 41). Critical realism views phenomena as generated by underlying mechanisms and structures in the world whilst simultaneously viewing language as mediating the construction of our knowledge of the world and those phenomena within it (Parker, 1992, 1998). This enabled me concurrently to acknowledge the views expressed by participants, contextual socio-historical factors and the impact of my own preconceptions on the analysis.

2.2 Methodology

I learned the importance of using a rigorous conceptual/theoretical framework and developing theory which accounts for phenomena rather than describes it. I learned to use a qualitative approach: Grounded Theory (GT) (Glaser & Strauss, 1967), to analyse data from disparate sources and generate theory in an under-researched area. This showed me how GT can help understand social processes in a different way from Interpretative Phenomenological

Analysis (which focuses more on subjective experience) (Willig, 2001) or Discourse Analysis (which focuses more on the use of language) (Potter & Wetherell, 1994). I learned to employ GT informed by Charmaz's (2006) social constructivist approach, which seemed consistent with my epistemological position.

Having used the abbreviated version of GT, using it in full (e.g. including theoretical sampling) would widen my experience, as would using alternative qualitative/quantitative methodologies and those involving service-users as participants. Although no major ethical issues arose, interviewing service-users can be more challenging ethically and might be very different.

I understand the qualities of a good theory: i.e. explaining findings, having implications and generating testable hypotheses. I also appreciate the importance of: making a theory's aim explicit (e.g. to account for rather than predict phenomena), considering its strengths and weaknesses and linking it to a conceptual framework rather than simply describing phenomena.

2.3 Analysis

I learned to use line-by-line coding to scrutinise data closely and focussed coding to sort through large amounts. Using theoretical coding helped me link categories with sub-categories and specify relationships between codes (Charmaz, 2006). I learned the constant comparative method and to help modify theory, examined negative cases (Charmaz, 2006) (i.e. examples which do not fit). For example, one participant argued that rather than increasing status, the RC role 'enshrined second class status', because the first two recommendations for detention still needed to be medical. This illustrated an alternative perception of the role as affecting status negatively. As no similar cases (i.e. quotes) occurred,

it was excluded from the analysis, but using full GT, one could have subsequently theoretically sampled this case, i.e. attempted to sample further instances.

2.4 Quality Assurance

I learned to follow guidelines (Henwood & Pidgeon, 1992; Williams & Morrow, 2009) for evaluation and 'trustworthiness' of qualitative research, using methods consistent with the epistemological position (Willig, 2001). I strove to avoid bias whilst planning (e.g. seeking consultation regarding the discussion guide) and collecting data (requesting participant feedback).

I learned to keep memos (Charmaz, 2006) (Appendix XVIII) to track decision paths, which I now feel sometimes lacked detail. I would therefore write more extensive memos in future. A research diary (Appendix XVII) helped me document the process, increasing reflexivity and awareness of when my preconceptions might be influencing the proceedings. At one point this helped me notice that, perhaps due to having met the focus group participants, or to their more detailed responses, their views were becoming more prominent in my thinking than survey respondents' views.

I found completing an audit trail and having supervisors audit categories and codes helpful in identifying potential problems, ensuring that categories/themes fitted the data and increasing my confidence regarding the analysis.

I also discovered how difficult obtaining respondent validation can be. No focus group participants responded, perhaps due to the long time interval since the focus group, competing demands or their already having responded for the previous submission. Completing future analyses sooner might increase responses.

2.5 Awareness of Personal Preconceptions and Bias

Inquiring what CPs believe CP is for may reflect a new recruit's attempt to manage a complex role by seeking certainty. Alternatively, a new recruit might have enough of an outsider's perspective to see that the question needs asking, as with the boy and the emperor's new clothes. A further possibility is that it reflects a defensive reaction to seeing my former profession (psychiatric nursing) frequently criticised by CPs. As with many questions within the human sciences, this question about CP may ultimately be contestable, but nevertheless seems important.

I value the idea of CP as observer and critic within services (Diamond, 2007). However, I have found acknowledgments of its enmeshed relationship with the state to be relatively rare, which surprises me in a supposedly 'reflective' profession. Admittedly, professions may have contradictions and are not particularly renowned for their reflexivity, but one advocating self-reflection whilst not theorising itself risks being seen as fraudulent.

As a psychiatric nurse, the dual social control and therapeutic role often felt more of a 'jailer' role. I was taught the 'bio-psychosocial model', but became disillusioned with the emphasis on the 'bio' element. Consequently I am now sceptical of highly partisan arguments regarding any approach, due to concern about being socialised into accepting another perspective and overlooking its shortcomings. Together with the thin evidence-base for internally-driven organisational change in healthcare, this makes me cautious about CP becoming more integrated within a system which it aims to change, lest it unwittingly becomes co-opted.

Consequently, I learned to reduce the potential impact on the study of my preconceptions using the quality assurance techniques. Although the results mostly fitted the preconceptions outlined, some surprised me and I did become slightly more supportive of CP's adoption of statutory powers. Perhaps partly due to having personal therapy at the time,

arguments about power being inescapable or coercion already existing subtly in therapeutic relationships seemed quite compelling, and I decided that I was insufficiently experienced to judge the role's appropriateness within specific specialities.

2.6 Using Available Support

Through research supervisors, peer supervision and consultation with individual trainees, I have sought academic feedback, constructive criticism and support. Whilst this initially felt exposing I now feel more comfortable doing it.

3.0 If you were able to do this project again, what would you differently and why?

3.1 Conceptual Frames and Theory Development

I would use a clear conceptual/theoretical frame with research questions rooted in theory and ensure that theory I developed explained phenomena rather than described it, had implications and testable hypotheses. I would address the strengths and weaknesses of any theory and any decision to collapse data.

3.2 Planning

I would commence planning and analysing sooner to reduce pressure towards the end. I would also conduct a pilot focus group. Despite practising working through the discussion guide individually with the consultants, conducting a focus group proved difficult. I found keeping questions in mind, finding appropriate interruption points, steering dialogue and maintaining a detached style challenging. Asking questions as intended was difficult when participants interrupted or changed the subject, perhaps partly due to the seniority of the participants.

3.3 Sampling

Analysing different data sets together had disadvantages: they used different populations (six senior CPs versus almost 300 of varying levels of seniority), different collection methods (questionnaire versus focus group) collected at different times (before and after: legislation, policy changes, altered demographics, economic difficulties). This might have led to over-emphasising one group or using groups which represented different populations.

Ideally one would have sampled from a single time frame. Whilst the survey data set was very large, available, highly relevant and appeared important, it was also old, which prevented this. If repeating the study I would have used a larger up-to-date sample to eliminate the possibility of unduly emphasising old data. I would have sampled additional participants with different bandings from various specialist groups to increase the generalisability of results and purposefully sampled more individuals with opposing or neutral positions, to ensure these were better represented. I would also record more demographic details (age, gender, ethnicity, private/public sector) to observe any patterns.

4.0 Clinically, as a consequence of doing this study, would you do anything differently and why?

4.1 Contextualising

This study has impressed upon me the importance of discussing with colleagues CP's purpose in relation to services. I believe that CP can be a confusing identity, especially when newly trained, and that better awareness of the contrasting perspectives may aid self-orientation. As I now feel that reliance on a uni-disciplinary body of knowledge can reduce breadth, flexibility and contextualisation, I would draw on (and draw colleagues' attention to)

other areas of human science more e.g. sociology, history, organisational and political psychology. Understanding maintenance processes from a broader perspective may reduce the possibility of expending energy ineffectively in trying to achieve change.

4.2 Increased Awareness of Power and Coercion

My awareness of power has been heightened, especially regarding whether clinicians locate CP's power in its expertise, collaborative approach or both. I have increasingly felt that the CP role is not completely non-coercive, due to the subtle processes through which coercion can be exacted upon clients (Szmukler & Appelbaum, 2008; Winick, 2008), and the network of compulsion within which CP exists. I am more aware that some perceive CPs who distance themselves from coercive practices as lacking credibility. I have some sympathy with this view – other professions have 'therapeutic relationships' too: why should theirs suffer but not ours? Yet I would still resist applying for the role because I perceive considerable value in relationships with some distance from coercive practice, however slight.

I am more aware of problems stemming from the fundamental contradiction in having services with the dual purpose of providing both security and care, such as the way in which consensual alternatives are rarely tried (May, 2005). I discuss detention powers with colleagues more now and note that their views often change following discussion as they have previously been insufficiently exposed to the arguments.

5.0 If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?

5.1 Further Research

Further research could devise a questionnaire to test and refine the model and determine relative belief weightings using a linear regression analysis. It could develop the theory more by investigating CPs' beliefs about underlying issues such as professional identity, the use of compulsion, drivers of organisational change and ambivalence about the two beliefs e.g. using other case studies.

This would require larger samples from a range of faculties, special interest groups and networks. Qualitative and quantitative questionnaire surveys and interviews could be used. As almost all focus group participants held senior posts, eliciting views from both managerial level and more junior clinicians would be necessary. Investigating perceptions of the degree to which CPs feel they do influence and change services could also be valuable.

Finally, some (e.g. Cattrall et al., 2001; Holmes, 2002) dispute suggestions that service-users support CPs having statutory powers. Therefore, establishing what importance service-users place on who detains them and what they believe CP is, or should be, for in relation to services, might be useful. Although they were not the focus of the study, the investigator informed it by seeking service-users' views, organising a research consultation meeting with an advisory group. There were notable difficulties eliciting views relating to CPs, perhaps indicating that the issue of CPs adopting a statutory role was less important to service-users than CPs.

Overall this study has been a difficult but valuable process. It has significantly developed my awareness and understanding of the context in which CP exists and the resulting conflicts and dilemmas. I am glad to have been able to contribute some valuable findings to this developing profession.

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Appendix I – Literature Search Methodology

First stage	
Search engines	ASSIA (1980-2011), ProjectMuse (1980-2011), IngentaConnect (1980-2011), Web of Knowledge (1980-2011), SAGE Journals Online (1980-2011), ScienceDirect (1980-2011), EBSCOHost (1980-2011), PscINFO (1980-2011), Google Scholar (1980-2011)
Search terms	"clinical psychology" AND "nature" OR "purpose"; "clinical psychologist" OR "clinical psychology" AND "beliefs" OR "values" OR "goals" OR "attitudes"; "clinical psychology" AND "relationship"; "clinical psychology" AND "mental health services" OR "mental health professions"
Inclusion criteria	• Articles, books or letters focussing on the nature or purpose of British clinical psychology in relation to mental health services
Exclusion criteria	• Articles, books or letters published before 1980 • Articles, books or letters published in a language other than English • Articles, books or letters published after 2011 (when search was conducted)
Results	• Relevant articles, books or letters were selected after scrutinising contents of titles and abstracts and references cited within selected articles, books or letters • 60 articles, books or letters were found
Second stage	
Search engines	ASSIA (1998-2010), CINAHL (1998-2010), Informaworld (1998-2010), Ingenta Connect (1998-2010), Project Muse (1998-2010), PsycARTICLES (1998-2010), PsycINFO (1998-2010), SAGE Journals Online (1998-2010), ScienceDirect – all journals (1998-2010), EBSCOHost (1998-2010), Cochrane Library (1998-2010) and Web of Knowledge (1998-2010).
Search terms	"responsible clinician" AND "clinical psychology" OR "clinical psychologist"; "compulsory detention" AND "clinical psychology"; "clinical psychology" AND "mental health act" AND / OR "identity"; "clinical psychologist" AND "mental health act" AND / OR "role", "approved clinician" AND "clinical psychology"; "approved mental health professional" AND "clinical psychology"; "clinical supervisor" AND "clinical psychology"; "clinical psychologist" AND "identity"; "clinical psychology" AND "role".
Inclusion criteria	• Articles or letters focussing on clinical psychology and either the RC or AMHP role • Articles or letters focussing on clinical psychology and compulsory detention powers
Exclusion criteria	• Articles or letters published before 1998 (when reform began) • Articles or letters published in a language other than English • Articles or letters published after 2010 (when search was conducted)
Results	• Relevant articles or letters were selected after scrutinising contents of titles and abstracts and references cited within selected articles or letters • 30 articles or letters were found
Third stage	
Inclusion criteria	• Research studies focussing on the views of British clinical psychologists on the RC / AMHP roles and / or powers of compulsion for the profession
Results	• 2 research studies were found.
Fourth stage	
Third stage	A later search for wider literature was conducted using the key search terms "compulsion"; "Mental Health Act"; "conceptualisation of mental illness"; "sociology of professions"; "clinical psychology" AND "history" using the above search engines

	and Google. The above articles or letters from the initial search above were also scrutinised for references to wider literature and individuals known to the author were asked for references.
Inclusion criteria	• Literature focussing on the use of compulsion in mental health • Literature focussing on the conceptualisation of mental illness • Literature focussing on the sociological theory of professions • Literature focussing on the history of clinical psychology and / or mental health services
Exclusion criteria	• Literature published before 1950
Results	• 33 items were selected

Appendix II – E-mail to Faculty of Psychosis and Complex Mental Health Members

Dear Faculty member,

I will be running a focus group at the end of the Faculty of Psychosis and Complex Mental Health meeting at the British Psychological Society London office on the 12th May. This will be carried out (Ethics Panel approval pending) as part of a doctoral thesis exploring Clinical Psychologists' views on the Responsible Clinician role and powers of compulsion for their profession introduced in the Mental Health Act (2007). (An information sheet is attached).

If you would like to participate in this focus group please e-mail me at: tp75@canterbury.ac.uk giving your name and an address where a consent form can be sent for you to sign. Thankyou for taking the time to read this message.

Yours sincerely,

Tom Parsloe,
Trainee Clinical Psychologist,
Canterbury Christ Church University.

Appendix III – Information Sheet For Focus Group Participants

INFORMATION SHEET FOR FOCUS GROUP PARTICIPANTS

Study: **Compulsory powers and the Responsible Clinician role:**

Clinical Psychologists' views

Researcher: Tom Parsloe, trainee clinical psychologist
Canterbury Christ Church University

You are being invited to take part in a research study. Before deciding whether or not to take part in the study, it is important to understand why the research is being carried out and what it will involve. Please read the following information carefully.

What is the purpose of the study?

Under the revisions to the Mental Health Act (1983) the clinical psychology profession has been granted new powers. By adopting a 'responsible clinician' role, it is now possible for clinical psychologists to fulfil the majority of the functions previously carried out by psychiatrists under the 'responsible medical officer' role. By adopting another role: 'approved mental health professional' role, clinical psychologists are conferred powers and responsibilities similar to those previously held by the 'approved social worker'. It is possible to adopt either of these roles or both.

Attempts to ascertain clinical psychologists' views regarding the responsible clinician role have been made but have obtained contrasting findings. Uptake of approved mental health professional training places by clinical psychologists has so far been limited.

The main aim of the investigation is to explore clinical psychologists' views on the responsible clinician role and powers of compulsion for their profession. As these developments potentially introduce significant changes to the roles of clinical psychologists it is important to ascertain their views in order to inform the future debate.

The study will collect data by means of a focus group containing clinical psychologists with a range of views. The focus group will be added onto the end of

the Psychosis and Complex Mental Health (PCMH) Faculty meeting at the British Psychological Society London Office on the 12th of May and will last for 1 hour.

If the researcher is unable to obtain enough participants with a range of views for the focus group he may carry out individual telephone interviews with those who are willing to do this instead.

Why have I been invited to participate?

The Psychosis and Complex Mental Health Faculty was chosen as a source of clinical psychologists likely to work in areas where detention under the Mental Health Act occurs. You have been invited to participate as you are a member of this Faculty. Up to 5 other people will be asked to participate.

Do I have to take part?

It is your decision whether or not to take part. If you do decide to take part you will be asked to sign a consent form and indicate on two opinion scales your views on the introduction of the responsible clinician role and compulsory powers in clinical psychology. You will still be free to withdraw at any time without giving a reason. You also have the right to withdraw retrospectively any consent given and to request that your own data, including recordings, be destroyed.

Is anyone excluded from participating?

In order to increase homogeneity and reduce the possibility of power imbalances within the group certain individuals will not be able to participate: Assistant Psychologists, Trainee Clinical Psychologists; Clinical Psychologists who do not practice in the UK and Clinical Psychologists who manage another participant / whose manager is another participant. In the event of a participant and their manager both wishing to participate it is requested that they decide between themselves who will attend.

In order to select participants with a wide range of opinions two scales are included in the consent form to ascertain where each person positions him / herself. The researcher will also deliberately try to recruit too many participants in case some agree to attend initially but are then unable to attend on the day of the meeting. Both of these factors may result in a participant not being selected for the study even if

they do consent. It may not be possible for the researcher to tell some participants this until the day of the meeting.

What will happen to me if I take part?

You will be asked to take part in an audiotaped discussion on the introduction of the responsible clinician role and the power to compulsorily detain in clinical psychology, indicating your views and reasons for these. This will last 60 minutes.

What are the possible disadvantages and risks of taking part?

A possible disadvantage is giving up 60 minutes of your time. There is also a potential threat to privacy should any participants choose to disclose outside the group personal information which was shared in the course of the discussion. You must agree not to do this if taking part. There is also a risk of over-disclosure i.e. disclosing more than you intend and regretting this in retrospect. The moderator will agree boundaries at the beginning in order to reduce the chances of this happening. There is also a potential risk of emotional stress from disagreeing with colleagues during discussion. To reduce this you will be free to leave the room or take a break from the discussion if you wish to do so.

What are the possible benefits of taking part?

A chance to further our understanding and your own of an important debate within the profession of clinical psychology.

Will what I say in this study be kept confidential?

All information collected about you will be kept strictly private and confidential. Professional banding, years since qualification and specialist area will be recorded but names and other potentially identifying information (such as places or events) will be removed or altered. Should use of comments in the analysis risk revealing your identity then the author would obtain permission from you before using them. The focus group audio-recording will be kept on a memory stick as a password protected file in a locked cabinet. Following the conclusion of the study the data will be kept according to Canterbury Christ Church University's policy. Data will be coded and

kept electronically on a password protected CD in the Clinical Psychology programme office of the Department of Applied Psychology, Canterbury Christ Church University, Broomhill Road, Tunbridge Wells, Kent TN3 0TG and on the memory stick in a locked cabinet in the investigator's residence for 10 years. After 10 years all data will be destroyed.

What should I do if I want to take part?

If you wish to take part please e-mail Tom Parsloe at tp75@canterbury.ac.uk giving your name and an address where he can send you a consent form to sign.

What will happen to the results of the research study?

The results of the research will be used for a thesis as part of a doctoral course in clinical psychology and will be submitted for publication. After completion of the study you will be provided with a summary. If you wish to receive a copy of the report in full you may request one by contacting the researcher at tp75@canterbury.ac.uk

Who is organising and funding this research?

Tom Parsloe is conducting the research as a trainee clinical psychologist on the Clinical Psychology Programme, Dept. Of Applied Psychology, Canterbury Christ Church University, Broomhill Road, Tunbridge Wells, Kent TN3 0TG. This organisation is funding the research.

Who has approved this study?

The research has been approved by the Research Review Panel and is pending approval by the Salomons Ethics Panel as part of the Clinical Psychology Programme, Department of Applied Psychology, Canterbury Christ Church University.

Concerns

If you have any concerns or wish to make a formal complaint about the way in which this research has been carried out you can do so to the researcher's supervisor at: anne.cooke@canterbury.ac.uk

Contact for further information

If you have any questions you can contact Tom Parsloe, trainee clinical psychologist for further information at tp75@canterbury.ac.uk

Thank you

Thankyou for taking the time to read the information sheet.

2

Survey on Proposed Reforms to Mental Health Legislation

Dear fellow DCP members,

We summarised the Government's proposed reforms to mental health legislation (i.e. the White Paper *Reforming the Mental Health Act*) in *Clinical Psychology 1*, May 2001. If they are enacted in their current form, the proposals are likely to impact substantially on clinical psychologists. We are involved with others in formulating a Society response to the proposals, and need to know the views of the members of the Division. We would therefore urge everyone to complete this brief questionnaire and send it to us.

Anne Cooke, Peter Kinderman and Dave Harper

1. Clinical psychologists as "Clinical Supervisors"

The government is proposing that the current Responsible Medical Officer role should be replaced by that of "Clinical Supervisor". Clinical Supervisors will be responsible for overseeing the compulsory care plans that will replace the current "sections", and it is explicitly stated that this role could be carried out by psychologists as well as psychiatrists. Some welcome this development, seeing it as a means of introducing psychological perspectives into decisions about compulsory treatment, whilst others fear that it might compromise our professional values. There has also been some debate about the likely effects on the profession itself in the longer term. Some welcome the additional power, viewing the development as a recognition of our contribution, an opportunity to play a more central role in services and as likely to enhance our professional status. Others fear that it could impact adversely on the balance and nature of our work, on therapeutic relationships and perhaps even on our professional values.

Please tick whichever (one) of these two statements best represents your views:

The profession should resist this development	[ ] a1
The profession should be open to this development	[✓] a2

It would also be helpful to know how many clinical psychologists are likely to volunteer to be Clinical Supervisors if they are given the choice. Which (one) of these three statements best represents your views:

I would be willing to be a Clinical Supervisor if offered appropriate training	[✓] b1
I would be unlikely to volunteer to be a Clinical Supervisor if given the choice	[ ] b2
I would refuse to be a Clinical Supervisor even if put under pressure to do so	[ ] b3

Please feel free to add any comments:

2. To whom should the legislation apply?

The existing Mental Health Act draws on the idea of diagnosable "mental illnesses" in deciding who comes under its scope. The current proposals draw instead on a broad concept of "mental disorder", defined as "any disability or disorder of mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning". The basis on which someone will be judged to be "mentally disordered" is unclear. The Society has recommended that this wide definition be augmented with specific, functional (i.e. behavioural) criteria, and that decisions should be based on the extent to which people are capable of making the relevant decisions (e.g. consent to treatment). It has suggested that the issue of people who retain such capacity but are considered a risk to others would be more appropriately dealt with under criminal justice legislation.

Do you agree or disagree with the following?

People should only be subject to mental health legislation if their judgement is (permanently or temporarily) impaired to the extent that they are incapable of making the relevant decisions for themselves (e.g. consent to treatment).

I AGREE [x] I DISAGREE [ ] c1

Please feel free to add any comments:

3. "Dangerous People with Severe Personality Disorder"

The government is proposing to use mental health legislation to impose compulsion on people who are considered dangerous "as the result of a severe personality disorder". Whilst highlighting the potential effectiveness of psychological interventions with offending behaviour, the Society has suggested that there are problems with this concept and that this issue would be more appropriately dealt with under criminal justice legislation.

Do you agree or disagree with the following:

To call someone who is habitually violent "personality disordered" is circular and adds nothing to our understanding of the causes of, or likely remedy for, such behaviour.

I AGREE [x] I DISAGREE [ ] d1

Access to psychological interventions for people who have exhibited violent behaviour should not be dependent on the person being assessed as "personality disordered".

I AGREE [x] I DISAGREE [ ] d2

Mental health legislation is an inappropriate vehicle for imposing controls on people thought to be dangerous who are capable of making valid decisions for themselves, whether or not they are thought to be "personality disordered".

I AGREE [x] I DISAGREE [ ] d3

It is not possible accurately to predict serious violence in someone who has not yet been violent. To base compulsion on such predictions would lead to a significant number of people being deprived of their liberty who would not have gone on to commit dangerous acts.

I AGREE [x] I DISAGREE [ ] d4

Please feel free to add any comments:

Please feel free to add any comments about the proposals in general or about this questionnaire (continue on another sheet if necessary):

I confirm, by completing and submitting this form, that I am a member of the British Psychological Society's Division of Clinical Psychology.

Name *(Optional)* Speciality

Please complete, and send by **Monday 10 September 2001** to: Anne Cooke, Doctoral Programme in Clinical Psychology, Salomons, Broomhill Road, Southborough, Kent TN3 0TG; e-mail a.cooke@salomons.org.uk; Tel: 01892 507631

Appendix V – Combined Interview Guide and Semi-structured Interview for Focus Group

Welcome and statement of purpose

Welcome to everybody and thank you all so much for agreeing to take part in this focus group today. As you know this focus group is part of a doctoral research study and the purpose of the group is to discuss the introduction of the responsible clinician role and power to compulsorily detain for clinical psychologists. This is an issue that people have different feelings about and I am interested in getting a range of views in order to contribute to the discussion. The plan is to spend about 60 minutes discussing it.

I will be moderating the group from a position of impartiality and trying to allow everyone an equal opportunity to say what they think. I would ask people to be respectful of each other's opinions and not to interrupt when another person is speaking. You are under no obligation to answer any of the questions if you do not wish to do so. If you are feeling at all uncomfortable or under stress at any point please feel free to take a break or leave the room.

It is sometimes possible to disclose more than one intends and regret it subsequently in such groups as this. In order to reduce the possibility of this happening perhaps I could ask if there is anything that anyone would prefer not to discuss?

Could I please ask everybody to switch off mobile phones because even if they are set to silent they use a frequency when receiving texts which can be picked up by the recording equipment?

1) If we could all introduce ourselves with our first name, professional banding and area of clinical psychology: my name is Tom Parsloe, Band 6 and as I am a trainee clinical psychologist I have no specialist area.

2) I would like to start by asking you to indicate where you position yourselves in the responsible clinician and powers for compulsory detention debate:-

   - Who feels more favourable towards this development?

   - And who feels less favourable towards this development?

   - Who takes a more neutral position?

   - Does anyone draw a distinction between how they feel about the responsible clinician role and the powers for compulsory detention i.e. does anyone see these as separate debates?

   - Could I now ask people why they hold particular positions - let's start with those who are in favour first, why do you take such a position? Could you tell me more about that? Why do you think that?

- And why do those who oppose this development take such a position? Could you tell me more about that? Why do you think that?

- And why do those adopting a neutral stance take such a position? Could you tell me more about that? Why do you think that?

- How about those who draw a distinction between the responsible clinician role and the powers for compulsory detention, taking different stances on these? Why do you take different positions here? Could you tell me more about that? Why do you think that?

3) Perhaps now if we look at some more specific questions. What are people's views on the implications for the therapeutic relationship and the effectiveness of therapy as a result of these new roles? Could you tell me more about that? Why do you think that? What other views are there?

   (If little discussion generated): Dave Pilgrim has pointed out that there are two contrasting views here: some people see clinical psychologists as existing on the outside of the coercive system of mental health services and think it is important to retain this whereas others argue that as part of the system of social control they are therefore coercive by implication already. What are your views? Could you tell me more about that? Why do you think that? What other views are there?

4) A related question is whether supporting colleagues is a factor or not in the positions you have adopted? What are your views? Could you tell me more about that? Why do you think that? What other views are there?

   (If little discussion generated): It has been suggested by John Taylor that clinical psychologists have been guilty of preciousness in expecting their multi-disciplinary team colleagues to carry out a distasteful role but then criticising them for the way in which they do it. What are your views? Could you tell me more about that? Why do you think that? What other views are there?

5) Another question is the balance of roles and whether capacity to provide psychological treatment will be affected by the new roles? What are your views? Could you tell me more about that? Why do you think that? What other views are there?

6) Another issue is that of the influence of psychology in mental health. Does anyone think the new roles have any implications here? What are these? Can you tell me more about that? Why do you think that? What other views are there?

   (If little discussion generated): Peter Kinderman feels that taking on these roles will increase the influence of psychological models and therefore improve the service provided because the system will be more humane. Others such as Guy Holmes and Dave Harper feel that influence will not necessarily increase because of this and that influence can be increased without additional powers anyway. What are your views?

Could you tell me more about that? Why do you think that? What other views are there?

7) Guy Holmes and Dave Harper are also concerned that having such powers may negatively influence the way in which psychologists practice, pointing to the Stanford Prison Experiment as an example of how this can happen. What are your views? Could you tell me more about that? Why do you think that? What other views are there?

8) Some people, such as Dave Pilgrim have suggested that the government's aim behind granting clinical psychologists the responsible clinician role has been to circumvent the difficulties with detaining dangerous people with personality disorders posed by the medical view that they are untreatable. What are your views? Could you tell me more about that? Why do you think that? What other views are there?

   (If little discussion generated): Tony Black argues that RMOs may make decisions for other professionals that they are not adequately skilled to make, for example choosing not to admit individuals who are in fact treatable psychologically. He feels that clinical psychologists having the responsible clinician role will solve such problems and such people will therefore not be denied treatment that they could benefit from. However Guy Holmes argues that you cannot force someone to comply with psychological therapy in any case. What are your views? Could you tell me more about that? Why do you think that? What other views are there?

9) The final issue is status and salary. Peter Kinderman suggests that these could be motivations for accepting the role. What are your views? Could you tell me more about that? Why do you think that? What other views are there?

10) Are there any points or issues that anyone feels have been missed? Would anyone like to add anything to what has been discussed? Could you tell me more about that? Why do you think that? What other views are there?

<u>Debrief</u>

How do you feel having discussed this today? What has it been like for you to talk about this subject? Has anyone found it difficult or distressing in any way? How might this be managed? What will people take from this after they leave?

We will end there then. I'd like to thank you all again for agreeing to take part today and for all of your contributions in what has been an extremely interesting discussion.

Appendix VI – Letter of Approval from Ethics Panel

THIS HAS BEEN REMOVED FROM THE ELECTRONIC COPY

INFORMATION SHEET FOR CONSULTANTS

Study: **Compulsory powers and the Responsible Clinician role:**

Clinical Psychologists' views

Researcher: **Tom Parsloe, trainee clinical psychologist,**
Canterbury Christ Church University

You are being invited to offer consultation as part of a research study. Before deciding whether or not to take part in the study, it is important to understand why the research is being carried out and what it will involve. Please read the following information carefully.

What is the purpose of the study?

Under the revisions to the Mental Health Act (1983) the clinical psychology profession has been granted new powers. By adopting a 'responsible clinician' role, it is now possible for clinical psychologists to fulfil the majority of the functions previously carried out by psychiatrists under the 'responsible medical officer' role. By adopting another role: 'approved mental health professional' role, clinical psychologists are conferred powers and responsibilities similar to those previously held by the 'approved social worker'. It is possible to adopt either of these roles or both.

Attempts to ascertain clinical psychologists' views regarding the responsible clinician role have been made but have obtained contrasting findings. Uptake of approved mental health professional training places by clinical psychologists has so far been limited.

The main aim of the investigation is to explore clinical psychologists' views on the responsible clinician role and powers of compulsion for their profession. As these developments potentially introduce significant changes to the roles of clinical psychologists it is important to ascertain their views in order to inform the future debate.

The study will collect data by means of a focus group containing clinical psychologists with a range of views. The combined interview guide and semi-structured interview for this focus group will be tested out in individual consultations with two clinicians working within clinical psychology to ensure that any potential problems with the questions are identified and addressed.

Why have I been invited to participate?

You have been invited to participate as you have professional knowledge and experience in the field of clinical psychology and are therefore likely to be able to identify potential problems which might occur when clinical psychologists are asked to respond to the interview guide and semi-structured interview questions.

Do I have to take part?

It is your decision whether or not to take part. If you do decide to take part you will be asked to sign a consent form and indicate on two opinion scales your views on the introduction of the responsible clinician role and compulsory powers in clinical psychology. You will still be free to withdraw at any time without giving a reason. You also have the right to withdraw retrospectively any consent given and to request that your own data be destroyed.

What will happen to me if I take part?

You will be asked to meet with the researcher individually for up to 1 hour to be consulted on a combined interview guide and semi-structured interview for a focus group. This will entail discussing the introduction of the responsible clinician role and the power to compulsorily detain in clinical psychology, indicating your views and reasons for these, before then being asked to express your views on the questions used for this discussion. The consultation will be audio-recorded.

What are the possible disadvantages and risks of taking part?

A possible disadvantage is giving up 60 minutes of your time. There is a risk of over-disclosure i.e. disclosing more than you intend and regretting this in retrospect. The researcher will agree boundaries at the beginning in order to reduce the chances of this happening.

What are the possible benefits of taking part?

A chance to further our understanding and your own of an important debate within the profession of clinical psychology.

Will what I say in this study be kept confidential?

All information collected about you will be kept strictly private and confidential. Professional banding, years since qualification (if applicable) and specialist area (if applicable) will be recorded but names and other potentially identifying information (such as places or events) will be removed or altered. Once any amendments have been made to the interview guide and semi-structured interview questions the consultation recordings will be deleted. In line with Canterbury Christ Church University's policy, electronic data will be coded and kept on a password protected CD in the Clinical Psychology programme office of the Department of Applied Psychology, Canterbury Christ Church University, Broomhill Road, Tunbridge Wells, Kent TN3 0TG and on a password protected file on a memory stick in the investigator's possession for 10 years after the completion of the research project. After 10 years all data will be destroyed.

What should I do if I want to take part?

If you wish to take part please e-mail Tom Parsloe at tp75@canterbury.ac.uk.

What will happen to the results of the research study?

The results of the research will be used for a thesis as part of a doctoral course in clinical psychology and will be submitted for publication. After completion of the study you will be provided with a summary. If you wish to receive a copy of the report in full you may request one by contacting the researcher at tp75@canterbury.ac.uk.

Who is organising and funding this research?

Tom Parsloe is conducting the research as a trainee clinical psychologist on the Clinical Psychology Programme, Dept. Of Applied Psychology, Canterbury Christ Church University, Broomhill Road, Tunbridge Wells, Kent TN3 0TG. This organisation is funding the research.

Who has approved this study?

The research has been approved by the Research Review Panel and is pending approval by the Salomons Ethics Panel as part of the Clinical Psychology Programme, Department of Applied Psychology, Canterbury Christ Church University.

Concerns

If you have any concerns or wish to make a formal complaint about the way in which this research has been carried out you can do so to the researcher's supervisor at: anne.cooke@canterbury.ac.uk

Contact for Further Information

If you have any questions you can contact Tom Parsloe, trainee clinical psychologist for further information at tp75@canterbury.ac.uk

Thank you

Thankyou for taking the time to read the information sheet.

Appendix VIII – Consent Form and Opinion Scale For Consultants

Faculty of Social and Applied Sciences
Clinical Psychology Doctoral Programme
Canterbury Christ Church University
Tunbridge Wells Campus

CONSENT FORM AND OPINION SCALE

Study: **Compulsory powers and the Responsible Clinician role:**

Clinical Psychologists' views.

Researcher: Tom Parsloe, trainee clinical psychologist,
Canterbury Christ Church University

✓

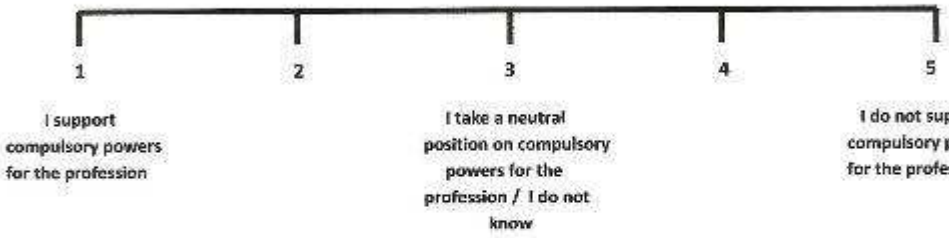
1) Please tick to confirm

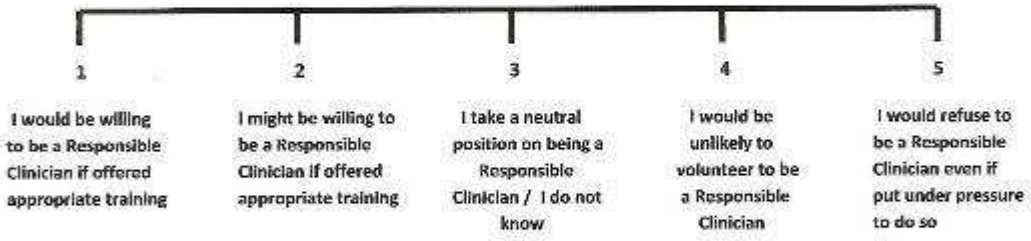
I confirm that I have read and understand the information sheet for the above study.	[ ]
I have been given the opportunity to consider the information, ask questions and have had these answered satisfactorily.	[ ]
I understand that the consultation is voluntary, that I am not obliged to respond to any questions asked and am free to withdraw at any time, without giving any reason.	[ ]
I agree to the consultation being audio-recorded.	[ ]
I understand that my personal identity will remain confidential but that professional grade, years since qualification and speciality may be included.	[ ]
I understand that because of this consultation, there could be violations of my privacy. To prevent violations of my privacy, I agree not to talk about any of my own experiences that I would consider too personal or revealing.	[ ]
I agree to take part in the consultation for the above research study.	[ ]

Name of Participant _____ Date _____ Signature _____

Faculty of Social and Applied Sciences
Clinical Psychology Doctoral Programme
Canterbury Christ Church University
Tunbridge Wells Campus

2) Please circle the number on each scale below which most closely corresponds with your view





THANKYOU FOR YOUR TIME

(PLEASE RETURN IN THE STAMPED ADDRESSED ENVELOPE PROVIDED)

Appendix IX – Explanatory Note Regarding Opinion Scale

For the focus group, in consultation with the research supervisor, the investigator developed two 5-point Likert Scales to assess participants' opinions regarding the introduction of compulsory powers for the profession and their degree of willingness to act as a RC. In the event of more than six participants (the maximum number required) volunteering for the focus group, the intention had been to use these scales to sample those with a range of positions from the volunteers rather than have one position disproportionately represented in the focus group. However, as only six participants volunteered for the focus group, the results of this measure were not used and consequently it is not discussed in the report.

Appendix X – Consent Form And Opinion Scale For Focus Group Participants

Faculty of Social and Applied Sciences
Clinical Psychology Doctoral Programme
Canterbury Christ Church University
Tunbridge Wells Campus

CONSENT FORM AND OPINION SCALE FOR FOCUS GROUP PARTICIPANTS

Study: **Compulsory powers and the Responsible Clinician role:**

Clinical Psychologists' views

Researcher: Tom Parsloe, trainee clinical psychologist,
Canterbury Christ Church University

1) Please tick to confirm	✓
I confirm that I have read and understand the information sheet for the above study.	[ ]
I have been given the opportunity to consider the information, ask questions and have had these answered satisfactorily.	[ ]
I understand that participation is voluntary, that I am not obliged to respond to any questions asked and am free to withdraw at any time, without giving any reason.	[ ]
I agree to the focus group / telephone interview (*delete if not applicable*) being audio-recorded.	[ ]
I agree to the use of anonymised quotes in publications. I understand that my personal identity will remain confidential but that professional banding, years since qualification and speciality may be included.	[ ]
I understand that because of this study, there could be violations of my privacy. To prevent violations of my own or others' privacy, I agree not to talk about any of my own or others' private experiences that I would consider too personal or revealing.	[ ]
I also understand that I have an obligation to respect the privacy of the other members of the group by not disclosing any personal information that they share during the discussion.	[ ]
I understand that data collected during the study, will be seen by responsible individuals from a transcribing company.	[ ]
I agree to take part in the above research study.	[ ]

Name of Participant _____ Date _____ Signature _____

Faculty of Social and Applied Sciences
Clinical Psychology Doctoral Programme
Canterbury Christ Church University
Tunbridge Wells Campus

2) **Please indicate your preference below**

If the researcher is unable to obtain enough participants for a focus group:-

a) I would be willing to be contacted by the researcher for a telephone interview and to arrange this could be contacted at _____ (please enter contact details).

b) I would not be willing to be contacted by the researcher for a telephone interview ____ (please tick).

3) **Please circle the number on each scale below which most closely corresponds with your view**

1	2	3	4	5
I support compulsory powers for the profession		I take a neutral position on compulsory powers for the profession / I do not know		I do not support compulsory powers for the profession

1	2	3	4	5
I would be willing to be a Responsible Clinician if offered appropriate training	I might be willing to be a Responsible Clinician if offered appropriate training	I take a neutral position on being a Responsible Clinician / I do not know	I would be unlikely to volunteer to be a Responsible Clinician	I would refuse to be a Responsible Clinician even if put under pressure to do so

THANKYOU FOR YOUR TIME

Appendix XI - Number of Questionnaire Respondents by Specialty

Specialty	Number of participants (n)	Percentage of total (%)
Addictions / Substance Misuse	2	0.7
Adult Mental Health	62	21.3
Assistant Clinical Psychologist	2	0.7
Child and Adolescent	19	6.5
Community Psychology	1	0.3
Dual Diagnosis	1	0.3
Eating Disorders	2	0.7
Forensic	29	9.9
Health / Medical Psychology	7	2.4
Learning Disabilities	18	6.2
Mixed Specialties	59	20.2
Neuropsychology	11	3.8
Older Adults	15	5.1
Pain Management	2	0.7
Personality Disorder	2	0.7
Primary Care	3	1.0
Private practice	1	0.3
Psychodynamic psychotherapy	1	0.3
Psychotherapy	3	1.0
Rehabilitation	9	3.1
Sexual Health	1	0.3
Severe and Enduring Mental Health	4	1.4
Trainee Clinical Psychologist	6	2.1
Unknown / Not specified	30	10.3
Total	292	100

Appendix XII - Category Development

53 initial focused codes

Paternalism and the protection of others justify coercion	Compulsion is a realistic and necessary feature of services	Involvement in compulsion is appropriate sharing of a difficult responsibility	Services are too medically oriented and / or harmful to clients	CPs understand the needs of some clients better	CPs are advocates for clients	Greater involvement of CPs will humanise the process of care	The powers will enable CPs to advocate for clients
CPs are already involved in detention / social control	Acknowledging involvement in compulsion is transparency / honesty	CP has a lack of agency to reduce harm	CP is a sensitive and humane profession	The powers offer an opportunity to use the relationship	Medical dominance over other models / professions will be reduced if CPs have the powers	Some clients' needs will be met better if CPs have the powers	Pay is an incentive to carry out the role
Opposition to the powers is immature, obstructive or avoidant behaviour	CPs are vulnerable to health service budget cuts	The powers will make CPs less vulnerable to cuts	The powers will enable CPs to influence the concept and treatment of mental illness	Change is more achievable from within the system	The powers will enhance the status of CPs	CPs should receive similar pay to psychiatrists	The powers will have a limited effect on other roles
Accepting the powers is a necessary compromise	Rejecting the powers would be impractical and harmful	Taking on the powers can be an optional role	The therapeutic role can be protected	Professional ability to predict risk is poor	The existence of mental health legislation or the practice of compulsion are contestable	Involvement in coercion is antithetical to nature of CP	The powers may prompt a departure from the profession / NHS
A coercive role is based on a conflicting model of mental disorder	Separation from coercion makes CP unique amongst the professions	CP is an autonomous discipline	There is a need for a non-coercive profession	Lacking powers of compulsion is an advantage	Separation from coercion enables collaborative empowering relationships	The powers might reduce CPs' ability to advocate for clients	The powers will have a negative effect on clients' perceptions of CPs
CP will lose its distinctiveness from Psychiatry	CPs will be socialised into a social control role	The powers may have a corrupting influence	The powers create an excess of roles	Accepting the powers is colluding with, rather than influencing the system	A desire for status or power is motivating acceptance of the powers and these are unlikely to be enhanced	Employers' expectations regarding the powers may change	CPs are powerless if employers' expectations change regarding the powers
The powers are incompatible with a collaborative therapeutic relationship	More power is unlikely to corrupt CPs	There is a localised consensus against having the powers	The powers will increase the credibility of CPs	The imperative to help clients outweighs other values			

These were refined and combined to form **17 sub-categories**

Compulsion is necessary and justifiable	CP is implicated in the process of compulsion	Psychiatric dominance in mental health services is often harmful to clients	Compulsion is incompatible with CP's values	The profession will be less dispensable	The powers will not increase the influence or enhance the status of CP
CP is distinctive and more autonomous because of its separation from the system of coercion	The powers will increase the influence, status and credibility of CP within mental health services	The powers are likely to result in an increase in pay	Clients will receive better quality care	CPs are sensitive, humane advocates with a more sophisticated understanding of some clients' needs	The powers will compromise collaborative alliances with CPs and reduce the effectiveness of CP
The powers will reduce the roles available to CPs	The powers will have a negative impact on the role and identity of CP	Separation from the coercive system is valuable and enables collaboration	The risks are limited	The principle of compulsion is contestable	

These were refined and combined into **8 categories**

Compulsory treatment is compatible with CP's values	The new role will increase the power of CP	Greater power for CP will lead to more humane mental health services	Consequences will be positive for clients	Compulsory treatment is ethically problematic	A collaborative CP is only possible if separate from compulsion	Consequences will be negative for CP	Consequences will be negative for clients

With **2 overall themes**

Belief that CP can transform services from within by opportunistically accreting power	**Belief that CP must defend against assimilation by maintaining separate spaces for collaborative work**

Appendix XIII – Themes, Categories, Sub-categories and Codes with Text Examples

Theme	Category	Sub-category	Codes	Text examples
Belief that CP can transform services from within by opportunistically accreting power	Compulsory treatment is compatible with clinical psychology's values	Compulsion is necessary and justifiable	Paternalism and the protection of others justify coercion	"There are times when an individual is so ill that we have to be 'paternalistic'" (Questionnaire General comments, Respondent 452, Lines 413-414) "The rights of individuals have to be balanced against the rights of society" (Questionnaire General comments, Respondent 611, Lines 546-547)
			Compulsion is a realistic and necessary feature of services	"I don't at all like the idea of detention powers...I can see that they're important...I know perfectly well I can't deal with somebody who's completely out of it" (Focus group, Participant 5, Lines 154-157) "this should be possible except for those who do not believe certain individuals pose a danger to themselves or society and need restraining. To me such a view is unreal" (Questionnaire 1, Respondent 164, Lines 193-196)
		CP is implicated in the process of compulsion	CPs are already involved in detention / social control	"We can't shy away from the fact that we're in that discussion anyway, we're influencing those decisions, every time we go into a ward review or every time we meet and have that conversation with the client" (Focus group, Participant 2, Lines 524-527) "To pretend that we are not to some degree agents of social control is naive" (Questionnaire 1, Respondent 46, Lines 62-63) "I think psychologists already take part in decisions around detention, that are maybe less visible" (Focus group, Participant 6, Lines 240-242) "As a psychologist you're in that position of you know, I know I said to you the other day that you don't have to do that work with me but we both know that really you do if you want to move on. So that's, that's there, it's obvious" (Focus group, Participant 1, Lines 511-514)
			Acknowledging involvement in compulsion is transparency / honesty	"So long as the psychologist makes clear what their legal role is – with or without custodial powers – then the client is clear. Psychologists are already to some degree agents of social pressure. Better to be clear when ambiguity exists." (Questionnaire 1, Respondent 341, Lines 352 355) "making it visible isn't a problem for me because I think that's transparency" (Focus group, Participant 6, Lines 242-243)
			Involvement in compulsion is appropriate sharing of a difficult responsibility	"I feel that our profession should...if they work with psychiatry, do so by sharing the responsibility for the MHA 1983" (Questionnaire General comments, Respondent 613, Lines 557-560) "the medical profession...got fed up of being the villains and they wanted to share the responsibility and it's a large responsibility to be fair, for both social workers and medics to take away someone's liberty, it's a huge responsibility and I think most people are benign and have come into the, the profession to do a sense of good, so actually it's a point, it's a kind of plea to, you know, to share some of that responsibility" (Focus group, Participant 6, Lines 1006-1017)

			Opposition to the powers is immature, obstructive or avoidant behaviour	"It's time our profession moved on grew up and stopped making trite comments" (Questionnaire 1, Respondent 117, Line 154) "I do feel we should act in professionally responsible and grown up ways, not always sniping from the sidelines" (Questionnaire, Respondent 3, Lines 8-10) "Why should my willingness to undertake these new and important responsibilities be put to a vote of members who will be able to refuse such duties?" (Questionnaire 1, Respondent 541, Lines 678-680) "it's important to convey that we're not afraid of responsibility" (Questionnaire General comments, Respondent 130, Lines 115-116) "I have answered the way I have to the questions because I do not believe it is appropriate to shirk responsibility" (Questionnaire General comments, Respondent 72, Lines 58-59)
	Greater power for clinical psychology will lead to more humane mental health services	Psychiatric dominance within mental health services is often harmful to clients	Services are too medically oriented and / or harmful to clients	"The medical model and its dependence on drugs is too dominant for people with severe and enduring mental health problems" (Questionnaire General comments, Respondent 333, Lines 347-348) "People can get stuck in the system because maybe their difficulties are being perceived as part of a biological problem" (Focus group, Participant 2, Lines 887-888)
			Clinical psychology has a lack of agency to reduce harm	"We had instances of a patient at a critical phase of treatment...where the RMO decided that a transfer should be effected before the programme had been completed. Leaving the patient in mid-air is unethical yet we were powerless to prevent it" (Questionnaire General comments, Respondent 669, Lines 748-754) "I have seen many people over-medicated and denied psychological treatment because we lack the influence to prevent this" (Questionnaire 1, Respondent 671, Lines 919-921)
		CPs are sensitive, humane advocates with a more sophisticated understanding of some clients' needs	CP is a sensitive and humane profession	"We should be involved in improving the humanity of all services" (Questionnaire General comments, Respondent 316, Lines 315-316) "There is a need for a more humane attitude in overseeing compulsory care plans" (Questionnaire 1, Respondent 463, Lines 577-578) "In services where the psychiatric input is of 'dubious' quality a psychologist may be able to offer more sensitive and appropriate care" (Questionnaire 1, Respondent 665, Lines 902-904)
			CPs are advocates for clients	"we often know the patient better than any other professional, and so could act as an advocate" (Questionnaire 1, Respondent 48, Lines 72-74) "I am concerned that an absence of direct clinical psychology involvement...will increase the opportunity of inappropriate management (i.e. medication for the post acute/confused patient for the benefit of staff, rather than the patient)" (Questionnaire General Comments, Respondent 567, Lines 489-494)
			CPs understand the needs of some clients better	"I am fed up of covering for incompetent doctors. Clinical psychology offers a much better understanding of personality disorder as well as lots of other 'detainable' conditions. In my experience the perspective taken by many RMOs is not holistic enough" (Questionnaire 1, Respondent 180, Lines 206-120) "Learning Disabilities may be an area where supervision by a psychologist may be more appropriate in view of the often complex behavioural management issues" (Questionnaire 1, Respondent 610, Lines 823-825)

				"In regard to personality disorders we are the most appropriate professionals to be 'Clinical Supervisors' " (Questionnaire 1, Respondent 454, Lines 568-569)
	Consequences will be positive for clients	Clients will receive better quality care	Greater involvement of CPs will humanise the process of care	"I think psychologists would add a degree of humanisation to the sectioning process" (Questionnaire General comments, Respondent 5, Lines 1-2) "I am glad that psychologists might have this opportunity because I would hope that their involvement would humanise the process" (Questionnaire General comments, Respondent 6, Lines 8-9)
			The powers will enable CPs to advocate for clients	"it gives psychology a chance to put forward the views of our clients in a balanced and productive way" (Questionnaire General comments, Respondent 452, Lines 411-412) "I feel we need to...promote a more "responsible" partnership with clients...This is already what the people themselves want (to be listened to – to be taken seriously etc.) (Questionnaire General comments, Respondent 301, Lines 284-296)
			Some clients' needs will be met better if CPs have the powers	"There may be people for whom a psychological lead is more appropriate to their needs than a psychiatric model" (Questionnaire General comments, Respondent 451, Lines 407-409) "There are undoubtedly some people who are much more in need of supervision by a psychologist than a psychiatrist" (Questionnaire 1, Respondent 235, Lines 307-308) "I believe psychology would provide a balanced view of a person's needs" (Questionnaire 1, Respondent 452, Lines 563-564)
			CP involvement may be more helpful for the relationship with the client	"It [openly supporting detention of particular therapy clients and explaining one's rationale] provided something that was a life skill...having the ...chance to kind of learn that it's not catastrophic if you disagree. So you can ...use it psychologically to help people develop...it doesn't have to be just a one off event and you just don't use it." (Focus group, Participant 6, Lines 428-437) "maybe there's more scope for repairing the relationship by having those more therapeutic conversations around it rather than drafting in a second person" (Focus group, Participant 2, 749-753)
	The role will increase the power of clinical psychology	The profession will be less dispensable with the powers	CPs are vulnerable to health service budget cuts	"In a new climate of cuts, I think we are going to be very exposed, we would be very easy to lop off because we don't have a vital function...we're expensive and we're seen as dispensable" (Focus group, Participant 5, Lines 191-195) "the motivation for taking on the RC role might be, well, you know, these are, insecure times, I need to kind of make sure I keep hold of my job" (Focus group, Participant 1, Lines 1107-1111)
			The powers will make CPs less vulnerable to cuts	"I think if we had a vital function like that then we'd be much less...easy to get rid of" (Focus group, Participant 5, 193-194) "as a profession we're being encouraged to look at making ourselves indispensable" (Focus group, Participant 1, Lines 1103-1005)
		The powers will increase the influence, status and credibility of CP within mental health	Medical dominance over other models / professions will be reduced if CPs have the powers	"I think it right to break the medical monopoly of RMO roles" (Questionnaire General comments, Respondent 331, Lines 341-342) "Psychologists carp about the power and dominance of mental health services by psychiatrists and others within the "medical model". This is a way to redress the imbalance" (Questionnaire 1, Respondent 40, Lines 55-57)

		services	The powers will enable CPs to influence the concept and treatment of mental illness	"I would be willing to take on the role as a way of influencing the current construction of mental illness and subsequent treatment of people who are deemed to be mentally ill" (Questionnaire 1, Respondent 477, Lines 593-595) "I would wish that...the influence of psychological models was much greater in the service" (Focus group, Participant 5, Lines 162-163) "Given the limited and narrow basis (i.e. bio-psychiatry) to present decision-making in Mental Health legislation and the anomalies this creates (e.g. "untreatable"), I feel that the formulation driven approach and wider perspective (bio psychosocial) of clinical psychology would be beneficial" (Questionnaire 1, Respondent 88, Lines 114-118) "Compulsory care plans can only benefit from the involvement of psychologists...[They] will 'balance' the view held by members of professions with more rigid ideas regarding the treatment of the mentally ill and psychopaths" (Questionnaire 1, Respondent 463, Lines 576-580)
			Change is more achievable from within the system	"We need to drive this debate from within, not by voting ourselves out of contention" (Questionnaire General comments, Respondent 454, Lines 418-420) "I believe we shall have more influence inside than if we stay out" (Questionnaire General comments, Respondent 91, Lines 83-84)
			The powers will enhance the status of CPs	"I think there's something about status and influence isn't there...I think that's maybe the correlation that is attractive to the profession" (Focus group, Participant 2, Lines 1163-1170) "Clinical psychologists as a body seem, on the one hand to whinge about our pay, professional status etc., yet on the other hand, cower away from developments which could enhance both of these" (Questionnaire 1, Respondent 602, Lines 799-802)
			The powers will increase the credibility of CPs	"If we refuse to take up the power and responsibilities on offer, we cannot complain when others do so and fall short in our estimation. We must put our money where our mouth is" (Questionnaire 1, Respondent 279, 360-363) "The profession, if it is to be taken seriously, must be prepared to participate in this difficult area" (Questionnaire 1, Respondent 10, Lines 20-21)
		The powers are likely to result in an increase in pay	Pay is an incentive to carry out the role	"it wouldn't be a role that I would take on unless there was some kind of financial incentive going with it, realistically, I wouldn't do it" (Focus group, Participant 2, Lines 1062-1064) "And extra pay!" (Questionnaire 1, Respondent 124, Line 163) "A substantial pay rise would make it a more attractive option" (Questionnaire 1, Respondent 235, Line 312) "I may consider the Clinical Supervisor role if: 1. My salary was doubled, 2. I did not have to do therapy with clients under my supervision" (Questionnaire 1, Respondent 248, Lines 324-325)
			CPs should receive similar pay to Psychiatrists	"The added responsibility involved should be accompanied by appropriate remuneration more akin to that commanded by the psychiatry profession" (Questionnaire 1, Respondent 125, Lines 165-166) "And equal recompense to psychiatrists" (Questionnaire 1, Respondent 23, Line 30) "We should...ensure we don't get forced into acting as cheaper psychiatrists" (Questionnaire General comments, Respondent 107, Lines 93-94)
		There are limited risks to taking on the powers	The powers will have a limited effect on other roles	"I do not believe this would infringe on our therapeutic relationship" (Questionnaire General comments, Respondent 452, Lines 414-415) "I think where I work...I don't think that would really be prejudiced by being a little bit more part of the team" (Focus group,

				Participant 5, Lines 766-770)
			More power is unlikely to corrupt CPs	"Powers and responsibilities will be moderated through the checks and balances of the clinical team" (Questionnaire General comments, Respondent 669, Lines 729-730) "but any profession, someone could be coercive, or you know, that's why we have, you know, good training, codes of conduct, supervision, we all should know how we should be behaving, if we deviate from that, then there are sanctions" (Focus group, Participant 6, Lines 1290-1294)
			The imperative to help clients outweighs other values	"We must not pass up this opportunity of professionally contributing to an especially needy group of people because of political-moral concern" (Questionnaire General comments, Respondent 454, Lines 416-418) "The profession runs the risk of having high principles and many opinions but not acting on a case by case basis where it counts" (Questionnaire 1, Respondent 158, Lines 188-190)
			Accepting the powers is a necessary compromise	"So, I'm for it – a necessary 'evil'...the 'power' of Clinical Supervisors!" (Questionnaire 1, Respondent 512, Lines 647-648) "It's difficult to see how we can hope to improve the quality of psychological care to people unless we're prepared to share the responsibility of its provision and delivery" (Questionnaire 1, Respondent 181, Lines 214-217)
			Rejecting the powers would be impractical and harmful	"Any attempt to reject the proposals as unworkable or unacceptable will only serve to harm the most vulnerable in our society" (Questionnaire General comments, Respondent 618, Lines 566-568) "If clinical psychologists turn away from this important role, the profession of psychology will be handicapped in its ongoing attempts to 'demedicalise' health and illness" (Questionnaire 1, Respondent 512, Lines 645-647)
			The therapeutic role can be protected	"Clear guidance on preventing overlap between therapy role and Clinical Supervisor role is essential" (Questionnaire General comments, Respondent 240, Lines 195-196) "(I'd) hope that the BPS will 'regulate' clinical values and provide an appropriate context in which patient-practitioner relations/boundaries etc. are safeguarded" (Questionnaire General comments, Respondent 512, Lines 452-455)
			Taking on the powers can be an optional role	"I consider psychologists should have a choice about whether to undertake this work" (Questionnaire General comments, Respondent 558, Lines 477-479) "It may be the right move for some CPs, I do not think it should be compulsory for all of us though" (Questionnaire General comments, Respondent 167, Lines 134-136)
Belief that CP must defend against assimilation by maintaining separate spaces for collaborative work	Compulsory treatment is ethically problematic	The principle of compulsion is contestable	Professional ability to predict risk is poor	"I feel no individual (professional or not) can exercise control and prediction over the behaviour of others and to attempt to do so under the guise of "professionalism" is ludicrous and a violation of the civil liberties of others" (Questionnaire General comments, Respondent 629, Lines 588-591) "Research consistently shows that mental health professionals over-identify (false positive) when attempting to predict dangerousness to self or others" (Questionnaire General comments, Respondent 53, Lines 49-51)
			The existence of mental health legislation or the practice of compulsion are contestable	"I would like to see a much wider debate on the whole mental health act including whether it should even exist" (Questionnaire General comments, Respondent 501, Lines 443-445) "I would refuse to act as a Clinical Supervisor and urge that we as a society object to such a move, and initiate discussion and debate on sectioning instead!" (Questionnaire General comments, Respondent 629, Lines 592-592)
		Compulsion	Involvement in	"I feel that the possibility of being a Clinical Supervisor would go against all my principles and values as a Clinical Psychologist

		is incompatible with clinical psychology's values	coercion is antithetical to nature of CP	and an individual" (Questionnaire 1, Respondent 501, Lines 616-618). "I believe the proposals are not suitable for the role and professional conduct of a Clinical Psychologist" (Questionnaire 1, Respondent 345, Lines 457-458) "I believe it is totally contraindicated with my role as a clinical psychologist" (Questionnaire 1, Respondent 680, Lines 945-946) " I did not enter this profession to force people to do things that they do not wish to do" (Questionnaire 1, Respondent 431, Lines 529-530)
			The powers may prompt a departure from the profession / NHS	"I would consider leaving this profession if this legislation is passed so contrary is it to my style of work and my ethical base" (Questionnaire General comments, Respondent 660, Lines 626-628) "If this role is imposed on our profession I will feel unable to continue working for the NHS" (Questionnaire 1, Respondent 639, Lines 873-874)
			There is a localised consensus against having the powers	"Unfortunately, most of my colleagues are not BPS/DCP – count these views 6 times!" (Questionnaire General comments, Respondent 668, Lines 639-640) "Colleagues in the XXXXXXX Department are strongly opposed to idea of clinical psychologists acting as Clinical Supervisors" (Questionnaire General comments, Respondent 255, Lines 199-200) "I asked members of our specialty to discuss these issues. There was a general feeling of disquiet against such developments as psychologists being "clinical supervisors" (Questionnaire General comments, Respondent 585, Lines 511-514)
			A coercive role is based on a conflicting model of mental disorder	"What is being proposed follows a medical model and not a psychological model." (Questionnaire 1, Respondent 496, Lines 613-614). "I believe we need to provide an alternative to the medical model within the NHS. This development would compromise that possibility." (Questionnaire 1, Respondent 310, Lines 402-404)
	A collaborative clinical psychology is only possible if separate from compulsion	CP is distinctive and more autonomous because of its separation from the system of coercion	Separation from coercion distinguishes CP from the other professions	"possibly the only profession in our services, that doesn't have to force people to do things " (Focus group, Participant 4, Lines 215-217) "I believe Psychologists have served a valuable function not having to enforce the system's rules, and can usefully occupy a more neutral position than those bound by their professions' responsibilities" (Questionnaire General comments, Respondent 660, Lines 622-626)
			CP is an autonomous discipline	"one of the core values of psychologists in my experience is therapeutic focus with independence from organisational and statutory obligations" (Questionnaire 1, Respondent 668, Lines 911-913) "The respect and autonomy we currently enjoy would be compromised" (Questionnaire 1, Respondent 604, Lines 810-811)
		Separation from the coercive system is valuable and enables collaboration	There is a need for a non-coercive profession	"It is vital that the NHS has some / totally non-restrictive personnel and it is appropriate for this to fall to psychologists" (Questionnaire 1, Respondent 630, Lines 863-865) "People should be given choices in treatment to facilitate the likelihood that they will engage with mental health services" (Questionnaire 1, Respondent 524, Lines 661-663)
			Lacking powers of compulsion is an	"our principal therapeutic tools are persuasion and a quality of relationship untainted by statutory powers" (Questionnaire 1, Respondent 529, Lines 666-667)

			advantage	"I feel that a key advantage that we have when working with distressed people is that we do not have powers to 'do things' to them against their will" (Questionnaire 1, Respondent 292, Lines 382-384)
			Separation from coercion enables collaborative empowering relationships	"Powers of compulsion seem hard to balance with a collaborative approach to working with clients" (Questionnaire 1, Respondent 562, Lines 732-733) " 'Compulsory' care directly contradicts a collaborative and empowering approach which has the potential to undermine any efforts we make" (Questionnaire 1, Respondent 310, Lines 400-402)
	Consequences will be negative for clients	The powers will compromise collaborative alliances with CPs and reduce the effectiveness of CP	The powers might reduce CPs' ability to advocate for clients	"I feel strongly that such a proposal would seriously compromise and jeopardise our abilities to act as advocates" (Questionnaire 1, Respondent 287, Lines 373-374) "one of the things I find myself doing as psychologist...is...to get the team to think...what does the client need to do...before you feel this person can...come off a section, now whether or not I could do that equally well if I was a Responsible Clinician, I don't know, maybe I could, I don't know" (Focus group, Participant 4, Lines 495-504)
			The powers will have a negative effect on clients' perceptions of CPs	"I think that when we're involved with clients it would be invidious, from my point of view, to start getting involved in forcing people to do things" (Focus group, Participant 4, Lines 203-205) "We would be feared rather than respected" (Questionnaire 1, Respondent 604, Lines 811-812)
			The powers are incompatible with a collaborative therapeutic relationship	"Due particularly to effect on therapeutic relationship" (Questionnaire 1, Respondent 114, Line 152) "We should be resisting compulsory treatment totally as a profession. Any involvement would compromise the possibility of collaborative and empowering therapy relationships" (Questionnaire 1, Respondent 207, Lines 266-268) "The proposed role would conflict directly with the DCP's core purpose and philosophy (2001), especially "..work with them (clients) collaboratively as equal partners towards achievement of mutually agreed goals" (Questionnaire 1, Respondent 559, Lines 722-726) "I am in no doubt that to take on such a role would "impact adversely on...therapeutic relationships" – I would find such a development totally unacceptable. "Therapeutic relationships would be fundamentally and completely changed by clinical supervisor status" would seem a more accurate description of what would happen" (Questionnaire 1, Respondent 392, Lines 510-515)
	Consequences will be negative for clinical psychology	The powers will have a negative impact on the role and identity of CP	CP will lose its distinctiveness from Psychiatry	"I don't particularly want to see a blurring of what we and psychiatrists do" (Focus Group, Participant 4, Lines 232-233) "This is another step in the worrying trend for clinical psychologists to play at being psychiatrists" (Questionnaire General comments, Respondent 272, Lines 230-231)
			CPs will be socialised into a social control role	"The danger of becoming social police officers is one I would strongly resist" (Questionnaire General comments, Respondent 281, Lines 254-255) "We have already been sucked far too deeply into the "regulation and control" role." (Questionnaire General comments, Respondent 272, Lines 237-238)
			The powers may have a corrupting influence	"I'm not passing comment about my colleagues sat round the table but it's also conceivable that some people would be seduced by power" (Focus group, Participant 4, Lines 381-383) "the idea of power 'per-se' has to be kicked into touch, let's not be seduced!" (Questionnaire 1, Respondent 276, Lines 14-15)

			The powers create an excess of roles	"I feel we have got too many strings to our bow as it is and we would be diluting our skills further by taking on this additional role" (Questionnaire 1, Respondent 328, Lines 343-436) "I am aware that 'sectioning' someone can take a considerable amount of time, if our clinics were regularly cancelled or disrupted due to this process, it would have a negative impact" (Questionnaire 1, Respondent 31, Lines 51-54)
		The powers will not increase the influence of or enhance the status of CP	Accepting the powers is colluding with, rather than influencing the system	"To go along with this would involve unhealthy collusion and not healthy influencing" (Questionnaire 1, Respondent 496, Lines 614-615). "Having complained for many years about Psychiatry as a means of social control, it seems ironic that some of us are falling over backwards to take on the role through the spurious argument that we are best suited to "deal with these people"...The thinking behind this is as wishful as the idea that we could influence the C.M.H.T.s in the same way" (Questionnaire General comments, Respondent 272, Lines 212-219)
			A desire for status or power is motivating acceptance of the powers and these are unlikely to be enhanced	"Any suggestion that our professional standing and status would be improved by Clinical Supervisor role is misguided and founded on the notion that self / professional aggrandizement is always best" (Questionnaire General comments, Respondent 287, 268-271) "Engagement in the process of invoking mental health act has not increased the status and power of social workers. Why would we assume it would for CPs. Why do we continue to seek parity with medics. Surely this is a redundant argument" (Questionnaire 1, Respondent 351, 467-470)
		The powers will reduce the roles available to CPs	Employers' expectations regarding the powers may change	"Somewhere between 2 and 3 depending on the nature of the pressure!" (Questionnaire 1, Respondent 435, 541-542) "But will we be given a choice necessarily?" (Focus group, Participant 4, Line 1065)
			CPs are powerless if employers' expectations change regarding the powers	"It is likely the CP will be in job descriptions for new psychologists so b3 will not be an option for long" (Questionnaire 1, Respondent 128, Lines 167-168) "I think we all have job descriptions which can be changed almost without consultation can't they?" (Focus group, Participant 4, Lines 1083-1084)

Appendix XIV - Questionnaire (Question 1) Responses During Line-by-line Coding Stage

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Appendix XV - Questionnaire (General Comments) During Line-by-line Coding Stage

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Appendix XVI - Focus Group Transcript During Focussed Coding Stage

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Date	Diary entry
February 2009	Really excited by the idea Anne talked about at the Research Fair for a study. Attracted by the interface between politics and CP. Think it's wrong for CPs to have sectioning powers – you would lose the neutrality you get from not being involved with that aspect of services and it would reduce your effectiveness as a therapist. Don't understand why this is not being discussed more.
February 2009	Discussion with Anne on phone about her idea for a study looking at CPs' views on the Responsible Clinician role. Not sure what she thought of my ideas. Felt I was rambling a bit. Think she made a good point about the importance of supporting other members of your team. I imagine quite a lot of other trainees might be interested in doing this study too so best not to get my hopes up about it too much.
March 2009	Had meeting with Anne about other ideas for research re: stigma of mental health services and mental health professions and the way in which the media contributes to this. Also considering idea about psychosis and trauma. She says she would be interested in supervising me on any of the ideas I discussed! Maybe as part of the service-users' perspectives cluster. Many other people are interested in the RC study apparently. I'm still tempted by it but it would be great to do something of my own.
19th March 2009	Had meeting with research cluster group. Bit confused really, don't understand how it's going to work, neither did the people there. As they said it's a new idea and they're just trying it out to see what develops. Not many people turned up though and the only other trainee says she doesn't think she's going to do it. Need to get a clearer idea of exactly what my study will focus on and to choose between the stigma and psychosis but struggling with this.
28th March 2009	Anne has given me some ideas for possible external supervisors to try. Haven't managed to find anyone interested yet though. Need to find someone pretty soon. Have been doing a lot of reading at Anne's suggestion e.g. Goffman but still don't really have a concrete idea for my study.
31st March 2009	Spoke to Anne on phone today. She hasn't got anyone for her study anymore and is asking if I would still be interested and consider switching projects. Have to agree with her after discussing the ideas I've come up with so far that I'm finding it difficult to come up with a convincing idea for a study based on stigma or psychosis – lots of general ideas but nothing really that specific. Feels like a really big switch to make. Not sure what to do. Going to mull it over.
2nd April 2009	Decided to do the RC study instead and told Anne today. It sounds really interesting and it's a big plus not to have to try and come up with an idea for a study from scratch. Feel really lucky to have got this. Going to speak to her about it after the Easter break. Brilliant – I have a study!!!
14th May 2009	Meeting with Anne. She suggested Dave as the external supervisor so going to get in touch with him. Would need to collect additional more recent data as available data is some years old now. Focus group would be a good method as it overcomes the weaknesses of the questionnaire and is relatively practical. She suggested the Faculty of Psychosis and Complex Mental Health would be good as people there are likely to be involved in sectioning. Will have to use the

	abbreviated version of Grounded Theory for the questionnaire as in Carla Willig because I can't collect more data from that point in time now.
2nd June 2009	Met with Dave and Anne. Anne has sent me some relevant info and the data files. Need to start going through it all. Dave going to send me some relevant info too. Discussed doing another questionnaire but they pointed out that this would be pretty difficult – don't know who previous respondents were because you didn't have to give a name etc. Shame but I will get more detail from a focus group.
August 2009	Conversation with psychologist at placement: he thinks a lot of CPs probably would take on role because of pecuniary considerations "they shouldn't, but when people have mortgages to pay etc., they will".
October 2009	Anne suggested including some theory after look at last draft research proposal – sociological theory and something around the conceptualisation of mental illness. Suggested looking at Pilgrim, Rose, Foucault etc. Have incorporated some of this in second draft. Now have further feedback from both Dave and Anne. Mainly to highlight the importance of the issue for the profession more and include some comments from people about how it could change our role. Once I've made the changes they want it can go to panel.
11th December 2009	Review panel want me to change quite a few things and they want psychological theory about underlying processes regarding the positions CPs adopt. This seems difficult as I haven't really seen much in the literature about psychological theory regarding this issue. It also seems to contrast with the idea of GT to speculate too much on what theory might be relevant at this stage before the study but that's the requirement.
February 2010	Have had revised proposal accepted. Have added in various ideas for psychological theory: a learning theory perspective i.e. conditioning in terms of why CPs might adopt certain positions, functional theories which see holding stances as contributing to well-being and performing functions. Also suggested cognitive consistency theories - that suggest we strive for consistency with our values and beliefs e.g. cognitive dissonance theory (Festinger, 1957) CPs who feel conflicted adopting both therapeutic and social control roles might try to achieve consonance in some way by choosing a position. Self-perception theory seems maybe relevant i.e. reflecting on behaviour itself can influence attitudes (Bem, 1967). Also mentioned impression management (presenting a consistent image of oneself to others (Tedeschi, Schlenker, & Bonoma). The theory of planned behaviour or the theory of reasoned action might be relevant too. Have suggested psychodynamic defence mechanisms e.g. splitting - I do think some CPs view Psychiatrists excessively negatively and can't help wondering if there isn't something more than just professional disagreement involved. I also referred to the life instinct i.e. facilitating self-preservation for the profession. A lot of these really feel quite contrived to me though, just to meet the review panel requirements - I'm not sure how convinced I am by any of them and wouldn't include them yet if I had a choice.
March 2010	Worrying about balance in focus group questions. Spoke to Anne who looked at them and thought that they were fairly balanced. Difficult to ask everything I want to given time constraints but I think the ones I've chosen are fairly

	representative of the main issues in the literature. May leave out question about advocacy as this doesn't seem to have come up as much as the other issues and need to think about how many questions I can practically ask in one group interview.
April 2010	Have received ethical approval! No changes needed apparently. Relieved that it went through so easily. Great to know I can definitely get on with consultation interviews for focus group now.
April 2010	Consultation interviews have been helpful. I feel reassured about the questions I am asking as both consultants gave positive feedback on them, feeling it was a really interesting subject area, they didn't feel many changes were needed and had plenty to say. One felt that the focus group members might have not considered all of the questions that much before so it might be helpful to put them at ease and address this at the beginning. Another suggested not reading the questions directly off the interview schedule in an effort to reduce the artificiality of the process.
May 2010	Focus group was extremely nerve-wracking. Found trying to follow everyone's arguments, moderate impartially and ask all of the questions I wanted to difficult to do. Found that as the discussion progressed in order to keep the discussion fluid and more of a natural process I selected questions when they linked well to where the focus group members were taking the discussion. However due to nervousness, being interrupted or getting carried away with the process of the discussion I didn't always manage to ask all the questions in the exact way that I had wanted to but I suppose this is inevitable in a focus group. On listening to it afterwards felt I had pretty much covered everything I had wanted to though. Might have been helpful to carry out a pilot focus group in addition to the two consultation interviews, would have helped me feel less nervous and conduct a better interview I think. Was fairly pleased with the range of positions people took, seemed to have people from across the spectrum really which was ideal, whilst a bit more weighted to those supporting. Luckily they were happy to give me longer than 60 minutes too. I vaguely knew one of the participants from a post some years earlier – had not anticipated this. However cannot see that it affected our interaction during the group. Glad it's done now, can get on with the transcribing.
Sep/Oct 2010	Transcribing: Listening to tape: extra responsibility should be reflected in salary: why else should you do it? Seems a fair point. I also like the argument about using the relationship during the sectioning process as material to work on to help client mentalise / learn new ways of dealing with disagreement. Also that it's wasting an opportunity not to.
07.11.10	Saw a video by Stephan Molyneux. Quite challenging views about society being based on coercion rather than freedom.
09.11.10	Re: increased pay for increased responsibility: which is coming first? If CPs will compromise on this issue for extra pay would they compromise in other issues, where does it end: prescribing meds?
13.11.10	Have been thinking it is more honest to acknowledge the social control aspect of mental health and CPs' role within it. Linked to this have been thinking about Rothbard – government is a monopoly on violence and Molyneux – coercion and violence as the basis of society or the state. Need to revisit Chomsky seem to remember he takes up this theme too. We are pretty compromised as CPs by choosing to be wedded to the state and this hardly ever seems to be acknowledged.

	Better to bring this out into the light? CPs are directly funded by the coercive system.
16.11.10	Was doing some coding and thinking that the argument that you should have a choice to embrace role or not if you feel strongly is quite appealing on a pluralistic level.
20.11.10	Writing literature review: Psychological theory advocates voluntarism not coercion (Winick, 2008) better for well-being and treatment works better.
23.11.10	Some possible relevant ideas whilst doing my literature review. Thinking about the relevance of forming storming norming etc. Hyman article. Belonging (membership of a team / institution) and its inseparability from identity (Lambert –French article). Dilks GT article. Integration and embeddedness within a team may limit time to widen role e.g. consultancy, training, supervision but increase acceptance within team and receptiveness to psychological perspectives.
30.11.10	Being a Trainee CP, might feel more inclined to accept arguments for freedom at moment because of feeling trapped!
3.12.10	We have been asked by Paul to write an abstract for Section B and imagine what the results might be made – this has me wonder about a possible model and the effect of specialist areas on the position adopted. Would you be likely to use strategies like impression management, cognitive consistency strategies, self-perception theory if your area was more likely to have to adopt the roles (rather than leave: Anne says many people said they would leave if the changes came in but then didn't) and be more to likely to be subject to pressures like social conformity or classical conditioning processes if in an area less likely to be subject to using these roles. OR would you be more likely to have sought out work in an area more compatible with your views on this in the first place?
4.12.10	Writing literature review: Reid (2000) BPS: obliged to hold interest and welfare of client at all times but simultaneously employees of system whose primary purpose is social control. Cognitive dissonance seems to be inevitable in this situation and therefore some kind of striving for consonance. CPs in high security settings arguably work alongside other MDT members more than in other areas: could this lead to becoming more inclined to accepting a social control role?
4.12.10	Writing literature review: Gelsthorpe's ideas about CPs working within a system with which they don't agree seem interesting: Self-protection (Keeping Ourselves Okay) (KOO) versus changing service (CS) if you don't agree. Focussing on wage as a defence / coping strategy. So accepting new roles in order to increase influence could be a way of CS. Could cognitive consonance be a way of KOO? Have just read about a BBC Prison study (Reicher). They say the Stanford Prison Experiment was simplistic: need group failure before tyrannical behaviour not just groups + power. Suggests that surveillance inhibits tyrannical behaviour. Supports Molyneux view that an unethical coercive system loses its power once people can see it for what it is. Not sure how convinced I am by that. Also have been reading about social identity theory: behaviour and identity work on a continuum depending on situation: highly individual at one end and collectivist at the other. low status groups: 1) leave 2) compete 3) make favourable comparisons with other groups.

	Thinking about anonymity versus visibility: is the questionnaire more likely to allow self-categorisation? This all seems quite relevant to Tajfel and Turner 1986 In Jetten et al p.2: Importance of group membership for the self-concept = high identifier or low identifier with group. Compared to low identifiers, high identifiers will search for a positive identity by means of an increased in-group bias. Differences between high and low identifiers are only observed when identity is threatened (Spears, Doosje, Ellemers). Self-stereotyping as the prototypical group member. Low identifiers may normally see themselves as prototypical too, but then try to distance themselves from the group psychologically or physically if the social identity is threatened. Enhancing group heterogeneity used as way of disassociating oneself from the group versus enhancing group cohesion and homogeneity
5.12.10	Still doing literature review: have been thinking about specialties and A) Who is drawn to a specific group? B) Whether people embrace a position depends critically on how it affects their membership of other valued groups (Emler & Reicher) from Haslam p.620. Groups transform the dispositions of members (Turner and Oakes 1986) from haslam p.620
11.12.10	Literature review: Gelsthorpe makes a good point: our ignorance of key elements of the system (e.g. the Mental Health Act) does not add to our kudos or views gaining more weight.
12.12.10	In the Miller and Dickens study: Consultants were least in favour. Is there something about more experience and power you have less you need or more able you feel to dissent before authority as you have less to lose: newcomers assistants and trainees etc. have far more hoops before them so more obedient? Is obedience a factor here?
11.02.11	Went through some of my coding with Anne the other week and she felt it looked fine. Many people in Anne's study were retired, not working or working in specialties they perceived as irrelevant to this issue. Am wondering how relevant are their views then? Many are also very interested in pay. Many don't feel they have enough information to properly make the decision.
25.02.11	Had a peer supervision GT group today. Wasn't really that helpful as most of the others haven't really started their analysis properly yet. Going to exchange some coding though with some other trainees so we can check each others' which will be helpful though.
29.03.11	Had more GT peer supervision – helpful but a bit stressful, lots of uncertainty around this methodology generally and a bit confusing because everyone is using slightly different approaches or using different epistemologies. Looked at some other projects which have used Charmaz. Met with Dave twice briefly today as well. He clarified quite a few points I wasn't sure on in feedback he had sent me on my Literature Review, which was helpful and said he would send me a reference on Psychiatrists' models of mental illness he thinks will be useful.
30.04.11	The style of some of the responses is reminding me of Sowell's idea of a conflict between two world views i.e. political views where there is the constrained tragic world view where people have limitations which prevent change in the world versus the visionary world view where the wise few can change people's natures thus improving the world. I wonder if what I am seeing may be a playing out of this sort of pattern. However I am finding it difficult to decide whether it is this

	sort of dynamic being played out or whether the division has more to do with the quite different experiences of those in different specialties. Or more probably there are multiple explanatory factors. It really is a shame that data on respondents with experience of forensic versus no experience are not available.
06.05.11	Rufus May did some teaching last week on Psychologies of Resistance and Resilience. He mentioned an article called "the myth of the hero innovator" which apparently makes some point about going into systems to try and change them not working because you have to change the system itself first. I didn't quite understand it fully but it sounded potentially relevant to my study so will try and get a copy. No joy yet though, not available in library, on any database or from Amazon as far as I can see.
10.05.11	Thinking about conflict between idealism and conditioning i.e. changing a system versus the system changing you. I am noticing that the focus group participants' views seem much more prominent in my mind than the questionnaire comments. Why is this? Could it be to do with having met them and their views or emotions somehow seeming more tangible as a result? I need to ensure that I don't allow my view to be skewed by them, they're a much smaller group of participants.
13.05.11	Had various thoughts today: With limited experience as a trainee CP working with Psychiatrists (although a fair bit as a nurse) I perhaps haven't had as much insight into how I might have improved care if I had the RC role as those CPs who have many years of experience. Might bias me more towards perceiving acceptance of RC as more power motivated. I am also noticing that I'm thinking more and more about the RC and less about the AMHP over time. Is it because this is what the participants did or is it because there is power in the RC role that isn't present in the AMHP? Thinking about Bruce Gillmer writing articles in Forum encouraging people to take up the role makes me wonder if some people are mistaking the power and influence of Psychiatrists as being actually located within the statutory powers. Maybe their power is more derived from association with medicine and medical authority. And as Thomas Szasz says it is logical historically. Whereas I think much of the public are perhaps more dubious about psychological knowledge and therefore the legitimacy of allocating power to this profession. Therefore CPs taking on the RC role might not actually make any difference to the power structure.
20.05.11	Unsure whether to categorise within positions or categorise regardless of positions. Categories seem pretty similar regardless. Need to speak to Anne about this. Feeling that a lot of my codes are quite long and Charmaz suggests keeping them short. Often seems very difficult to convey the arguments with a short code.
21.05.11	Am unsure whether to use Strauss and Corbin's Axial Coding or not as Charmaz describes it, or whether to just use Theoretical Coding instead. Think I will use Axial Coding as it seems more suitable for a novice. Seems fairly straightforward – Conditions – Actions – Consequences. So thinking that perhaps a process model with some kind of pathway might be the best way to conceptualise this.
25.05.11	Am getting a sense from the data of two large categories or perhaps themes. Not sure what to call them – one is

	'Evolving' / 'Overcoming constraints' / 'Improving the system'. The other is 'Protecting' / 'Protecting a valued role' / 'Loss. Sent Anne some coding for her to audit some time ago and she told me today to say that she is happy with the way I have been doing it.
27.05.11	Spoke to Anne today about literature review and analysis and discussed 'Evolving' and 'Protecting a valued role' categories which she felt sounded okay. Asked about categorising as wasn't sure about whether to combine some categories or not: she thought I should incorporate all role conflicts into 'conflict of roles' rather than separate categories of role conflicts.
28.05.11	I think that my research questions place a frame on the analysis because I have to think in terms of what participants' positions are whilst coding and whether it's regarding compulsion or taking on the RC personally. This is not possible for most of the responses as the two are so intertwined and I am not convinced that I can even tell for many responses. It also feels a bit like forcing to an extent and I'm not sure it's helpful because there are so many overlapping categories – the same views seem to crop up in each position (i.e. RC or compulsory powers for the profession). It might be better to merge all of the data, remove this frame and just let the themes emerge.
29.05.11	Decided to merge the data. Merging positions makes more sense because then I can simply look at it in terms of the arguments for and against (compulsion and the RC in general) not which position the person making the argument holds and whether it might be more to do with compulsion than the RC, because that will make for very repetitive multiple models! Am going to combine the focus group with questionnaire data now as mostly the same issues are appearing in focus group and questionnaire too. Can't see any benefit in keeping them separate any longer. Also need to start thinking about the next stage. Will look at it following the Strauss and Corbin Axial Coding frame that Charmaz describes. She suggests that students might find this helpful and it looks like a simpler way of building a theory than theoretical coding so I will start to use this shortly.
30.05.11	Just finished refining categories and codes and constructing a provisional model with the frame. Am absolutely exhausted. Categories and sub-categories look good though. Am a little unsure about where to fit the Awarding Low Priority part in the model but as a condition seems best. I am including it as I know that it is very relevant and updates the study a bit although obviously there is nothing about it in the questionnaire data. In terms of theory Dave mentioned System Justification Theory which seems quite relevant but need to read up on it a bit more before deciding.
01.06.11	Really tried to refine categories and codes a bit more today because there are so many and the model looks quite confusing I think.
2.06.11	I suppose that striving for 'balance' could actually skew results that were not actually balanced in some way. There might be a risk that I could over-compensate for my bias and go too far the other way i.e. not be critical enough with the views of those for the role. You could say that Evolving might be changed to the more critical 'Acquiring Power' instead and I

	feel you could perhaps argue for either of those. The data for those in favour could be seen as suggesting the role is adding to adaptive value by improving the chances of survival, strengthening defences, increasing influence, power and effectiveness etc. Evolving fits with the history of the profession's roles too. It might be that someone more in favour of the role would be more happy to opt for Acquiring Power instead, I'm not sure. Have been thinking many CPs felt that the introduction of the new powers were antithetical to their values and contradicted their reasons for entering the profession – having a relationship which did not involve compulsion. I should try to remember that I have probably seen more use of compulsion than many CPs joining the profession. That could influence my views – maybe that could go in the review somewhere. Have finally got a copy of "the myth of the hero innovator"! It's interesting and seems quite relevant so I may use it in my discussion.
04.06.11	Achieving parsimony is difficult because it seems to necessitate glossing over complexity, contradictions and overlapping parts in order to simplify. I find that as a result I often need to have sub-categories which are actually quite disproportionate to each other.
11.06.11	Have been doing a lot more refining of codes and happier with the results. Categories and sub-categories seem to fit together better. Struggling with the model a bit though. Not sure how to incorporate the interaction between there being a perception of a lack of commitment at service level and awarding low priority as an interacting condition alongside 'organisational support' when these happened at different times and also not sure about whether positions participants adopt should be part of action/interaction or consequence. If they are a consequence then there needs to be a second action/interaction and a second consequence i.e. awarding low priority. That doesn't really fit the frame that Strauss and Corbin suggest. Not sure how to address that yet. Showed another trainee some ideas for the model and she suggested maybe having stages of interaction/action rather than just one.
12.06.11	Reflecting on theory in discussion. Georgiades and Phillimore's arguments are echoed in Holmes (2002) CPs would be more effective concentrating on what they are trained and experienced at doing and working where they can be most effective: "many psychologists have spent enormous amounts of energy (sometimes whole careers) trying to change intransigent systems and institutions such as hospitals".
12.06.11	Kinderman (2009) uses the idea of evolution with regard to theory (biomedical to bio-psychosocial to mediating psychological processes).
17.06.11	Met with other trainees for Grounded Theory peer supervision today. Everyone struggling with models and how best to illustrate to examiners the process of generating codes and categories. The way I am doing seems similar to others although one had done it a very different way which I couldn't understand. Going to look at the study she got the idea

	from to try and understand this better in case it's helpful. Showed other trainees my model, their feedback was positive, that it made sense and seemed logical. They also suggested a 'funnel' model to me as an alternative possibility. So I have looked at doing this but don't think it quite works so well – I think visually it would look far too 'busy' with text boxes within the funnel so not going to use it, it needs to be parsimonious.
18.06.11	Received feedback from Anne after sending her first draft of Section B and table of categories. Starting to work through it. She suggests 'Dismissing Values' rather than 'Belittling Values'. She thinks the latter is too value-laden. She also suggests Evolving identity and Protecting identity as she feels 'Evolving' and 'Protecting' on their own aren't really particularly meaningful, so I am changing these. Dave has looked at coding and model. He feels that my coding on the transcripts seems fine and that the themes make sense. However he suggests amalgamating some of the boxes / categories within the model i.e. having one box for evolving and one for protecting rather than two. So resisting and perceiving threat would be one box. This is what I had originally done but I was trying to show a process and it doesn't really seem to work visually so I will follow his advice. He also thought the ambivalent / neutral position in the model needed more elaboration. He suggested even considering removing Evolving and Protecting completely as a possibility and just having the underlying categories as a solution. But I think it works with just merging the boxes.
20.06.11	Spoke to Anne today, she thinks the model is ok and I can carry out respondent validation now. Also discussed with Dave, he has had a further look at coding, the summary for participants and the new model incorporating his suggested amalgamation of the perceiving threat / opportunity and countering and discrediting boxes. He suggested having less of a focus on the model in the summary for participants and making it more of a narrative summary as he felt it was a bit disembodied. He also thought it needed re-wording with far less jargon and needed to be much shorter. Feels disappointing as it took a long time to do and I really need to get this summary sent off soon. He also suggested some changes to category names e.g. perceived / expected organisational support rather than just organisational support and changing 'countering and discrediting' to 'countering and criticising'. Discussed the merging of data with him and he felt that revising the initial heuristic in terms of abandoning trying to model all the different positions because this heuristic was too simplistic was an example of good practice.
23.06.11	Have been reading an interesting passage in Pilgrim & Treacher (1992) about it being difficult for some CPs to have coherent identities because of the inherent contradictions in the structure of the profession and training. I do agree with what they say to an extent.
24.06.11	Excellent! Dave has looked at my revised letter to participants and he thinks it's a lot better, has only suggested some minor changes. Should now be able to send it off this weekend.
28.06.11	Another trainee has finished looking at my coding, categories, model etc. and feels that it is clear – she suggested highlighting what codes represent more in the list of codes. I'm not sure what to do with the theoretical codes, they seem

	to overlap a lot with the focussed codes and I don't think having them both in the same table is very parsimonious or that helpful really so I think I will perhaps append them instead.
05.07.11	Feedback from Dave re theory – although Anne liked the idea of people's political world views about the changeability of systems (Sowell) influencing their position on this he feels it is less relevant so I am going to remove this. I feel a bit conflicted about it as I think it's an interesting idea but at the same time I do really need to cut words out so it will just have to go. He also suggested looking at social comparison theory due to the limited amount of references to AMHPs. This seems quite helpful and isn't complicated to explain. I think I will include this in the discussion if possible to fit it there.
07.07.11	Discussion with Dave – he felt that using Sowell's constructs did have relevance to the model as they are about social change but that the real issue is whether or not social change is achievable from within or outside a system. He suggested community psychology for theories on social change in particular work by Pilgrim after the inquiry into Ashworth.
30.09.11	Following the referral, Anne and I met with John to clarify some of the comments. I can see the point that the examiners were making – the importance of there being a clear theoretical/conceptual framework – without which, if you don't agree that the RC is a fundamental change to the profession (and as John pointed out, not everyone would), then what is the basis for the study? I think this is a fair criticism, but how to address it is not so obvious to me yet. John feels that the study is relevant to CP but you could transfer 'change' to any profession so there needs to be more theory driving it, although it doesn't necessarily have to be CP theory. I can see how a model should really explain beliefs about the RC as John suggests, in terms of some kind of 'wider truths', explaining the phenomena rather than describing it and relating it to wider theoretical issues about CP or our work. It also needs to be more elegant and parsimonious, as an example John suggested looking at a study of decision making by cyclists re: doping, which was certainly a good example of a parsimonious model. I agree my model is rather descriptive (perhaps because it is trying to look at too much) and would be improved by somehow honing it down more, maybe focussing on the central two boxes more – Evolving Identity and Protecting Identity - with a more precise rationale. We discussed some possible alternative questions e.g. 'what underlying factors might influence beliefs about the RC role?' John seemed to feel that this might be ok. I hadn't really anticipated that anyone might think my model was trying to identify predictors for uptake of the role either - I can see now that I did need to make it clearer exactly what it was trying to explain.
04.10.11	I met with Anne and Dave at UEL today to discuss changes to the MRP. We agreed that to address the criticism of an inadequate conceptual framework in the introductions to A and B, I will examine the different beliefs regarding the RC and the factors likely to influence these. I think that these factors might include underlying beliefs (i.e. nature of mental disorder, what effectively treats this, the principle of compulsion and what the purpose of Clinical Psychology is) as well as theory regarding attitudes/beliefs, identity and sociological theory of professions.

	To better justify the need to generate a theory I think I will argue that: a) CP theorises itself and its beliefs as a profession very little b) only a limited number took part in the published debate so it is not clear if the beliefs expressed are representative c) there appears to be a possible discrepancy between BPS policy re: compulsory powers and the uptake of the role so it is unclear if this policy fits with the beliefs of CPs in general d) the RC debate offers a useful vehicle for accessing beliefs CPs have about what the role of their profession is now (e.g. therapeutic, managerial, leadership etc.) as it prompts them to articulate these. This could be seen as a litmus test for what CPs think about the profession and its future e) that such a theory would be important in the context of cuts as it could be used to inform DCP decisions regarding the profession, what CP's role is now, why people need CP etc. f) a theory could be used to develop a questionnaire based on the factors influencing beliefs about compulsory powers, which could establish the relative importance of different factors through a linear regression. This seems like it would give a stronger grounding for the research question and need to generate theory. The research question could then be re-phrased as: What factors influence Clinical Psychologists' beliefs about powers of compulsion for the profession? I need to also discuss the strengths and weaknesses of collapsing the data with reference to the contextual differences. The points that the examiners made about emphasising this more seem important. I think I'd better highlight changes in the profession itself over this time in terms of numbers, demographics as well, as one of the examiners said – it's not the same profession in 2010 and 2001. So talking about policy changes here seems essential as well. In order to make a more coherent, parsimonious model I can dispense with the themes and categories and alter some of the sub-categories so that they relate to beliefs more. The model would then simply consist of two boxes focussing on: A) Factors influencing the belief that compulsory powers are a positive development for the profession and B) Factors influencing the belief that compulsory powers are a negative development. I'll then just discuss contextual factors and perceived lack of commitment at service level as points of interest instead of including them in the model. But I also need to critique the strengths and limitations of the model more. I can see now that by just discussing the methodological weaknesses I've effectively just presented a model without criticising it, which you can't do.
06.10.11	Social identity theory seems to fit with those who claim a consensus against in that those who feel that the distinctiveness of the group identity is being threatened are supposed to encourage homogeneity within the group. For the others perhaps

	it is also difficult to identify with CP as a whole for many as it has become quite a jack of all trades profession? Increasing status, influence, making the profession more indispensable all seem to fit with Weberian theory.
08.10.11	Revised model, focussing on two themes: 'Belief that the powers are a positive development for the profession' and 'belief that the powers are a negative development for the profession'. It then has categories and sub-categories for beliefs and perceptions influencing these two beliefs. Sent it to Anne along with storyline. Worried that this model is still a bit descriptive.
11.10.11	Anne felt that the model was nice and simple but as I feared, still a bit descriptive. She suggested that homing in more on the two different identities I had suggested in the storyline might work better as a frame and theoretical explanation for the beliefs within the model.
14.10.11	Have revised model again: as a 'model by identity' split into a Benign Expert Insider identity versus Collaborative External Ally identity. Beliefs about the powers are then explained according to these two professional identities. Also had a think about the different relationships CP has too: Psychiatry, state, service-user, mental health system. This seems very relevant here but am not really sure how to develop that idea further.
17.10.11	Anne has looked at this model and likes it, suggesting some minor alterations. She suggested that we should consider whether the emphasis is primarily on attitudes to/beliefs about the powers - and explaining them - OR the emphasis is on CP identity/beliefs about their role and work, using this (their reactions to the powers) as a sort of illuminative case study.
18.10.11	Telephone conference call with Dave and Anne. Dave has now looked at the model by identity but he was less enthusiastic as he felt it might not be grounded in the data enough. Although it is grounded in the data to an extent, he suggested trying to have themes which are grounded in every single category, pointing out that this model wasn't grounded in every single one of them. We have eventually agreed upon looking at the relationship with services instead, as Belief in the Transformative power of CP (i.e. the belief in the ability of cp to transform services from within by opportunistically accreting power) versus Belief in the need to defend against assimilation (i.e. belief that the profession needs to defend against assimilation by maintaining separate spaces for collaborative work). The best way we can think of to illustrate ambivalence seems to be to have three outcomes in the model i.e. one box leading to each of the two belief themes and one to ambivalence.
19.10.11	But is this model enough of an explanation or will the examiners say again it is just another description? Dave and Anne both think it's theoretical enough because it explains "wider truths" about the nature of the work and the profession. Dave also feels that I could then develop the two positions theoretically more in the discussion using the organisational literature which I had discussed in the previous submission, acknowledging the context of changing mental health service policy and structure. The lack of theorising of the profession is really the rationale for the study rather than trying to draw on specific existing models, as none seem to map that well onto the issues in question.
19.10.11	Discussion with Anne today. The conceptual work has taken too long. Deciding to resubmit in March. As we have

	considered alternative theory i.e. model by identity, I think I will mention this in the discussion as it's theoretical, relevant and interesting.
15.11.11	Discussion with Anne regarding Section A as this has become absolutely vast. Advised me to focus more on Section B first and to focus on the beliefs about the nature and purpose of the profession in relation to the mental health system i.e. the relationship rather than just the nature and purpose of the profession, as that is the debate that the data/model appear to speak to most.
16.11.11	Think I am probably more sceptical about the potential for CP to change the system from within. I'm not sure I believe that systems are very easily changed that way.
22.11.11	Feedback from Anne re: my storyline for Section B. She agrees it is too broad and trying to fit too much in. She advised me to focus more specifically on the nature of CP in terms of its relationship with the mental health system. Suggested speculating on various belief continua as a lead in after explaining that there is virtually no theoretical literature.
23.11.11	E-mail from Dave re: some queries of mine. I feel very uncomfortable about discussing theories of motivation, conditioning, consistency etc. as the whole point of this study is that it is about theorising what CPs believe not why they believe it. Dave thinks I am right to be wary of talking about motivation, although he points out that the examiners seemed to be interested in this. He pointed out that I could argue that motivation is more of an individual level of explanation whereas organisational models would be more appropriate here and do organisations have motivations? They have interests or functions but perhaps not motivations. He said he did not think I needed to answer this question but suggested that I could perhaps speculate a little bit and suggest this as an area for further research.
29.11.11	Discussion with Anne. I suggested information processing theory of ambivalence along with cognitive dissonance and impression management theories as a way of speculating on motivation and ambivalence. She felt this would be fine so I am going to include something about it in the Discussion. I explained that there is some literature (Smail, Diamond) on what they think CP should be although it doesn't really explain the relationship to services very well. The only literature that really theorises what CP is in that sense is Pilgrim's application of Weberian theory. Anne felt that literature on what it should be could be appropriate – maybe saying this is what some people think it should be and this is what one person i.e. Pilgrim is suggesting it is. We also discussed the analysis. Although I have done a lot of recoding I have not reanalysed. Reanalysing seems to contradict the spirit of GT in that I am not supposed to have preconceptions when analysing the data and the only argument for reanalysing that I can think of would be to look at it through some different sort of lens. This does not seem necessary as when I originally analysed I wanted to know what they were saying their beliefs were and this has not changed. I still want to know this. I am now simply drawing additional inferences about what this implies about their beliefs about the profession as well. So I don't see an argument for reanalysing and neither does Anne.
30.11.11	The cited goal by many participants of 'reducing medical dominance' seems to fit quite obviously with Pilgrim's

	application of Weberian professional dominance strategies to the profession. For balance one might argue that those fearing assimilation are in effect, actually attempting to preserve a sort of guild monopoly on collaboration – not sure that completely works as for example would OTs maybe feel they weren't coercive either? But it could fit with Weberian social closure strategies.
03.12.11	Unsure whether to include anything about Marxian theory as applied to British CP by Pilgrim. Is perhaps relevant to relationship with the state but not so much to relationship with mental health system which is what I'm really focussing on. Could also look at Feminist theory as the relationship with Psychiatry does come up in it, but obviously it does this in gender terms, i.e. in terms of Psychiatry being male-dominated and therefore dominating CP as it is female-dominated. Ideally I would include all of these but I think that perhaps it is most sensible to prioritise the most relevant theory as am so over word limit anyway, which would be Weberian theory of professions as its focus is specifically on the relationship between professions.
03.12.11	Am aware that the focus of the two belief systems might be slightly different in that the transformers may be focussing more on the power they think goes with the RC role and the defenders may be focussing more on the detention powers that go with the RC role. Not sure if that's helpful to explore or not, really, given the word limit.
07.12.11	Have changed my mind about post-structuralists. Wasn't going to include them in the literature review initially as didn't think they were so relevant specifically to British CP's relationship with mental health services. But then the 'psy-complex' is so well-known that it might seem odd not to mention them. Secondly, I think the idea of the development of 'mutual social control' alongside voluntary relationships as emphasised by Foucault, DeSwaan, Miller & Rose etc really seems to support the emphasis placed on collaboration by the 'defenders'. So that seems important to mention in the discussion and it might seem strange mentioning them there if I haven't mentioned them in the introduction or at least in the literature review paper.
08.12.11	Notice that I am feeling less strongly opposed to the introduction of statutory powers than at the beginning of the study and am wondering if I can perhaps accept and oppose them at the same time.
09.12.11	Including some thoughts about social identity theory as applied to organizations (Ashforth and Miel, 1989) in Discussion for Section B. Seems very relevant.
18.12.11	Interesting to think that there is very little evidence for either view about organisations being changeable or not changeable from within. With that in mind the introduction of the RC role seems perhaps a good opportunity to try and generate some.
22.12.11	Couldn't get hold of a copy of this before but have discovered that Mollon's (1989) article applies Oedipal theory to CP and its relationship with Psychiatry. I am going to briefly mention it in the literature review and / or introduction to Section B as it is an example of theory being applied to the profession and its relationship with Psychiatry. But I'm not sure it would be helpful to focus too much on this as it is using a more individual level of explanation to explain the

	nature of an organisation / profession.
10.01.12	I have really no space to include it, but if I could I would perhaps discuss the strengths and weaknesses of using instrumental case studies as well. It may be that beliefs about the detention powers cannot be completely generalised to beliefs about the profession. It might be useful to carry out further case studies e.g. a complimentary one looking at beliefs about IAPT to see if they generate similar themes.
13.01.12	Realise that I haven't explained in the diary that I removed an extensive section on non-UK CP's beliefs some time ago because a) I simply couldn't find a way to fit it in without it taking up too much space and b) the studies either weren't really focussing on what they thought CP was for or they weren't really relevant to the relationship with services e.g. US CPs ethical beliefs, theoretical orientations etc. I think it's also very difficult to use literature from other countries because the structure of the healthcare systems and the history and structure of the professions are so different that I don't think you can convincingly argue that they're comparable as the same profession, particularly in relation to the relationship to the wider system. British CP was born out of, and developed in tandem with the NHS so has a very close relationship to the state and to wider mh services e.g. the funding of UK CP training by the NHS is highly unusual internationally. American CP for example is very different – lots of individual therapy, 34% of US psychologists are self-employed, US CPs place less emphasis on trans-diagnostic processes, those employed within the Dept of Veteran Affairs are more highly dominated by Psychiatry and the medical model. Or with Australian CPs, their expertise is comparatively undercapitalised in mh services and they hold less senior posts than in the UK. Then there is also the fact that a medical diagnosis criterion for state or health insurance reimbursement entangles both Australian and US CPs rather inextricably within the medical model. So lots of different issues to think about.
15.01.12	Anne has pointed out that in some of the beliefs there are conceptual overlaps with more general political positions and has suggested that the positions in the models might perhaps be represented on a chart, similar to ways in which more general political positions can. I did explore this idea a little with the last submission at one point before removing it. She suggested seeing if I could relate the model to a Nolan chart. I had a try but I have so little space for words and couldn't really see of way of doing this in a pithy way as my model is binary and Nolan charts aren't. Saw an analysis of the modern UK political spectrum by Lightfoot and Steinberg who have found that the dividing factors today are attitudes to isolationism and criminality. One end is isolationist and tough on crime whilst the other is internationalist and believes more in social determinants of crime. Considered trying to relate this to the model but didn't feel these concepts were so applicable here. Sowell's analysis might fit better because it's binary but then I think Nolan charts offer a much better representation of the range of political positions than Sowell's. Had a discussion with another CP who felt that although it was interesting and might be of some relevance, it did seem to be getting rather divorced from CP itself. I think I may leave this idea out ultimately.

10.03.12	I wanted to make the point that as the document on change management i.e. National Co-ordinating Centre for NHS Service Delivery and Organisation Research and Development (2001) which I mention in the Discussion points out that limited evidence exists regarding organisational change processes in healthcare, an opportunity to generate better evidence may therefore now exist via measurement of change outcomes following the adoption of the powers. (This would of course require outcomes to be clarified first). However I lack the space to make this point. I have also attempted to find more literature to support the belief of some participants that change is more possible from within as I realise that I have mentioned more references for the opposite argument and need to guard against taking a biased position in the Discussion. However I have struggled to do this which may be more of a reflection that there does genuinely seem to be little evidence on this subject in healthcare systems, as the above document acknowledges.
12.03.12	I would like to make the point in the Literature Review that Bell (1989) and Roy-Chowdhury (1991) have made that some CPs working in learning disabilities services have indeed managed to effect some political change, but I am too constrained by the word limit.
15.03.12	The problem with separating oneself from the system is that people feel that distance and are less likely to be influenced by someone perceived as an outsider. There is an argument for simply being more part of a team simply in order to influence it as Dilks mentions.
16.03.12	I note that the critic role mentioned by Diamond didn't really seem to emerge during the study. If I had more space I might discuss this more and consider the possibility of exploring it in future research.
19.03.12	Pilgrim and Treacher (1992) criticise Mollon (1989) for assuming that individual developmental processes such as Oedipal development can explain development in a profession, and accuse him of making "the classical error of the psychologist – he seeks to explain historically determined processes by utilising a psychological theory" (p. 126). Perhaps I could similarly be criticised for psychological reductionism, by asking CP to theorise itself. I would accept this to some extent, but it still seems inconsistent for a profession to place such emphasis upon its research and interventions being theory-driven or formulation-based and then not to have any theory regarding what it is trying to achieve itself. Surely CP would be more likely to achieve some of its goals if it clarified them as it could then apply its own theories / principles to that end, as Mary Boyle (2011) suggests when she advocates exposure for CP (to addressing the socio-environmental causal factors of distress which she sees it as avoiding due to the threat of the associated political implications)?
21.03.12	Part of me feels that perhaps it is possible to hold two positions at the same time regarding whether the purpose of CP is to transform the system or defending against assimilation i.e. perhaps I am becoming more inclined to the ambivalent position. I think that a lot of our role involves trying to introduce some measure of flexibility into the system in terms of helping people think in less rigid ways. In that respect it would be fitting that we would ourselves adopt a role which

	itself requires considerable flexibility to hold in mind. I still feel hesitant about the RC though as I still feel really unsure about how far it is possible to change such a system from within.
22.03.12	If there had been more space in the literature review and empirical paper it might have been good to have explored arguments against integration more i.e. for CP becoming more independent from the NHS e.g. Church (1990) or more profession led than team-led e.g. Mistral and Velleman (1997).
23.03.12	Have just been reflecting on the original feedback from the examiners and I do feel that I really have now addressed their central concerns. This study does now have a clear conceptual framework and leads coherently into a question which clearly indicates the need for theory generation in order to address the lack of theory in the reviewed area. It explains rather than describes the phenomena and relates to "wider truths" i.e. wider theoretical issues about the nature and purpose of the profession in relation to mental health services. It really speaks to how we understand sociological and psychological issues relating to the wider profession and the factors influencing our work. I've considered the qualities of a good theory in presenting a better model, I've discussed its strengths and weaknesses and also the contextual differences of the data sets more in relation to collapsing the data.

Appendix XVIII – Excerpts From Memos

Date	Stage	Data	Participant	Line	Memo
16.11.10	Initial coding	Questionnaire Question 1 comments	3		Hypocrisy Note that this participant is making a slightly hypocritical statement, does not seem aware that by making that statement they are taking the very stance that they are condemning in others, i.e. saying you shouldn't "snipe from the sidelines" whilst simultaneously explaining that they won't be involved (and therefore are 'sniping from the sidelines' themselves)
20.11.10	Initial coding	Questionnaire Question 1 comments	242		Compromise Re: increased pay for increased responsibility: which is coming first? If CPs will compromise on this issue for extra pay would they compromise in other issues, where does it end: prescribing meds?
26.04.11	Focussed coding	Questionnaire Question 1 comments	625		Compulsion creating choice. This argument seems to me quite illustrative of the dilemma CP experiences. It is contradictory yet one can see the point the writer was trying to make. Or one could see the writer as trying to justify something unjustifiable?
06.05.11.	Focussed coding	Focus group		193	RC role as a survival strategy for profession Participant 5 As well as concern about effect of services on clients through dominance of medical model participant is advocating RC role to make CP less vulnerable to cuts
08.05.11	Focussed coding	Focus group		399 - 418	Long-term versus short-term effects of coercion on relationship or Relationship rupture as opportunity to learn new skills Participant 6 has had experience of involvement in coercion with own clients and argues that transparent coercion (i.e. with a clear rationale) can have a positive effect in the long term because the client can reengage and learn a new relationship skill: reframing disagreement in a less catastrophic way as something which it is possible to overcome. Sees honesty as essential to facilitating this. Perhaps those who only perceive coercion as having a negative effect on the therapeutic relationship have not experienced this or less able to reframe? 430 For some how they relate to others is a core issue. 437 & 443 – Intimating that not using the detention therapeutically is perhaps wasteful. Emphasises the need for support in doing this.
08.05.11	Focussed coding	Focus group		451	Seduced by power Participant 1 disagrees with corrupting influence of power argument. Sees psychologists as less vulnerable to corrupting influence of power and power existing within therapeutic relationship anyway. Categorises this as a process dynamic that we have to be aware of like any other. Sees profession as protecting itself from influence of power through supervision and training. However one could argue that psychologists have more power in the therapeutic relationship and this might contradict his argument slightly. If they were completely invulnerable to the seductive effects of power why have they chosen to be in a powerful position in the first place?

12.05.11	Focussed coding	Focus group		1492	Little mention of AMHP role P4 Lacking knowledge about SWs. Know so much about Psychiatrists but apparently much less about SWs. AMHP role much less discussed. Why so much focus on those with more power? Surely could influence as well through AMHP role if that is the true motivation?
20.05.11	Focussed coding	Questionnaire General Comments	N/A		Values versus responsibility Sense of moral obligation for many to accept role in order to change system. Also seems to be a perception in some who feel this way that there is no trade-off between values and improving the lot of some clients. Values are simply not important enough to stand in the way of helping a particular group of clients. Values are placed much lower on the moral hierarchy than helping a small group. This seems to contrast with the opposite position which seems to be that to compromise values is everything because these are placed at the top of the moral hierarchy, so compromising values in order to help one group of clients would harm another group of clients. Initially I found myself disagreeing with the former view but now realise that if one looks at this in terms of the latter group seeing this as a one-size-fits-all debate and the former group seeing this as a choice for particular specialties then I find myself able to be sympathetic to both positions.
25.05.11	Axial coding	N/A	N/A		Two large categories Am getting a sense from the data of two large categories or perhaps themes. Not sure what to call them – one is 'Evolving' / 'Overcoming constraints' / 'Improving the system'. The other is 'Protecting' / 'Protecting a valued role' / 'Loss'. Loss? Am thinking many codes might actually fit under 'loss'. Considering antithetical to values as under 'principled resistance' with 'criticising detention' and 'claiming a consensus against'. Could also have a 'conflict of roles' category' which could contain 'excess of roles', 'balance of roles', 'incompatibility of roles' and 'effect on client's perception'. May also have 'fear of the future' category containing ' corrupting influence' and 'uncertainty around future choice'
29.05.11	Focussed coding	Focus group	N/A	N/A	Overlap Not really getting a sense of there being enough distinct reasons for position on being an RC personally to justify separating these categories from those for position on compulsion. It is the same with the categories for the questionnaire, there's too much overlap, arguments aren't really distinct enough from one another. It is going to make more sense to just amalgamate the reasons for these as either a supporting position, opposing etc.
29.05.11	Focussed coding	N/A	N/A	N/A	Influence and benefits of role Categorising focussed codes. Not sure about influence and benefits of role as influence seems a big category, or maybe that's just because it seems to come up a lot. I think influence should go under benefits of role rather than a separate category.
29.05.11	Focussed coding	Focus group	N/A	N/A	Neutral position Focussed coding and categories for Focus Group. Similar arguments coming up for neutral position

					as opposing and supporting, person is simply torn between them and only one person. Feel it is difficult to say that I have neutral views from questionnaire because of the wording of question about volunteering, not really a neutral position so it's difficult to know for sure who the neutral participants are. A handful say they are ambivalent or torn but they are simply offering the same arguments as in supporting and opposing too so I think it makes more sense to look at this issue in terms of opposing and supporting views as interacting with reach other due to the degree of overlap I am noticing. This would make a theory more realisable. Evolving versus protecting? I think Protecting maybe works better than Loss on reflection.
29.05.11	Focussed coding	Focus group	N/A	N/A	<u>Differences between groups</u> I have also noticed that the ad hominem attacks of the opposing view are much less present in the focus group. Arguably one would expect this due to the lack of distance and safety provided by the questionnaire. Apart from this the main difference appears to be that there is a perception that there is no commitment towards CPs being RCs in services and this is therefore a pretty low priority for the participants.
30.05.11	Focussed coding	N/A	N/A	N/A	<u>Competing with Psychiatry</u> Going to remove 'Competing with Psychiatry' as a sub-category. There are very few codes in it and they would mostly fit in status, reducing medical power or improving care. Moving 'Client needing variation and choice' to within 'losing a valued role'. Refining categories and codes. Taking out competing with Psychiatry. Reducing medical power covers this. Am removing sharing and similarity as it's such a small sub-category doesn't really warrant inclusion. More of a negative case.
04.06.11	Axial coding	N/A	N/A	N/A	<u>Countering and discrediting</u> Refining categories and code. Am subsuming 'perceiving limits to effects on other roles', 'countering corrupting influence of power' and 'criticising resistance of role' into a wider sub-category of 'countering and discrediting' as this seems to encompass these sub-categories and having them separately seemed less parsimonious.
09.06.11	Axial coding	N/A	N/A	N/A	<u>Training, guidance and pay</u> Am subsuming 'Increased Pay' sub-category into 'Training and Guidance' sub-category to form 'Training, guidance and pay' as I think this fits better as a sub-category within conditions. Although pay is an extremely frequently cited condition there are a limited number of further categories within it, so on reflection it seems better to simply have 'increased pay' as a code within a 'training guidance an pay category'.
10.06.11	Axial coding	N/A	N/A	N/A	<u>Defence</u> Under 'Defence' am moving 'justifying role' into 'enhancing survival' as there seems no need for this to be a separate focussed code. This sub-category comes much more from the focus group but it seems justifiable to have 'Defence' as a sub-category because the economic climate was not as threatening when the questionnaire survey was carried out and so job retention would not be as likely to be raised as a concern as during the focus group.

10.06.11	Axial coding	N/A	N/A	N/A	Obstruction The 'Obstruction' focussed code needs to be changed to 'obstruction and choice' as it didn't acknowledge the fact that many of the comments about obstruction were also making the point that they felt there should be a choice not a one size fits all approach.
11.10.11	Recoding	N/A	N/A	N/A	Belief that the powers should be conditional and optional This need to be incorporated somehow as removing the Conditions and Consequences from the original model risks obscuring the fact that many participants in favour of the powers felt strongly about this being a choice. Adding it as a category.
17.10.11	Recoding	N/A	N/A	N/A	Perception of limited risks Introducing a new sub-category. This will encapsulate: 'limited effects on roles', 'belief that the powers are unlikely to corrupt CPs', 'belief that an opportunity to help clients outweighs professional values', 'belief that accepting the powers is a necessary compromise', 'belief that rejecting the powers would be impractical and harmful'
18.10.11	Recoding	N/A	N/A	N/A	Compulsory treatment is not incompatible with clinical psychology's values Joining previous two sub-categories on compulsion ('belief that compulsion is necessary and justifiable' and 'belief that CP is implicated in the process of compulsion') from the categories 'beliefs about the nature of mental health services' and 'beliefs about the nature of clinical psychology' to form this one. Have re-labelled one of the sub-categories 'Belief that psychiatric dominance in mental health services is harmful to clients' which can now go with 'Belief that CPs are sensitive, humane advocates with a more sophisticated understanding of some clients' needs' to for a new category called: 'Greater power for clinical psychology will lead to more humane mental health services'.
20.10.11	Recoding	N/A	N/A	N/A	Changing 'Beliefs about the nature of mental health services' to 'Compulsory treatment is ethically problematic' This can then include 'The principle of compulsion is contestable' and 'Compulsion is incompatible with clinical psychology's values'
17.11.11	Recoding	N/A	N/A	N/A	Adding two sub-categories to 'There are limited risks to taking on the powers' : 'The therapeutic role can be protected' and 'Taking on the powers can be an optional role'. Beliefs about pay can then be subsumed into 'The role will increase the power of CP'. This dispenses with the need for an extra category for 'Belief that the powers should be conditional and optional'.
18.11.11	Recoding	N/A	N/A	N/A	Involvement in compulsion is appropriate sharing of a difficult responsibility Have reintroduced this category into the model. Decided not to include it in the previous model as it was made by fewer participants than other categories but it seems more important now as it relates to the relationship with other professions.
22.11.11	Recoding	N/A	N/A	N/A	Identity needs to be a theoretical code under both 'CPs are humane sensitive advocates etc.' and 'the powers will have a negative impact on the role and identity of CP'
01.12.11	Recoding	N/A	N/A	N/A	Created two new codes which had previously been coded as 'humanising the process' so as to give slightly richer detail. Now coded as 'CP attitude more humane' and 'balancing more rigid ideas

					about treatment'
05.02.12	Recoding	N/A	N/A	N/A	Consequences will be positive for clients Having this category means that there is inevitably some slight overlap between its sub-categories and those of Greater power for CP will lead to more humane mental health services i.e. both have subcategories relating to advocacy, needs and humanising services. However, I am deciding to leave it in because 'Greater power...' illustrates implied beliefs about CP and consequences for services more whilst 'Consequences...' illustrates beliefs about consequences for clients more. Alternatively the former category could subsumed under 'Greater power for CP...' but I think the distinction between what is implied about CP and services and what would happen to service-users' experience of services might be lost a little in doing this. It also has a neatly opposing category i.e. 'consequences will be negative for clients' under the opposing theme. Conceivably, this choice may partly represent my concern that the focus on professions and the system in this project may result in the client becoming rather overlooked. Ultimately I think the decision can probably be argued either way though.
10.03.12	Recoding	N/A	N/A	N/A	Psychiatrists' salaries are higher because of the powers Changing this code to 'CPs should receive similar pay to Psychiatrists', because although respondent statements like "Equal pay to Psychiatrists" may imply an underlying belief that the powers are a reason for Psychiatrists' higher salaries, Dave feels that they do not necessarily indicate that, they may simply indicate wanting to have the same pay as Psychiatrists.
13.03.12	Recoding	N/A	N/A	N/A	Medical dominance over other models / professions will be reduced if CPs have the powers Having considered this further am moving this code to a different sub-category. I am moving it from 'Clients will receive better quality care' to 'The powers will increase the influence, status and credibility of CP within mental health services' as it fits that sub-category better.
13.03.12	Recoding	N/A	N/A	N/A	Opportunity to use the relationship Am changing this focussed code as both Dave and Anne have found it confusing and / or disagreed with it. Have changed it to CP involvement may be more helpful for the relationship with the client. It refers to points made about CPs being able to help repair the relationship with the team after ruptures with clients and being able to use the experience of being detained in some positive way e.g. as an opportunity to learn that disagreement can be managed within relationships

Appendix XIX – Summary of Findings to Participants

Summary of Preliminary Findings for Research Project: 'Clinical Psychologists' Beliefs About The Purpose Of Their Profession In Relation To The Wider Mental Health System: A Case Study Of Views On New Powers Of Compulsion'

Dear all,

The research project: 'Compulsory powers and the Responsible Clinician role: Clinical Psychologists' views' which you participated in has been amended in order to meet the requirements of the Salomons Doctoral Training Programme in Clinical Psychology Board of Examiners. I am therefore writing to you with a summary of the preliminary research findings from the amended project. The amended project also investigates Clinical Psychologists' views on new powers of compulsion for their profession, but goes beyond this to examine what these suggest regarding Clinical Psychologists' underlying beliefs about the nature and purpose of their profession in relation to the wider mental health system.

As you know, after the focus group I analysed your comments and those of other participants from a past questionnaire survey conducted in 2001, prior to the introduction of the new powers. I identified common views and combined these to form sub-categories, categories and themes. For the amended project I have added a further layer of interpretation, so many of the original categories and themes have now been revised. The themes and categories are listed below with brief explanations. Where differences existed between your views and the survey group's views I have tried to make this clear.

Summary of preliminary findings

Two main themes/beliefs emerged. Some people expressed a belief that clinical psychology could transform mental health services from within by opportunistically accreting power (Theme 1) whilst others expressed a belief that clinical psychology needed to defend itself against assimilation by maintaining separate spaces for collaborative work (Theme 2).

Theme 1 – Belief that clinical psychology can transform services by opportunistically accreting power

• *Compulsory treatment is not incompatible with clinical psychology's values*

More people in both groups were broadly supportive of than opposed to the powers. Many emphasised the necessity of compulsion for protecting the public and helping clients. They described feeling implicated in social control, regarding acknowledgment of their involvement as transparency and seeing the powers as appropriate sharing of a difficult responsibility. Consequently, various questionnaire respondents perceived opposition as obstructive and understood it as fearfulness, immaturity or avoidance of responsibility.

• Greater power for clinical psychology will lead to more humane mental health services

People in both groups believed that psychiatric dominance in services was harmful to clients. They felt that services were too bio-medically oriented, often increased client dependency or dysfunction and that clinical psychologists currently lacked agency to reduce such harm. In contrast, they regarded clinical psychologists as sensitive, humane advocates with a more sophisticated understanding of some clients' needs (e.g. people with personality disorders or learning disabilities) than other disciplines.

• Consequences will be positive for clients

People in both groups adopted a discourse of advocacy or meeting clients' needs. They argued that greater clinical psychology involvement would humanise the system and reduce medical dominance over other models and professions. Certain people in the focus group perceived in the role an opportunity to use therapeutic relationships to help clients develop new skills e.g. learning from disagreement.

• The role will increase the power of clinical psychology

People from both groups believed that the role would lead to greater influence with which they could change the system from within, altering the concept and treatment of mental illness. Some people from the questionnaire group believed the powers would increase credibility whilst people from both groups saw them as enhancing status and salaries. People from both groups perceived limited risks from the role and felt compromise was possible, although focus group participants saw this as dependent on context. A small number of people from both groups dismissed fears that power might corrupt clinical psychologists, viewing power as inescapable in client-therapist relationships and / or checked by protective mechanisms. Some people in the focus group believed the powers made clinical psychologists less dispensable. Some from the questionnaire group advocated a pragmatic response, perceiving opposition as impractical and potentially harmful. Many from both groups believed that regulation could and should safeguard therapeutic relationships by ensuring that clinicians could not adopt both a therapist role and role of compulsion for the same client. They also believed that the role could and should be optional.

Theme 2 – Belief that clinical psychology must defend against assimilation by protecting separate spaces for collaborative work

• Compulsory treatment is ethically problematic

A small minority in the questionnaire group questioned professional ability to predict behaviour accurately, challenging the need for mental health legislation and the practice of compulsion. Many participants believed that involvement in compulsion was incompatible with clinical psychology's values and a minority in the questionnaire group also believed that it was based on a conflicting model of mental disorder. A small number from the questionnaire group claimed a localised consensus of opposition or foresaw their departure from the profession / NHS if the role was to be introduced.

• A collaborative clinical psychology is only possible if separate from compulsion

Many people believed that clinical psychology enjoyed a distinct professional advantage or relative autonomy as it could operate independently from the coercive system. They perceived a need for such a non-coercive profession in the system. They valued this characteristic as they believed it enabled collaborative empowering relationships with clients.

• Consequences will be negative for clients

People in both the questionnaire group and focus group therefore believed that negative consequences would ensue for clients because the powers would compromise collaborative alliances with clinical psychologists and undermine their effectiveness. They saw the powers as incompatible with collaborative therapeutic relationships, negatively affecting clients' perceptions of clinical psychologists and potentially making advocating for clients harder.

• Consequences will be negative for clinical psychology

People in both the questionnaire group and the focus group believed the powers negatively altered clinical psychology's role and identity, reducing its distinctiveness from Psychiatry and socialising it into a system of social control. Small numbers from both groups also expressed concern about the potential corrupting influence of power and the creation of an excess of roles. Many from the questionnaire group believed that accepting the powers was simply colluding with the system as it was unlikely to increase influence or enhance status. They also believed that adopting the powers was motivated by envy of medical status and power-seeking. Some people from both groups expressed concerns that if employers' expectations were to change, clinical psychologists could be powerless to prevent the role becoming an obligatory one.

(Themes 1 & 2 were not mutually exclusive as some people had overlapping views. A small number felt very conflicted between the two and adopted an ambivalent / neutral stance).

Feedback

Thank you very much for reading the results. Whilst I appreciate that you may have already provided me with feedback on the previous occasion, I would still be extremely interested to know what your views are regarding the findings of the amended project, which you can give me by replying before the 9th March, 2012 to the e-mail this summary was attached to. It would be particularly helpful to know:-

- Do the new findings make sense to you?
- Do they reflect your views?
- Do you disagree with anything?
- Do you feel anything important is missing?

This would all help me to ensure that these results are reliable. However you are under no obligation at all to provide me with feedback if you do not wish to do so. Once again, I would very much like to express my gratitude to you for giving up your time and taking part in this study.

Yours sincerely,

Tom Parsloe,
Trainee Clinical Psychologist,
Canterbury Christ Church University.

Dr M.M.Callanan
Chair of the Salomons Ethics Panel
Department of Applied Psychology
Faculty of Social and Applied Sciences

Friday, 23rd March 2012

Dear Chair,

Please find a brief summary of the findings from the amended Major Research Project: Compulsory Powers And The Responsible Clinician Role: Clinical Psychologists' Views. The title of this project has now been altered to: Clinical Psychologists' Beliefs about the Purpose of Their Profession in Relation to the Wider Mental Health System: A Case Study of Views on New Powers of Compulsion. No major ethical issues arose during the course of the study. A debrief was completed at the end of the focus group and participants reported that they had found it thought-provoking. No complaints were made, no distress was apparent in participants at any time and no participants left during the interview.

Summary

Despite the profession's putative reflexivity, little theoretical or empirical literature addresses British clinical psychologists' beliefs about the nature of their profession and its relationship with the wider mental health system. This case study examined attitudes towards one new development – the adoption of compulsory powers – in order to discover the implicit beliefs that clinical psychologists draw upon in practice. Written comments from 292 clinical psychologists responding to an earlier questionnaire survey in 2001 were analysed using Grounded Theory, together with data from a focus group interview conducted with 6 clinical psychologists from the Division of Clinical Psychology's Faculty of Psychosis and Complex Mental Health.

Two contrasting constellations of belief emerged. Some clinical psychologists appeared to believe in the profession's ability to transform services from the inside by opportunistically accreting power. Others appeared to believe in a need to defend the profession against assimilation within a system that is sometimes antithetical to its values, by maintaining separate spaces for more collaborative relationships with clients. These overarching beliefs were associated with different beliefs about specific issues, namely professional identity, its compatibility or otherwise with coercion, where power is located and what drives organisational change.

These findings suggest a need for greater professional self-examination. They are considered with reference to organisational, sociological and psychological literature. Limitations and areas for further research are discussed.

Yours sincerely,

Tom Parsloe,
Trainee Clinical Psychologist

Appendix XXI – List of themes, categories, sub-categories and codes

Key

1 Theme
A Category
B Sub-category
C (Theoretical codes)
D Focussed code
1. Initial code

1: Belief that CP can transform services from within by opportunistically accreting power

A: Compulsory treatment is not incompatible with CP's values

B: Compulsion is necessary and justifiable

C: (Necessity, protection)

D: Paternalism and the protection of others justify coercion

1. Paternalism necessary if very ill
2. Wants versus needs
3. Short-term versus long-term view
4. Protecting the public
5. Possible to forget the needs of the public
6. Utilitarian principle justifying detention

D: Compulsion is a realistic and necessary feature of services

7. Coercion as realistic
8. Disliking detention powers but acknowledging their necessity
9. Psychology powerless to deal with severe problems

B: CP is implicated in the process of compulsion

C: (Compatibility, involvement, transparency, sharing, maturity)

D: CPs are already involved in detention / social control

10. Psychologists taking a false position
11. Disingenuous to act as if not implicated
12. Already involved and influencing sectioning
13. Not seeing as implicated in social control system as naive
14. Hypocrisy in colluding if disagreeing with system

D: Acknowledging involvement in compulsion is transparency / honesty

15. RC as transparency around being implicated in social control
16. Transparency and clarity are preferable

D: Involvement in compulsion is appropriate sharing of a difficult responsibility

17. Appropriate to share the responsibility
18. Wanting help with a difficult responsibility

D: Opposition to the powers is immature, obstructive or avoidant behaviour

19. Criticising from an external position as not acting maturely
20. Acting maturely
21. Growing up
22. Choice should not be restricted by others
23. Resistance as obstruction
24. Obstruction from those who could opt out or are not eligible
25. Involvement as taking responsibility
26. Involvement as duty
27. Opting out as avoidance
28. Fear of responsibility
29. Cowardice
30. Using values to avoid responsibility
31. Avoiding involvement in decision making as unprofessional

A: Greater power for CP will lead to more humane mental health services

B: Psychiatric dominance in mental health services is often harmful to clients

C: (Dominance, harmfulness, powerlessness, goals)

D: Services are too medically oriented and / or harmful to clients

32. Medical conceptualisation of mental illness as obstacle
33. Psychiatric input and decisions causing harm
34. Process of care harmful
35. Medicine too powerful
36. Trapped by the medical model
37. Services as traps sucking people in
38. Service disabling clients
39. Medics as unmanageable
40. Psychological features not considered
41. Being denied help
42. No access versus too much exposure to institution
43. Risk aversion
44. Protecting clients from service

D: CP has a lack of agency to reduce harm

45. Poor care due to lack of influence
46. Non-psychology staff admitting or refusing to admit for psychological treatment
47. Treatment being disrupted by medical staff
48. Illogical to treat without the power to carry out treatment
49. Psychologists needing more power

B: CPs are sensitive humane advocates with a more sophisticated understanding of some clients' needs

C: (Humaneness, advocacy, expertise, identity)

D: CP is a sensitive and humane profession

50. CP care more sensitive
51. CPs involved in improving the humanity of services
52. CP attitude more humane

D: CPs are advocates for clients

53. Better knowledge of client enabling advocacy or aiding decisions
54. CPs ensure better treatment of clients than other professions

D: CPs understand the needs of some clients better

55. CPs having better understanding of some conditions e.g. personality disorders
56. Supervision by CPs more appropriate for Learning Disabilities
57. Most appropriate CSs for personality disorders
58. Biological model not always most relevant

A: Consequences will be positive for clients

B: Clients will receive better quality care

C: (Consequences, humanisation, needs-based care, power transfer)

D: Greater involvement of CPs will humanise the process of care

59. Humanising the process
60. Looking at the person versus looking at the problem
61. CPs as potentially ensuring humane use of Community Treatment Orders
62. Preventing a punitive approach in developments
63. Compulsory detention as less distressing within a trusting relationship
64. Allowing a more holistic approach
65. Reducing distress for all
66. Reducing admission length and risk aversion
67. Promoting collaboration
68. Empowering
69. Increasing client choice
70. Maximising human rights

D: The powers will enable CPs to advocate for clients

71. Opportunity to advocate
72. Promoting advocacy

D: Some clients' needs will be met better if CPs have the powers

73. Addressing needs better

74. Possibility of admitting under more relevant regime
75. Psychological input as important for detained clients
76. Increasing access to services
77. CP as more suitable than Psychiatry for some

D: CP involvement may be more helpful for the relationship with the client

78. CPs as helping to repair relationship
79. Using opportunity to learn to manage disagreement within relationships

A: The role will increase the power of CP

B: The profession will be less dispensable with the powers

C: (Consequences, vulnerability, survival)

D: CPs are vulnerable to health service budget cuts

80. CP as expensive and dispensable
81. Threatening economic climate

D: The powers will make CPs less vulnerable to budget cuts

82. RC as justifying role
83. Making profession indispensable
84. Making self indispensable

B: The powers will increase the status, influence and credibility of CP within mental health services

C: (Consequences, power, agency, equality, credibility)

D: Medical dominance over other models / professions will be reduced if CPs have the powers

85. Preventing medicalisation
86. Reducing client treatment by medical model
87. Breaking medical monopoly of RMO roles
88. Reducing medical dominance
89. Redressing power imbalance
90. Needing to take power from Psychiatrists
91. Changing medical model culture

D: The powers will enable CPs to influence the concept and treatment of mental illness

92. Greater influence of psychological models
93. Opportunity to spread skill based knowledge
94. Broadening perspectives
95. Having a valuable perspective
96. Increase in formulation in care planning
97. Influence as improving care and social control
98. Difficulty influencing without role like Psychiatrists
99. Balancing rigid views about treatment

D: Change is more achievable from within the system

100. Change as only coming from or more easily achieved from within
101. Not participating as not changing anything
102. Involvement as increasing influence
103. Involvement as engaging with a flawed system
104. Involvement as ability to monitor legislation, shape role and contribute
105. Involvement in developments to improve psychological services
106. Involvement in developments to help those at risk from developments

D: The powers will enhance the status of CPs

107. Enhancing status
108. RC as an indicator of status
109. Wanting equality with Psychiatrists

D: The powers will increase the credibility of CPs

110. Role necessary for credibility
111. If refusing responsibility then criticism of others unjustifiable

B: The powers are likely to result in an increase in pay

C: (Consequences, incentives, fairness, reciprocity)

D: Pay is an incentive to carry out the role

112. Depending upon pay
113. Pay making it a more attractive option

D: CPs should receive similar pay to Psychiatrists

114. Equal pay to Psychiatrists
115. Not being taken advantage of

B: There are limited risks to taking on the powers

C: (Consequences, compromise, pragmatism, preservation, choice)

D: The powers will have a limited effect on other roles

116. Compromise possible
117. Not perceiving conflict of roles
118. Dependent on context

D: More powers are unlikely to corrupt CPs

119. Power in all relationships and inescapable
120. Protective mechanisms existing

D: The imperative to help clients outweighs other values

121. Opposing values as moral superiority
122. Principles versus action
123. Helping needy outweighs political moral concerns
124. Misconceived humanitarian stance
125. Preciousness

D: Accepting the powers is a necessary compromise

126. Necessary evil
127. Lack of other ways of improving care

D: Rejecting the powers would be impractical and harmful

128. Not possible to avoid sectioned clients
129. Impractical to resist involvement
130. Resisting as marginalising or weakening profession
131. External positioning as fringe and self-defeating
132. Rejecting proposals as harming vulnerable

D: The therapeutic role can be protected

133. Needing regulation
134. Clear rationale for chosen RC
135. Safeguarding therapist role or therapeutic relationship
136. Protecting different roles
137. Safeguarding boundaries in patient-practitioner relationship
138. Separating CS role from role of CP involved in a therapeutic relationship
139. Rationale for chosen RC involving consideration of effect on therapeutic relationship

D: Taking on the powers can be an optional role

140. Needing a choice regarding roles
141. Needing a choice to refuse the role

2: <u>Belief that CP must defend against assimilation by maintaining separate spaces for collaborative work</u>

A: Compulsory treatment is ethically problematic

B: The principle of compulsion is contestable

C: (Contestability)

D: Professional ability to predict risk is poor

142. Disputing ability to predict and control behaviour
143. Disputing professional justification of compulsion

D: The existence of mental health legislation or the practice of compulsion are contestable

144. Questioning the existence of the MHA
145. Calling for a debate on detention itself

B: Compulsion is incompatible with CPs' values

C: (Compatibility, resistance)

D: Involvement in coercion is antithetical to the nature of CP

146. Contradicting reason for entering profession
147. Values behind choosing profession
148. Different client relationship
149. Not wanting compulsory powers
150. Importance of relationship without compulsion

D: The powers may prompt a departure from the profession / NHS

151. Threatening to leave NHS
152. Threatening to leave CP

D: There is a localised consensus against having the powers

153. Localised consensus against
154. BPS representation inaccurate

D: A coercive role is based on a conflicting model of mental disorder

155. Role not psychologically based
156. Wanting an alternative to the medical model

A: A collaborative CP is only possible if separate from compulsion

B: CP is distinctive and more autonomous because of its separation from the system of coercion

C: (Externality, identity, distinctiveness, autonomy)

D: Separation from coercion distinguishes CP from the other professions

157. The only profession that doesn't have to force people to do things
158. Neutrality not possible for other professions
159. Psychologists as coming from the outside
160. Privileged precious position
161. Loss of distinctive identity
162. Excessive pressure to be assimilated

D: CP is an autonomous discipline

163. Compromising independence
164. Autonomy as compromised

B: Separation from the coercive system is valuable and enables collaboration

C: (Goals, value in separation, collaboration)

D: There is a need for a non-coercive profession

165. Importance of client choice
166. Position meets a need
167. Need for non-restrictive staff

D: Lacking powers of compulsion is an advantage

168. Persuasion and lack of powers as key tools
169. Lack of compulsion as key advantage for CPs
170. Finding external positioning useful

D: Separation from coercion enables collaborative empowering relationships

171. Separation from MHA process as facilitating therapeutic relationship
172. Collaborative empowerment and compulsion as incompatible
173. Compulsion and collaboration as incompatible
174. Contradiction between coercion and engagement

A: Consequences will be negative for clients

B: The powers will compromise collaborative alliances with CPs and reduce the effectiveness of CP

C: (Consequences, undermining effectiveness)

D: The powers might reduce CPs' ability to advocate for clients

175. Compromising ability to act as advocate
176. Conflict in accountability between risk management and advocacy
177. Effect on human rights

D: The powers will have a negative effect on clients' perceptions of CPs

178. Negative perception from clients
179. Inviting resentment
180. Respect as compromised
181. Clients as fearing CPs
182. Divisive effect on clients

D: The powers are incompatible with a collaborative therapeutic relationship

183. Compromising therapeutic relationship
184. Coercion as anti-therapeutic
185. Incompatibility of Clinical Supervisor role with CBT with unusual beliefs
186. Power to detain sometimes making psychological therapy unsafe
187. Therapeutic relationship affected by professional association with other CPs involved in detention
188. Unenforceability of psychological therapy
189. Psychodynamic role may not be possible

A: Consequences will be negative for CP

B: The powers will have a negative impact on the role and identity of CP

C: (Consequences, identity, transformation, assimilation, depreciation)

D: CP will lose its distinctiveness from Psychiatry

190. Morphing into medics
191. Risk of emulating Psychiatry
192. Wanting to limit overlap between Psychiatry and Psychology

D: CP will be socialised into a social control role

193. Perceiving control as focus of legislation not compassion
194. Being used to police
195. Fearing becoming agent of social control
196. Increasing social control role
197. Already compromised too much by social control system
198. Socialisation into coercive system
199. Losing awareness through conditioning

D: The powers may have a corrupting influence

200. Disputing impartiality of psychologists
201. Being seduced by power
202. Fearing use of power for profession and not for client

D: The powers create an excess of roles

203. Having too many roles already
204. Becoming less skilled
205. Using up time
206. Balance of roles

B: The powers will not increase the influence of or enhance the status of CP

C: (Consequences, scepticism, questioning integrity)

D: Accepting the powers is colluding with, rather than influencing the system

207. Belief in ability to change established power centre as delusional
208. Role not necessarily increasing psychological influence
209. Alternative means of increasing psychological influence
210. Alternative to medical model less possible this way
211. Participating as collusion, not influence

D: A desire for status or power is motivating acceptance of the powers and these are unlikely to be enhanced

212. Envy of medical status and privilege
213. Role based on power seeking
214. Perception of positive effect on status as misconceived
215. No need for higher status
216. Challenging the idea that role will enhance status with reference to Social Workers
217. Pattern of power being given in theory but not in practice

B: The powers will reduce the roles available to CPs

C: (Consequences, uncertainty, powerlessness)

D: Employers' expectations regarding the powers may change

218. Uncertainty around future expectations
219. Once trained may be little choice regarding role

D: CPs are powerless if employers' expectations regarding the powers change

220. Losing pay
221. Taking on role versus losing job

Appendix XXII – Author Guideline Notes for 'Clinical Psychology & Psychotherapy'

THIS HAS BEEN REMOVED FROM THE ELECTRONIC COPY