RESEARCH ARTICLE

UK clinical and community psychology: Exploring personal and professional connections

Miles Thompson[1,2] | Jenny Stuart[3] | Rose E. Vincent[1] | Louise Goodbody[3]

[1]Department of Social Sciences, University of the West of England, Bristol, UK

[2]School of Psychology and Life Sciences, Canterbury Christchurch University, Canterbury, UK

[3]Salomons Institute for Applied Psychology, Canterbury Christchurch University, Canterbury, UK

Correspondence
Miles Thompson, Department of Social Sciences, Room 3A028, University of the West of England (UWE Bristol), Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY, UK.
Email: miles@mvdct.co.uk

Present address
Rose E. Vincent, School of Health in Social Sciences, University of Edinburgh, Edinburgh, UK.

Abstract

This paper explores the personal and professional connections between clinical psychologists in the United Kingdom (UK) and critical/community psychology (CCP). Specifically, it asks how clinical psychologists define the area, how they relate to it and how they apply it in their work. Twenty clinical psychologists responded to an online survey, 12 of whom went on to take part in a follow-up telephone interview. Data were analysed using inductive thematic analysis. The results are divided into three sections: i. "describing CCP": social justice and a questioning stance are considered, ii. "relating to CCP": an interplay between lifespan events and personal responses are described and iii. "applying CCP": a dynamic between role-specific applications and reality checks that either enable or constrain is illustrated. Although the continued need for a CCP is described, the results highlight both challenges and tensions of practising CCP within clinical psychology.

KEYWORDS
clinical psychology, community psychology, connections, critical community psychology, personal, professional, social justice

1 | INTRODUCTION

As noted in the first chapter of the recent *APA Handbook of Community Psychology*, the discipline continues to grow 'in the sophistication and reach of its theories, research, and practice' (Bond et al., 2017, p. 3). Of course, the continued development of the discipline varies from place to place around the globe, with different histories, contexts and tensions influencing any growth. In Chapter 2 of the same handbook, these different histories and current contexts are described by Reich et al. (2017). In this chapter, it is noted how clinical psychology is often, but not always, a precursor to the development of community psychology (see table 1 of the chapter). For countries such as the United Kingdom, the development of community psychology is not as advanced as in other areas of the world (see Burton & Kagan, 2003; Burton et al., 2007). As such, the relationship between clinical psychology on the one hand and community/critical community psychology (CCP) on the other is an area of relevant interest. One reason for this is that it may currently represent one of the main professional routes through which ideas from community psychology can get put into practice. As such, this qualitative study explores the personal and professional connections between UK clinical psychologists and CCP. With the above in mind, the following introduction will firstly explore the context of clinical, community and critical community psychology in the United Kingdom. It will then highlight why the need for CCP continues. Finally, it will introduce the current study which builds on research published by Thompson in 2007.

1.1 | Clinical psychology

In the United Kingdom, clinical psychology grew as a profession following the end of the second world war and by 1979 all training took the form of a 2-year Masters degree (National College for Teaching and Leadership & Health Education England, 2016). Since 1995, trainee clinical psychologists complete a funded 3-year Doctorate in Clinical Psychology before they can qualify and practice as a clinical psychologist. Training is funded by the National Health Service (NHS) and places are highly competitive with just 18% of applicants securing a position in 2020 (Clearing House for Postgraduate Courses in Clinical Psychology, 2020). On completion of their training, newly qualified clinical psychologists generally work within the NHS, where mental health treatment is generally free at the point of access (Full Fact, 2013).

Clinical psychologists generally deliver individualised treatments, such as Cognitive Behavioural Therapy (CBT), which tend to dominate treatment options under the National Institute for Health and Care Excellence (NICE) guidelines (NICE, 2009, 2014, 2019). Some argue that the treatment interventions generally available within the NHS are becoming increasingly manualised (Binnie, 2015). Equally problematically, the individual focus of interventions such as CBT can locate both the problem and solution to mental health issues within the individual (Prilleltensky, 1994), rather than considering the influence of wider societal structures (Nelson & Prilleltensky, 2004). Against this backdrop, there is an extensive and growing evidence base, which demonstrates the relationship between wider societal structural contexts in the United Kingdom and mental health inequalities (Friedli, 2009; Marmot et al., 2020; Muntaner et al., 2004; Wilkinson & Pickett, 2010). It is also the case that mental health services within the NHS in England are under strain—with a 21% increase in the number of people in contact with mental health services between 2016 and 2019; little growth in the mental health workforce and job vacancies running at about 12% (British Medical Association, 2019). On top of this, unsurprisingly, demand for mental health services increased during the pandemic [Rethink Mental Illness, 2021 (which has taken place since the data collection for this study)].

1.2 | Community and critical community psychology

Concerns about the individualistic focus of clinical psychology are not new. Community psychology first arose, in part, due to this potential dissatisfaction. In this regard, the 1965 Swampscott Conference (Boston, USA) is

considered a (US-centric) foundational milestone for the development of community psychology. The conference occurred at a time of civil unrest and pivotal social movements in race, class, gender, sexuality and disability (Evans et al., 2017). From the outset, community psychology explicitly recognised the impact that wider social, cultural, economic and political factors can have on individual mental health (Orford, 1992; Reich et al., 2017).

Of course, as community psychologies emerge and evolve, they do so, in part, in response to specific societal and political structures. So, community psychology theory and practice vary from location to location. In the United Kingdom, it has been argued that the reach of community psychology has been less extensive than in other countries (Burton & Kagan, 2003; Burton et al., 2007). With it being characterised as a 'relatively small field' (Burton et al., 2007, p. 219), that is 'relatively underdeveloped' (p. 220) and in some ways a 'minority pursuit' (p. 232). By way of illustration, there are no UK doctoral training pathways that singly qualify individuals as a community psychologist. Moreover, there is currently only one Master's level programme that solely focuses on community psychology. As a result, those with interests in community psychology who wish to become professional psychologists are likely to follow either an existing applied route such as clinical psychology or follow academic and research pathways. However, the current standards for the accreditation of Doctoral programmes in clinical psychology only mention the phrase 'community psychology' once in 84 pages (British Psychological Society, 2019).

Globally within community psychology, a key tension remains. Can it move beyond ameliorative, first-order change and create transformative, second-order change that challenges and dismantles oppressive systems (Evans et al., 2017)? In part, in response to this tension, a more explicitly politically oriented, radical approach has emerged, including in the United Kingdom, Critical Community Psychology. Critical Community Psychology aims to liberate people from the systems that bind them with core values of social justice, stewardship and community (Kagan et al., 2011). The role of the critical community psychologist is to stand in solidarity with those experiencing social injustices, to work in partnership with oppressed groups and, crucially, to actively challenge structural disadvantage (Evans et al., 2017). However, to reflect the somewhat limited development of both community and critical community psychology in the United Kingdom, in the following paper, both terms will be referred to jointly using the acronym: CCP.

1.3 | Further exploring the relationship between clinical psychology and CCP

Following a decade of economic austerity, there is arguably a continued need for approaches like CCP to push applied psychology and wider society to engage with the increasing health and social inequalities of our times (McGrath et al., 2016). In the United Kingdom specifically, health inequalities have widened, life expectancy has stalled (in some places is falling), mental health is in decline and the Covid-19 pandemic has further exposed and exacerbated existing inequalities (Cummins, 2018; Marmot & Allen, 2020; Marmot et al., 2020).

An approach to applied psychological practice, which both recognises and tries to tackle, at root, the significant impact that poverty and socioeconomic inequality continues to have on mental health and well-being seems increasingly important. But as noted above, the relationship between the ideas of CCP and the practice of clinical psychologists in the United Kingdom might not be without tension.

In 2007, Thompson published research that explored the views of UK trainee clinical psychologists on CCP. In this study, first individuals around the globe with knowledge of CCP generated and then rated statements concerning the concepts, values and ideas of CCP. The 43 statements were then rated by 354 trainees on 22 UK clinical psychology training courses. An exploratory factor analysis of the items suggested four factors: i. reflective practice, ii. radical sociopolitical ideas, iii. acknowledging and understanding and iv. core sociopolitical ideas. The mean rating of these factors suggested that trainees, on average, tended to find all CCP ideas relevant to the future of clinical psychology as they saw it. Follow-up qualitative analysis supported the notion of positive endorsement, but also asked questions about how CCP could be enacted, how to mix the personal and professional and questioned the role of politics.

As the introduction and the above previous research has suggested, in the United Kingdom the profession of clinical psychology may be one of the locations that psychologists with an interest in CCP try and apply CCP-related ideas. However, this may not be a straightforward process. Building on Thompson (2007), and wishing to explore the area further, this current research continues to explore the relationship between clinical psychology and CCP in the United Kingdom. Extending from Thompson (2007), first this new research will target qualified clinical psychologists, rather than the clinical psychologists in training. This will enable participants to report on the reality of on the ground working as a qualified professional. Second, rather than surveying clinical psychologists broadly, the research will target those with an interest in CCP. This will enable the study to explore any tensions between working as a clinical psychologist and applying ideas from CCP. More broadly, we will explore the understandings of and relationships with CCP in the context of both personal lived experiences and professional/work contexts. Specifically, this study will ask participants how they define CCP, how they relate to it and how they apply it in their work.

2 | METHOD

2.1 | Design

This study used a two-part qualitative design to explore the areas above. It involved an online qualitative survey (Part one) with a follow-up semi-structured telephone interview (Part two). The data collected from both were analysed using inductive thematic analysis (TA; Braun & Clarke, 2006). For both parts participants first read information sheets before deciding to consent. The study was approved by the Independent Research Review Panel and the Ethics Panel at the host institution.

2.2 | Participants

Participants were all qualified UK clinical psychologists who self-identified as having an interest in CCP. Participants were recruited for Part one via a community psychology listserv, Twitter and at a community psychology meeting held locally to one author. In total, 20 clinical psychologists responded to the online survey, 13 of whom agreed to be contacted regarding the telephone interview, of whom 12 went on to be interviewed. Survey participants ranged from ages 26 to 62 years, and interview participants from 27 to 51 years. Further demographic characteristics are detailed in Table 1.

2.3 | Data analysis

Data from both sources were analysed using inductive TA (Braun & Clarke, 2006). TA, as originally described, is flexible in terms of approach, theory and epistemology. It involves 'searching across a data set... to find repeated patterns of meaning' (p. 86). We applied the six phases of TA, as outlined by Braun and Clarke (2006), as guiding principles. Namely, transcribing the data set, familiarising oneself with the data set; initial coding, searching for themes, reviewing and refining themes; reporting the analysis. Jackson (2000) talks about the risks of 'disguising the researcher's role' (p. 249) in qualitative analysis and invites researchers to consider what 'the reader need[s] to know about the research context to make sense of the data' (p. 248)? With this in mind, and following Guest et al. (2012), we present these results owning the researcher's role in the interviews, and so are both explicit about the areas of questions asked before providing analysis of the answers given.

TABLE 1 Demographic characteristics of participants

| Demographic characteristics	Part one—survey (20)		Part two—interview (12)	
	n	%	*n*	%
Gender				
Female	14	70	9	75
Male	6	30	3	25
Ethnicity				
White British	14	70	9	75
White	3	15	2	166
White-other	1	5	1	8.3
English	1	5	0	0
Indian British	1	5	0	0
Main client group(s) at work				
Adult Mental Health	12		7	
CAMHS (child and adolescent)	5		3	
Learning/Intellectual Disabilities	2		1	
Health Psychology	1		1	
Forensic Mental Health	1		0	
Non-Government Organisation	1		0	
Physical Health	1		0	
Teaching/Training	1		0	
Trauma and Refugees	1		0	

Abbreviation: CAMHS, Child and Adolescent Mental Health Services.

3 | RESULTS

The results below are divided into three sections, each related to a different focus across the survey and interviews: i. describing CCP, ii. relating to CCP and iii. applying CCP. Overarching, midlevel and subthemes are presented to capture different levels of detail (see Figure 1). Unless stated, themes and sub-sections are presented in order of frequency: most prevalent first. Themes with additional levels are illustrated using thematic maps. Later, simple descriptive data are presented to indicate theme frequency. Quotes are used to illustrate theme content.

3.1 | Describing CCP

Only in the survey, participants were asked to describe CCP in their own words. Analysis of their responses (20 survey respondents) identified two overarching themes: 'social justice' and 'a questioning stance'. Further development of what 'social justice' and a 'questioning stance' mean to the participants can be seen in the later sections, which involve survey and interview data combined.
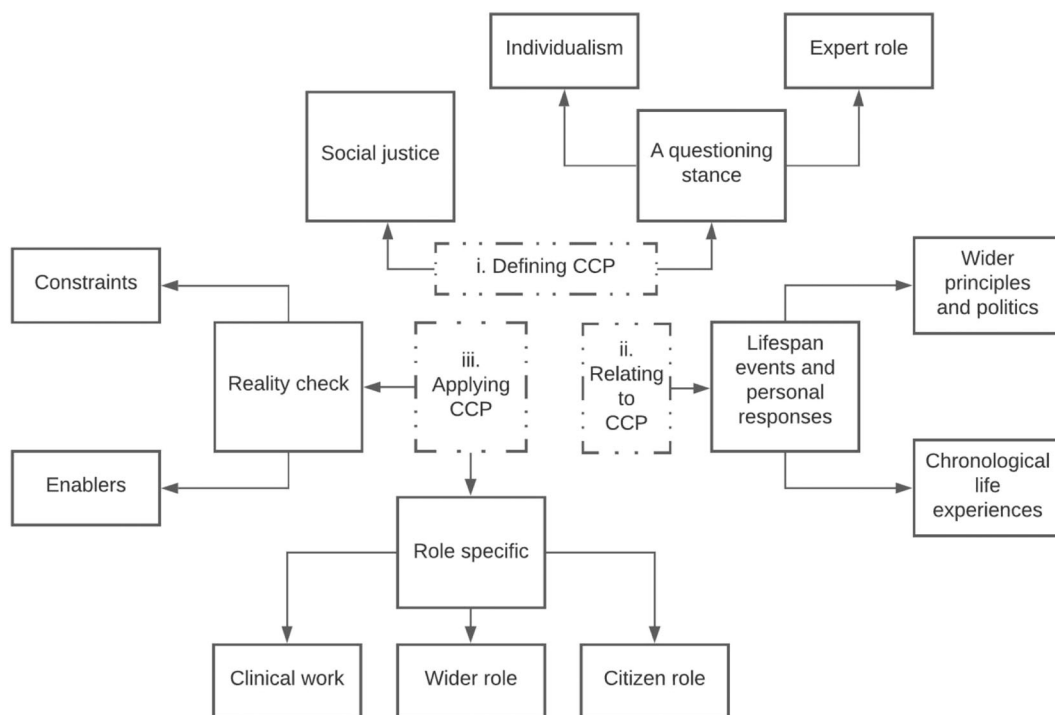
FIGURE 1 Overview of the overarching and midlevel themes in relation to the three study focus areas: i. defining CCP, ii. relating to CCP and iii. applying CCP

3.1.1 | Overarching theme 1: social justice

Social justice (16 survey responses) has been defined as a push for 'the fair and equal distribution of wealth, opportunities and privileges within society' (Molony & Duncan, 2016, p. 256). From the participant's own words they detailed how ideas related to social justice are key to their understanding of what CCP is for them and how it relates to clinical psychology. For example, 'An understanding that social arrangements mean that many people, particularly those labelled with mental disorders, are structurally disadvantaged in their access to opportunities and power' and 'an understanding of how social power and social support impact upon the experience of the individual and the implications this has for clinical practice' (survey participant 9). As the quotes illustrate, participants describe their understanding not just of social justice, but how it can impact mental health.

3.1.2 | Overarching theme 2: a questioning stance

The other overarching theme was labelled, 'a questioning stance' (12 survey responses). The theme notes how participants describe CCP as being more critical than traditional clinical psychology. For example, 'a questioning stance to taken for granted ways of understanding distress' (survey participant 17). The theme was sub-divided into two midlevel themes: 'individualism' and 'expert role'.

3.1.3 | Individualism

Many participants (nine survey responses) were critical of the 'individualism' that clinical psychology can unthinkingly apply when explaining/treating mental health. The individualistic approach represents a tendency to locate distress within the individual and treat the individual without understanding the wider context. In this way, CCP was described as, 'an approach which challenges the individualistic values of "mainstream" psychology/society' (survey participant 18), and 'challenging the notion that the problems that people face are "internal"' (survey participant 5).

3.1.4 | Expert role

A second midlevel theme shows a questioning stance specific to the 'expert role' (nine survey responses) sometimes adopted by clinical psychologists. This theme suggests that CCP tries to avoid the assumption that the practitioner is the expert on individual distress. This includes valuing individual experience and being open and sensitive to professional limitations. References to this were made in comments such as 'A rejection of the "expert" position within the professional of psychology' (survey participant 1) and being 'honest about what we don't know as psychologists and the limit of our knowledge' (survey participant 14).

3.2 | Relating to CCP

The second section of the results explores how participants came to develop a relationship with CCP. All survey participants provided answers, and in the interviews, participants were asked to develop their responses.

3.2.1 | Overarching theme 3: lifespan events and personal responses

Participants answers to this question often mixed both lifespan events (from childhood to the workplace) with their responses to these events (wider principles and politics). Therefore, the overarching theme was labelled 'lifespan events and personal responses' and two midlevel themes were identified: 'wider principles and politics' and 'chronological life experiences'. Importantly, both seemed intimately linked to one another (Figure 2).

3.2.2 | Wider principles and politics

Participants' experiences from different life stages (discussed below) were interspersed with comments about 'wider principles and politics' they held or developed (12 interview responses). For example, 'I've always been questioning even before psychology, my values have always been about social justice, equality and I tried to bring these to psychology' (survey participant 14). The midlevel theme was subdivided into two subthemes: 'value of social justice' and 'political views'. The 'value of social justice' (11 interview responses) was tied up with many participants' growing relationship with CCP: 'as a human being I needed to work towards creating a just - you know, even if supporting other people - to create a just world' (interview participant 7), 'I was wanting to get involved and make a difference, if that doesn't sound too corny' (interview participant 8). Participants had already identified social justice to be a key component of their definition of CCP, so this resonating with their own principles and politics is a natural fit.
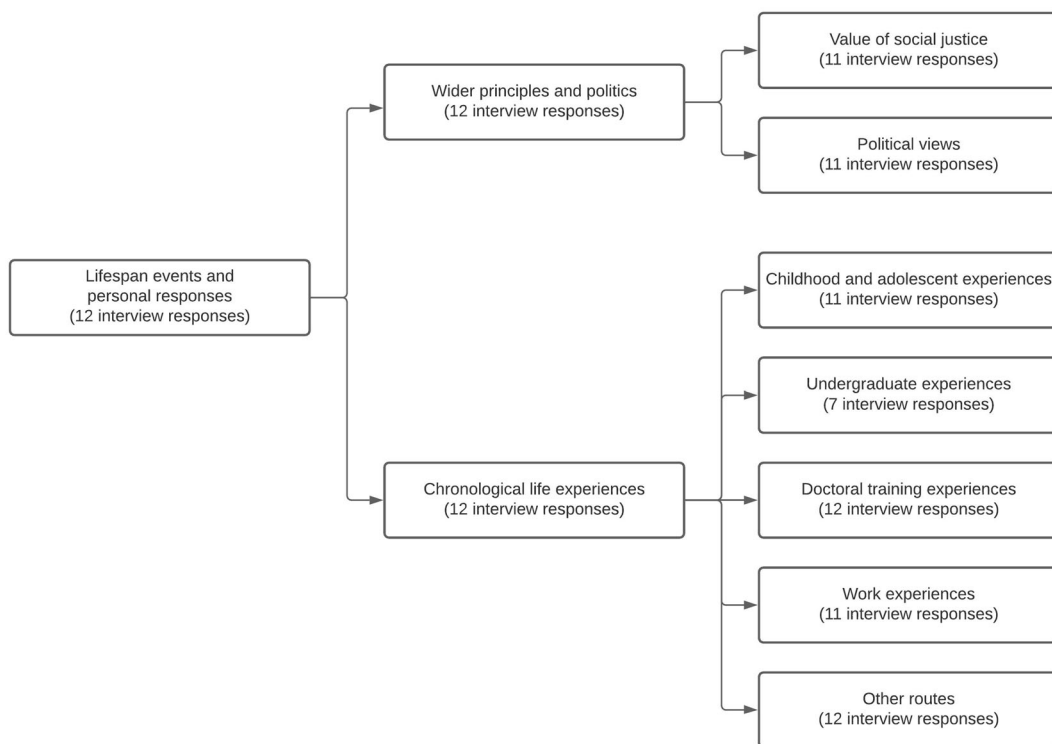
FIGURE 2 Overarching theme 3, midlevel and subthemes: lifespan events and personal responses

Perhaps more concretely, another link to CCP was through more explicit 'political views' (11 interview responses), which were frequently discussed. Comments such as 'the ideas fitted with my kind of political and philosophical views of the world more of a kind of socialist activist kind of stance on things' (interview participant 3) and 'I find it difficult to accept things at face value, but I think in terms of what probably helped that I think I've always had a, you know a certain kind of political orientation' (interview participant 6).

These principles and politics were frequently tied into 'chronological life experiences' (six interview responses), which are themselves detailed below. For example, 'my own personal background and political background, kind of growing up in a family that was quite left wing' (interview participant 1).

3.2.3 | Chronological life experiences

All interview participants (12 interview responses) referred to 'chronological life experiences' relevant to their relationship with CCP. For narrative purposes, the following subthemes will be presented in chronological not frequency order.

Eleven participants discussed the role of 'childhood and adolescent experiences', for example, 'growing up in a family where social justice was quite important generally in the family, not just in my family of origin but in my extended family as well' (interview participant 7) and 'I think coming from a working-class background makes me aware of, sometimes how those opportunities aren't there for people and that's not about people's personal failings' (interview participant 8).

The second subtheme was 'undergraduate experiences' (seven interview responses). Participants described experiences of different teaching and tensions in the undergraduate course syllabus. For example,

'I suppose my undergraduate degree was kind of interesting because…. it had a bit of a split, not a split but maybe a healthy tension between I suppose the more straightforward experimental psychology and a more social constructionist' (interview participant 6). Other comments suggested a growing sense of something missing, such as 'I probably spent my undergrad degree thinking, I don't think this is right, I don't think this fits, I don't think you can measure it like that…' (interview participant 2).

Every interviewee (12 interview responses) and a high proportion of survey responses (12 survey responses) talked about the third subtheme: 'doctoral training experiences'. Some responses indicated the discomfort participants had with the approach to clinical psychology they were being taught: 'I think I felt like the course, wanted us to, subscribe to a particular model of clinical psychology' (interview participant 7). Others gave insight into their responses to the teaching: '…spent half of my first year sitting at the back putting my hand up saying can we just discuss the validity of the DSM'? (interview participant 2) and 'some of our lectures just filled me with despair' (interview participant 6). A few survey responses also highlighted how some doctoral training courses did not cover CCP: 'I can't remember knowing that CCP existed when I was a trainee' (survey participant 13) and 'Training did not allow me to develop these ideas' (survey participant 7). That said, other interviews, from other courses, did give detail of some CCP teaching: 'I think it was an afternoon session' (interview participant 8), 'we had something like three mornings' (interview participant 2) and 'I think it was like maybe two days or three days' (interview participant 7).

'Work experiences' (11 interview responses, 6 survey responses) were also reflected on as people described their relationship with CCP (expanded on in 'applying CCP' below). Participants describe witnessing the real-life impact of wider systems and context and the limitations of a more individualistic approach. For example, '…that me just doing loads of individual therapy really wasn't going to help and mostly what I was seeing was a lot of poverty and deprivation of all sorts' (interview participant 11) and '…ended up falling into working with groups that probably could be better served by community psychology than sometimes by mainstream psychology' (interview participant 9).

Finally, 'other routes' (12 interview responses, 13 survey responses) referred to active steps that participants took to further develop their relationship with CCP. For example, connecting with others '…nurtured by meeting with other clinical and community psychologists to share frustrations and ideas about how we can incorporate community practice into our everyday work' (survey participant 9). Also, engaging with related groups was discussed as another route to develop their interest in CCP. For example, 'contact with the UK Community Psychology Network and attending conferences, I came into further contact with critical community thinkers and thinking and have developed my own understanding through further work and research activity' (survey participant 12).

3.3 | Applying CCP

Questions in both the survey and interviews asked participants to reflect on the day-to-day application of CCP within their lives. Responses split in two directions which are illustrated in two overarching themes: role-specific and reality checks. First, overarching theme 4: a discussion of 'role-specific' applications (i.e., clinical work, wider role, citizen role). Second, overarching theme 5: how applying CCP within these roles is moderated by 'reality checks' which either 'enabled' or 'constrained' the application of CCP.

3.3.1 | Overarching theme 4: role specific

As noted, the first direction was role-specific applications of CCP (12 interview responses), which encompassed clinical work, wider work and citizen roles (Figure 3).
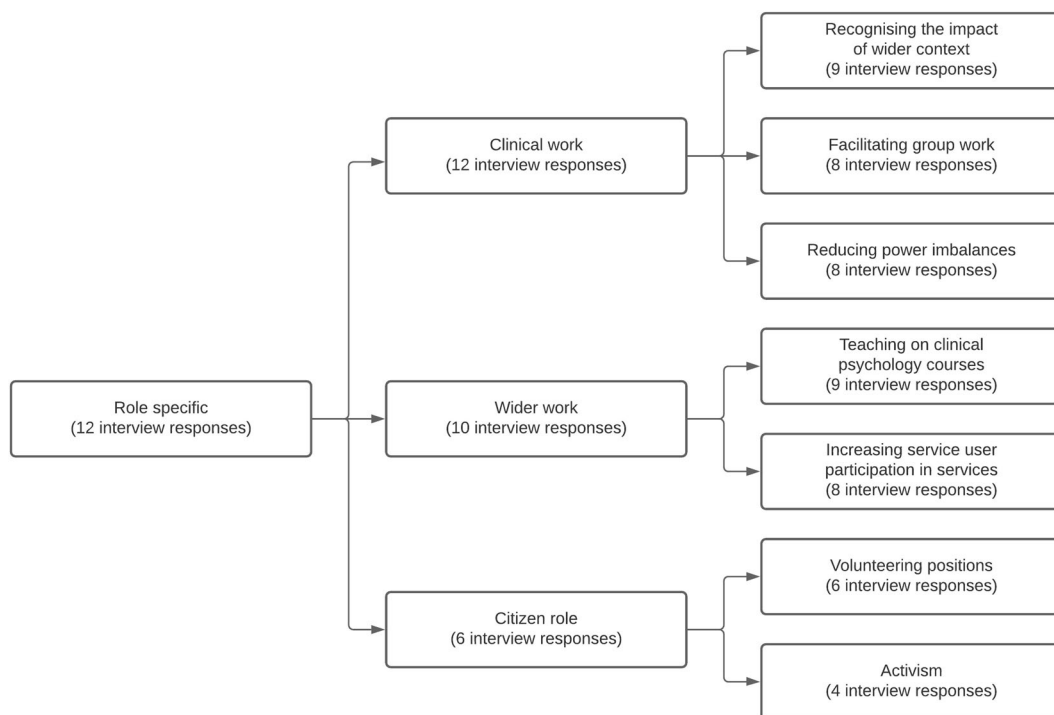
FIGURE 3 Overarching theme 4, midlevel and subthemes: role specific

3.3.2 | Clinical work

Participants discussed concrete ways they attempted to apply CCP in their clinical work, including, in order of decreasing frequency: 'recognising the impact of wider context', 'facilitating group work' and 'reducing power imbalances'.

The most frequent area 'recognising the impact of wider context' (seven survey responses, nine interview responses) often involved adding context and depth to shared formulations. For example, 'You know with individuals I do try and share ideas and formulate with people around their culture and their environment' (interview participant 8) and

> my formulations when 'I'm working with people are, fairly kind of, wide, kind of very, they go to the macro level of what influences are on others. So, in terms of kind of what governments in at the moment…which media they're listening to or reading is influential in how much distress or what's on their minds at the moment (interview participant 3).

One participant described attempting to involve aspects of the wider context as part of the intervention itself:

> …the benefit system, the legal system, employment system and we made contact with them to have a discussion with them about some of the difficulties that our patients you know experienced and also we used to get them to come into the pain management programme to talk about what they could offer and so it was more of a supportive role rather than a unsupportive role (interview participant 4).

'Facilitating group work' was frequently mentioned (four survey responses, eight interview responses) as an application of CCP. For example, 'I run a group which encompasses the ideas of social support/capital and offers insights into why distress may not just be due to the experience of having [a serious illness] per se' (survey participant 9).

Participants also discussed their attempts at 'reducing power imbalances' in interactions with service users (eight interview responses). For example, avoiding the use of diagnostic labels was discussed by four interview participants: 'I would consider myself to avoid using diagnostic labels wherever possible' (interview participant 2). A further way that participants described trying to reduce power imbalances was by bringing different practices into their clinical work. For example, 'using narrative therapy but that, you know that in itself isn't a community thing, but it does break down quite a lot of the power and the language based, disadvantage' (survey participant 11). This seems similar to the challenge to the expert role mentioned earlier in the results.

3.3.3 | Wider work

Participants also discussed applying CCP to their wider role as a clinical psychologist (10 interview responses), that is, work not directly involving therapy with clients/service users. This was primarily through 'teaching on clinical psychology courses' (nine interview responses), such as 'so I teach on clinical psychology courses and the teaching that I do tends to be influenced by critical community ideas' (interview participant 7). One participant discussed how this role enabled them to influence the curriculum, to increase community psychology coverage, 'helping to develop kind of curriculum here.... you know we had quite a few extra teaching days and everyone was keen to get in a community psychology, you know teaching' (interview participant 12).

Many participants (eight interview responses) also discussed attempts at 'increasing service user participation in services'. For example:

> I've tried to encourage the team that I work in to think more about getting involved with social action and service user led projects, and we now have a service user involvement group, well not a group, but a service user involvement project (interview participant 7).

3.3.4 | Citizen role

Six interviews and 12 survey participants discussed ways they applied CCP as citizens. Activities included charity or voluntary work, activism, research and engaging with community psychology networks. For example, the perceived opportunity to apply CCP in 'volunteering positions' was mentioned (six interview responses): 'I've always wanted to be connected with voluntary sector organisations, ... so if I can connect with them and they are involved in campaigning, it sort of gives me a way in' (interview participant 7).

Finally, 'activism' (4 interview participants) was presented as a way to engage with CCP values as a citizen. Participants identified campaign work they had done:

> I felt more comfortable being involved in a general campaign outside of work, kind of the North West right to refuse electric shock campaign, than I would, through, you know, having a demonstration outside the ECT machines in the hospital where I worked for instance (interview participant 12).

3.3.5 | Overarching theme 5: reality check

The second direction related to applying CCP was the notion of a 'reality check' (11 interview responses). This refers to constraints or enablers on participants' attempts to apply CCP in the real world (Figure 4).
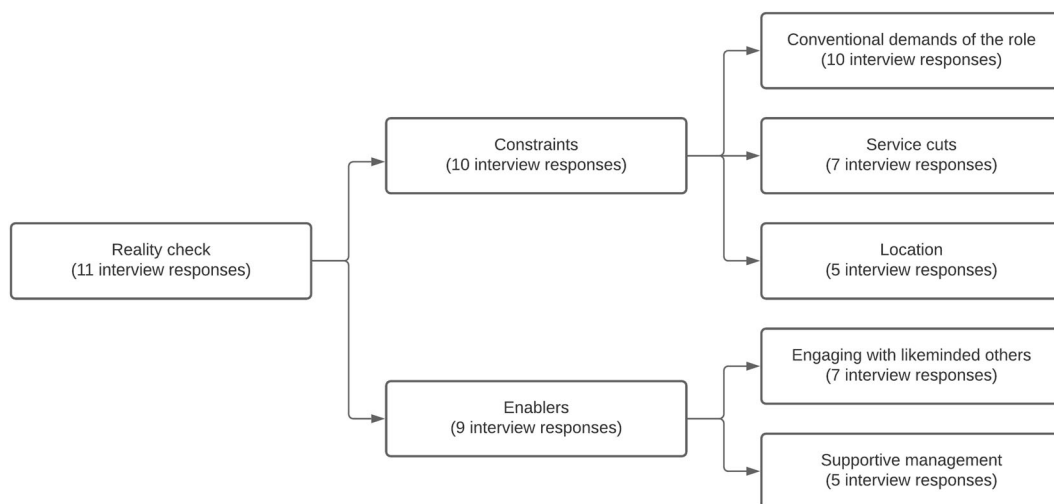
FIGURE 4 Overarching theme 5, midlevel and subthemes: reality check

3.3.6 | Constraints

Participants reported multiple 'constraints' (10 interview responses) in terms of applying CCP. Specific constraints include: 'conventional demands of the role', 'service cuts' and 'location'.

First, the 'conventional demands of the role' (10 interview responses) can result in participants having little time to engage with wider interests in CCP. For example, 'its balancing it up with the time demands that come from being a psychologist in a busy service' (interview participant 8), 'I don't have the time to do what I want to do, and the expectation is that I should offer one to one therapy because that's where the highest demand is' (interview participant 3) and 'there's an expectation that as a psychologist you are just grinding your way through a waiting list' (interview participant 9).

Furthermore, clinicians feel the need to adhere to the dominant approaches making it more difficult to practise CCP. For example, 'very difficult to fully embrace a critical community psychology approach whilst working in the NHS, because you are ultimately bound by the expectations of the NHS as your employer and your colleagues' (survey participant 4) and 'I'm sure you could do community psychology work but not so much as a clinical psychologist in the NHS' (interview participant 4).

'Service cuts' (seven interview responses) was the next subtheme. Here, participants discussed how service cuts impact on what they can provide. For example, 'suddenly all the funding gets pulled, austerity sets in there was a complete lack of opportunity' (interview participant 11).

Finally, the possible constraint of 'location' was also noted (five interview responses), with a perception of community and work opportunities focused around London. For example, 'I know London has quite a lot going on but I think, just got to get there' (interview participant 4).

3.3.7 | Enablers

Alongside 'constraints', some enablers were also discussed (nine interview responses). Specific enablers included 'engaging with likeminded others' and 'supportive management'.

In terms of 'engaging with likeminded others' (seven interview responses) participants noted how:

> it was really important to have contact with those people who had similar values to me and who were interested in similar things to me... in order to keep myself ok, I need to make contact with other people who share those ideas (interview participant 7).

Groups and conferences were also identified as ways to engage with allies. For example, 'My interest and enthusiasm is nurtured by meeting with other clinical and community psychologists to share frustrations and ideas about how we can incorporate community practice into our everyday work' (survey participant 9).

'Supportive management' (five interview responses) was also noted by some participants in terms of enabling their use of CCP. For example,

> It does help to have.... a manager who is actively supportive of you pursuing your interests, whether that's because that manager shares your interests or whether that manager is interested in you developing as a practitioner, those things are really important (interview participant 7).

Furthermore, 'I've found some space, I've been given some space by the system to be able to be and do, what I think is helpful' (interview participant 11).

4 | DISCUSSION

The aim of this study was to explore UK clinical psychologists' relationship with CCP. Deliberately owning the questions asked, the results were clustered into three sections: i. describing, ii. relating to and iii. applying CCP.

We will begin by exploring the i. describing and ii. relating to material. Participants tended to describe CCP around two hubs: social justice and a questioning stance towards 'traditional' clinical psychology. The findings are perhaps not surprising. Community psychology, from its US-centric Swampscott roots, has sought to extend its scope wider than individual well-being alone and move towards social change. Moreover, from its outset, CCP has often positioned clinical psychology as both its past and the mainstream it rebels against (Reich et al., 2017). That said, definitions of CCP vary and even the supposedly simple act of defining it has been described as problematic in the United Kingdom with some resisting it (see Kagan et al., 2011, p. 21). As such, just gaining some participant-led clarity on CCP as embodying both social justice and a questioning stance towards 'traditional' clinical psychology is useful. These findings, especially concerning social justice, echo previous research. For example, Serrano-Garcia et al. (2009, as cited in Bond et al., 2017) conducted a literature review and found social justice to be a core value of the discipline in the Americas. The term is also a uniting hub in Reich et al. (2017) as they describe the histories of community psychology around the world.

In terms of personally relating to CCP, the intertwined connections between personal developmental history and wider principles and politics provide interesting glimpses into how our current personal values and political interests link to our earlier life experiences. This, of course, echoes the 'explicit recognition of the guiding role of values' (Kagan et al., 2011, p. 36) within the area of CCP generally, and so it seems with the development of an interest in CCP within the individual. As such, these results highlight the contributing role of personal developmental history in forming relationships with CCP. Parallel findings have recently been published. Browne et al. (2020), interviewed UK clinical psychologists engaged in public policy work. They focused on clinical psychology generally, not CCP specifically. But they too noted that 'participants' decisions to enter clinical psychology arose from early influences, comprising social and political ideologies, and personal values' (p. 375). What in some ways, may seem obvious, also seems important to note: when thinking about an individual developing an affiliation with an area there are often echoes and traces from personal developmental journeys that can be reported on.

Under applying CCP, participants explored 'role-specific' aspects (i.e., clinical work, wider and citizen role) and the 'reality check' of both constraints and enablers. In terms of clinical roles, the most frequent example of applying CCP was formulating around context. The frequency with which it was mentioned suggests it represents a primary way that participants felt that they can embody their interest in CCP within clinical practice. However, is context-driven formulation solely the preserve of CCP? Some might suggest it is part of good practice within clinical psychology generally. For example, the Division of Clinical Psychology good practice guidance on psychological formulation already recommends that 'clinical psychologists always formulate from a broad-based, integrated and multi-model perspective which locates personal meaning within its wider systemic, organisational and societal contexts' (Johnstone et al., 2011, p. 2). The quote, from a decade ago, suggests this is something that should be included within formulation by all psychologists, not just those with an interest in CCP. Furthermore, individual formulation—no matter how contextual—which only leads to traditional individual treatment, may be limited in the extent to which it moves beyond amelioration towards transformative change. It seems possible then that focusing too much energy on examples like this to embody CCP risks 'co-optation', that is, becoming unwittingly aligned with the social forces that preserve the status quo (Prilleltensky, 2014). It was with such risks in mind that, back in 1990, Albee wrote about 'the futility of psychotherapy' Albee, 1990.

In a related way, participants discussed their attempts to 'reduce power imbalances' during interactions with patients, for example, by avoiding the use of diagnostic labels. However, again, it could be argued that the avoidance of unnecessary hierarchy or diagnostic labels is not limited to those with an interest in CCP. Moreover, the criticality of the psychiatric influence on clinical psychology has long been noted in parallel to community psychology ideas (e.g., Johnstone, 1989, 1993). So, a repeated finding seems to be that participants' self-described applications of CCP are not exclusively the domain of CCP, but examples of good clinical practice.

Perhaps another example of this is 'facilitating group work'. Of course, group work could represent an alternative to traditional individual paradigms. It could offer an opportunity to reduce power imbalances and expert roles. It may even provide a way to amplify oppressed and under-represented voices (Peters et al., 2003). At the same time, it can be used as a more 'efficient' way to deliver individually focused therapeutic messages to multiple people at one time. For example, the England-wide CBT focused low-intensity IAPT (Increasing Access to Psychological Therapy; Perfect et al., 2016) scheme is both frequently delivered in group formats and is much questioned, even in non-CCP circles (Binnie, 2015; Hamilton et al., 2011; Thompson et al., 2021; Turner et al., 2018; Williams, 2015). So while, in this instance, what is specifically done within groups settings might help distinguish it from conventional therapeutic working, it potentially remains another example of normal clinical practice being held up as an example of CCP.

This repeated tension made us wonder whether any participant account explicitly explored the idea that trying to apply ideas from CCP could simply be understood as good clinical practice. By conducting a supplementary analysis of the data set, we found some limited evidence of this. For example,

> I'll say I'm quite interested in critical psychology and my head of department will say well what does that mean? And I'll explain somethings and she'll say well yes obviously that's just good psychology, that's not a movement or anything left wing that's just proper thinking (interview participant 2).

Oddly this blurring between potential applications of CCP and good clinical practice has been highlighted in the literature before. In Thompson (2007), 43 statements were reduced down to four factors through exploratory factor analysis. The factors spanned a range of activities from: i. reflective practice, ii. acknowledging and understanding, iii. core sociopolitical ideas to iv. radical sociopolitical ideas. That first factor, reflective practice included 10 statements such as, 'recognising that professionals are not the only people who hold expertise' and 'challenging the dominance of medical/psychiatric conceptualisations of distress'. Potentially similar items to the examples our participants described under applying CCP. However, notice how different they are to the items from radical

sociopolitical ideas: 'challenging the purpose and prevalence of capitalism in contemporary society' and 'challenging governments and other institutions that perpetuate social injustice'.

So while the ways of working described by participants in this study may not seem very radical and may seem to blur with examples of normal, contemporary good clinical practice, they do also represent one legitimate part of one conceptualisation of CCP. That said, even if they do fit as one part of CCP, perhaps more pertinent is to ask whether they live up to the definition of CCP offered by the participants in this study.—In other words, do these actions directly help advance social justice? Moreover, do they directly help bring about transformative change? Under this scrutiny, the answer seems to be no.

Broader than direct clinical work alone, participants frequently discussed opportunities to teach on doctoral courses as a way to share their knowledge of CCP with the next generation of clinical psychologists. There does seem to be another point of tension here. Students are being taught about a subset of psychology that the teachers themselves seem to be struggling to fully embody in their everyday clinical work. It is important to note that no criticism of the participants in this study is implied. As noted in the introduction, results and below in this discussion, there seem to be strong contextual reasons why applying CCP in formal clinical roles proves difficult.

Reasons for participants being less able to fully embrace CCP are addressed under 'constraints' in the overarching theme 'reality check'. Specific constraints include service set-up, pressures and cuts. As UK NHS workers know only too well, clinical psychologists can operate in services with long waiting lists and limited treatment options. Moreover, within the NHS cost-effective treatments for individuals can take precedence over addressing the systemic or structural factors, which evidence suggests contribute to individual distress (Allen et al., 2014). Specific jobs with specific client groups, specific therapies and specific outcomes can reduce individual practitioners' flexibility to both do differently or act wider than the individual. Again, these ideas have echoes in the findings of Thompson (2007) where trainee clinical psychologists could on the one hand endorse CCP ideas, but at the same time felt unsure how they could become part of clinical practice, especially in the NHS (pp. 76–77). And, this tension is not new, even for community psychology broadly defined. Back as far as 1992, Orford referred to content analysis of over 700 community psychology research articles, of which only 8% had employed a level of analysis that was beyond the individual. The individual lens seems to be constraining even for those who try and move beyond it.

Given these tensions, it is perhaps not surprising that participants described investing their CCP energies into their citizen roles outside of their clinical and wider professional work. Perhaps, it is in this citizen role that some feel they can truly embody the sociopolitical aspects inherent in many conceptualisations of CCP. These same tensions are found in Thompson (2007), both in terms of the distinction between what is legitimate in personal and professional roles and in terms of exploring professional psychology's relationship with politics. It is of course worth restating that psychology has a relationship with politics. As Kidner (2001) notes, writing in The Psychologist [the official monthly publication of The British Psychological Society (BPS)]: 'whether we like it or not, psychology, like any other discipline, contains an implicit political ideology; and silence or denial of our involvement is no less a political act than an explicit political action' (p. 178). And of course, while this is true of both psychology and of clinical psychology—just being aware of it does not make it any easier to act in an explicitly political way, especially if our managers, services or even professional bodies are less at ease with making our inherent political roles more explicit.

Generally speaking, it is interesting how much the results of this study mirror many of the findings and complexities found in Thompson (2007). In the time elapsed since the original research, and shifting participant recruitment from trainees to practitioners, it does not seem that (m)any of the tensions have got any easier. Indeed arguably, in the time since: the proliferation of IAPT, the imposition of austerity following the global financial crash and the implications of the coronavirus pandemic (which has happened since data collection) all suggest that fully embodying CCP ideas within clinical psychology may have become more challenging, even if more needed. The pandemic has highlighted and heightened health inequalities generally, especially those experienced by ethnic minorities (Kirby, 2020). At the same time, the Black Lives Matter protests has reminded everyone, including

the clinical psychology workforce of the continuing need to address systematic racism (Ahsan, 2020). The call for CCP remains great. But the ability to work in CCP ways that genuinely move towards transformative social justice seems limited. This study seems to have confirmed that the professional clinical role can be confining for UK clinical psychologists with an interest in CCP. How then can clinical psychologists in the United Kingdom move beyond 'reflective practice' and develop more explicitly political and radical possibilities that sit within broader conceptualisations of CCP?

Historically in the United Kingdom, many point to the work of Holland (1991) whose community work in Battersea and White City in London helped individuals and groups move from intrapsychic to social and then to political spaces. In other words, from pills to therapy, to self-advocacy and social action (e.g., Fenner, 1999 who replicated this model of working in Nottingham). Of course, this study took place in the 1970s and 1980s, different political times and outside of NHS structures. A more contemporary UK example is 'the benefits project' founded by the South West group of Psychologists for Social Change (Camilleri et al., 2020). Motivated by the degrading way individuals claiming benefits can be treated in the United Kingdom, the group decided to apply their clinical skills to support those who find themselves in this process. They deliver pro bono clinics, supporting applications, psychological assessment, writing reports and attending tribunals. While the wider system, which demonises and penalises those seeking benefits, remains untouched, this study is clearly explicitly more political than traditional therapeutic ways of working. And as such, may be more useful than offering individual therapy in isolation to a client who more acutely needs support with their benefits than their cognitions. The wider Psychologists for Social Change network (http://www.psychchange.org/) sees many types of, mainly clinical, psychologists coming together in parallel to their professional roles. As noted in the 'enablers' theme of 'reality check', allowing participants to 'engage with likeminded others' seems to provide an important supportive function. Although, of course, networking by itself may only be a precursor to future action. At the same time, the existence of this network perhaps also points to a national context where CCP lacks more established structures that offer both training and work opportunities.

It is also worthwhile to return to Browne et al. (2020). A recent study explored the professional journey of 37 clinical psychologists engaging in policy work in the United Kingdom. Although policy work can be described as macrolevel work, the paper itself does not explore the extent to which participants and the policies they contributed to produced outputs that were transformative, ameliorative or subject to co-optation. Of course, this is understandable as engagement in policy work is still a rarity for the field and so initial research in this area might not expect to be this nuanced. But it remains a question for future work. As Maton et al. (2017) note in the US context and Walker et al. (2018) in the United Kingdom, working in the policy area can bring challenges and risks as well as potential rewards. Moreover, as Walker et al. (2018) note, policies can be driven as much by ideology as by evidence. Together, this may mean there are limits for transformative change through policy if the wider political and ideological context is unreceptive.

In light of all of the above, it seems important not to rush to optimistic or simplistic practice, training or policy recommendations. It is perhaps too easy to simply say: more teaching, more training and more job opportunities are needed. While it is the case that other parts of the world and Europe have evolved these opportunities (see Reich et al., 2017), this has taken decades of work and might not immediately transplant to the United Kingdom. Burton and Kagan (2003) along with Burton et al. (2007) has noted that CCP has failed to thrive in the United Kingdom, in part, because clinical psychology can be too focused on therapy, educational psychology has too great an administrative burden, the BPS has too constraining an influence on curricula and research assessment exercises can prove too restrictive for academics. None of these are simple contexts to shift. That said, clinical psychologists interested in CCP can continue to highlight the difficulty of moving beyond individually focused 'good clinical practice', and more closely explore the potential for using policy or activism to make transformative shifts. Pushing against these boundaries may either develop new opportunities or harden dissatisfaction with the status quo to the extent that it also inspires different steps forward. At the same time, while contextual differences may not mean global community psychologies offer immediately adoptable models for working, they still bring rich opportunities for both collaboration and learning.

4.1 | Limitations

The sample for this study was self-selecting and limited in number. Different researchers favouring different frameworks and alternative ways of presenting the data may draw different conclusions. This study deliberately chose to own the questions it asked and foreground those to the reader (Guest et al., 2012; Jackson, 2000). Other researchers using a 'whole corpus' approach may have produced different results. That said, the findings in this study mirror and extend some of those reported in Thompson (2007). Read in combination these two papers appear to show that the tensions around CCP anticipated by trainee clinical psychologists in 2007 are echoed by clinical psychologists working in practice more recently.

5 | CONCLUSION

This study set out to explore aspects of the relationship between qualified UK clinical psychologists and CCP. More specifically, the research explored how participants defined CCP, how they came to be interested in it, how they drew upon it in their work and any tensions they experienced in doing this. The opportunities to apply more radical CCP ideas in the clinical work of participants appear limited, with many examples seeming to also be examples of good clinical practice generally. As such, much CCP application seems to occur outside of client-facing clinical roles and may have limits in terms of furthering social justice. Wider examples of work from applied psychologists with an interest in CCP exist (e.g., Browne et al., 2020; Camilleri et al., 2020), but questions remain in terms of their transformative potential. For example, it is, as yet, unclear how transformative policy work can be in a potentially co-optive ideological climate.

None of this is to say that many UK clinical psychologists do not have the passion, intent and desire to apply CCP inside and outside of their work roles. Instead, it seems that they can be significantly hindered by systems and structures that limit the scope of this application. The challenge for UK clinical psychologists interested in CCP seems to remain similar to how Holland described it back in the 1990s when she asked do we help to tranquilise (maybe today, we might say 'therapize') or help to 'organise' (Holland, 1991, p. 59). In light of the challenge of this quote, it might be noted that the extent to which we have organised ourselves, let alone able to organise others could be improved. The reality of organising and promoting CCP within student, professional and even personal networks presents challenges for clinical psychologists in the United Kingdom. In a country where applied psychological training and career paths that truly embody the ideas and application of CCP are limited, there may currently also be limits on the extent to which clinical psychologists interested in CCP are able to reach their full potential in their quest for transformative social justice. On the one hand, this may seem like a bleak assessment. On the other, like previous publications in this area (Burton & Kagan, 2003; Burton et al., 2007), it may act as a muster point for future action.

ORCID
Miles Thompson http://orcid.org/0000-0002-1358-1962

REFERENCES

Ahsan, S. (2020). Holding up the mirror: Deconstructing whiteness in clinical psychology. *Journal of Critical Psychology, Counselling and Psychotherapy*, *20*(3), 45–55.

Albee, G. (1990). The futility of psychotherapy. *The Journal of Mind and Behavior*, *11*(3/4), 369–384.

Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry*, *26*(4), 392–407. https://doi.org/10.3109/09540261.2014.928270

Binnie, J. (2015). Do you want therapy with that? A critical account of working within IAPT. *Mental Health Review Journal*, *20*(2), 79–83. https://doi.org/10.1108/MHRJ-11-2014-0044

Bond, M. A., Serrano-García, I., & Keys, C. B. (2017). Community psychology for the 21st century.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

British Medical Association. (2019). *Measuring progress: Commitments to support and expand the mental health workforce in England*. British Medical Association. https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/mental-health-workforce-report

British Psychological Society. (2019). *Standards for the accreditation of Doctoral programmes in clinical psychology*. British Psychological Society.

Browne, N., Zlotowitz, S., Alcock, K., & Barker, C. (2020). Practice to policy: Clinical psychologists' experiences of macrolevel work. *Professional Psychology: Research and Practice*, *51*(4), 371–382. https://doi.org/10.1037/pro0000301

Burton, M., Boyle, S., & Kagan, C. (2007). Community psychology in Britain. In S. M. Reich, M. Riemer, I. Prilleltensky, & M. Montero (Eds.), *International Community Psychology* (pp. 219–237). Springer. https://doi.org/10.1007/978-0-387-49500-2_11

Burton, M., & Kagan, C. (2003). Community psychology: Why this gap in Britain. *History and Philosophy of Psychology*, *4*(2), 10–23.

Camilleri, K., Voss, K., & Weare, V. (2020). The benefits project in Covid times. The Psychologist. https://thepsychologist.bps.org.uk/benefits-project-covid-times

Clearing House for Postgraduate Courses in Clinical Psychology. (2020). *Homepage*. https://www.leeds.ac.uk/chpccp/

Cummins, I. (2018). The impact of austerity on mental health service provision: A UK perspective. *International Journal of Environmental Research and Public Health*, *15*(6), 1–11. https://doi.org/10.3390/ijerph15061145

Evans, S. D., Duckett, P., Lawthom, R., & Kivell, N. (2017). Positioning the critical in community psychology.

Fenner, J. (1999). Our way: Women's action for mental health (Nottingham). *Journal of Community & Applied Social Psychology*, *9*(2), 79–91.

Friedli, L. (2009). *Mental health, resilience and inequalitie*. WHO Regional Office for Europe.

Full Fact. (2013). *The NHS: Not always 'free at the point of use'*. Full Fact. https://fullfact.org/health/nhs-not-always-free-point-use/

Guest, G., MacQueen, K., & Namey, E. (2012). *Applied thematic analysis*. SAGE Publications, Inc.

Hamilton, S., Hicks, A., Sayers, R., Faulkner, A., Larsen, J., Patterson, S., & Pinfold, V. (2011). *A user-focused evaluation of IAPT services in London. Report for Commissioning Support for London*. Rethink.

Holland, S. (1991). From private symptoms to public action. *Feminism & Psychology*, *1*(1), 58–62. https://doi.org/10.1177/0959353591011007

Jackson, P. (2000). Writing up qualitative data. In D. Burton (Ed.), *Research training for social scientists* (pp. 244–252). SAGE Publications Ltd.

Johnstone, L. (1989). *Users and abusers of psychiatry: A critical look at traditional psychiatric practice*. Routledge

Johnstone, L. (1993). Psychiatry: Are we allowed to disagree? *Clinical Psychology Forum*, *56*, 30–32.

Johnstone, L., Whomsley, S., Cole, S., & Oliver, N. (2011). *Good practice guidelines on the use of psychological formulation*. British Psychological Society. https://shop.bps.org.uk/good-practice-guidelines-on-the-use-of-psychological-formulation

Kagan, C., Burton, M., Duckett, P., Lawthom, R., & Siddiquee, A. (2011). *Critical community psychology critical action and social change*. Wiley.

Kidner, D. (2001). Silence is a political act. *The Psychologist*, *14*, 178.

Kirby, T. (2020). Evidence mounts on the disproportionate effect of COVID-19 on ethnic minorities. *The Lancet Respiratory Medicine*, *8*(6), 547–548. https://doi.org/10.1016/S2213-2600(20)30228-9

Marmot, M., & Allen, J. (2020). COVID-19: exposing and amplifying inequalities. *Journal of Epidemiology and Community Health*, *74*(9), 681–682. https://doi.org/10.1136/jech-2020-214720

Marmot, M., Allen, J., Boyce, T., Goldblatt, P., & Morrison, J. (2020). *Health equity in England: The Marmot Review 10 years on*. Institute of Health Equity. Retrieved March 8, 2021, from https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., & Geddes, I. (2010). *Fair society, healthy lives—The Marmot Review: Strategic review of health inequalities in England post-2010*. The Marmot Review. Retrieved March 8, 2021, from https://www.parliament.uk/globalassets/documents/fair-society-healthy-lives-full-report.pdf

Maton, K. I., Humphreys, K., Jason, L. A., & Shinn, M. (2017). Community psychology in the policy arena. In M. A. Bond, I. Serrano-García, C. B. Keys, & M. Shinn (Eds.), APA handbook of community psychology: Methods for community research and action for diverse groups and issues (Vol. 2, pp. 275–295). American Psychological Association. https://doi.org/10.1037/14954-016

McGrath, L., Walker, C., & Jones, C. (2016). Psychologists Against Austerity: Mobilising psychology for social change. *Critical and Radical Social Work*, *4*(3), 409–413. https://doi.org/10.1332/204986016X14721364317537

Molony, E., & Duncan, C. (2016). Income, wealth and health inequalities—A Scottish Social Justice Perspective. *AIMS Public Health*, *3*(2), 255–264. https://doi.org/10.3934/publichealth.2016.2.255

Muntaner, C., Eaton, W. W., Miech, R., & O'Campo, P. (2004). Socioeconomic position and major mental disorders. *Epidemiologic Reviews*, *26*(1), 53–62. https://doi.org/10.1093/epirev/mxh001

National College for Teaching and Leadership & Health Education England. (2016). *Review of clinical and educational psychology training arrangements report*. Department of Health. https://www.gov.uk/government/publications/review-of-clinical-and-educational-psychology-training-arrangements-report

National Institute for Health and Care Excellence. (2009). *Treating depression in adults (NICE Guideline 90)*. Retrieved August 22, 2021, from https://www.nice.org.uk/guidance/cg90

National Institute for Health and Care Excellence. (2014). *Psychosis and schizophrenia in adults: Prevention and management (NICE Guideline 178)*. Retrieved August 22, 2021, from https://www.nice.org.uk/guidance/cg178

National Institute for Health and Care Excellence. (2019). *Generalised anxiety disorder and panic disorder in adults: Management (NICE Guideline 113)*. Retrieved August 22, 2021, from https://www.nice.org.uk/guidance/cg113

Nelson, G., & Prilleltensky, I. (2004). *Community psychology: In pursuit of well-being and liberation*. Palgrave Macmillan.

Orford, J. (1992). *Community psychology: Theory and practice*. Wiley-Blackwell.

Perfect, D., Jackson, C., Pybis, J., & Hill, A. (2016). Choice of therapies in IAPT: An overview of the availability and client profile of step 3 therapies. British Association of Counselling & Psychotherapy.

Peters, M., Lankshear, C., & Olssen, M. (2003). Introduction: Critical theory and the human condition. In M. Peters, C. Lankshear, & M. Olssen (Eds.), *Critical theory and the human condition: Founders and praxis* (pp. 1–14). Peter Lang.

Prilleltensky, I. (1994). *The morals and politics of psychology: Psychological discourse and the status quo*. State University of New York Press.

Prilleltensky, I. (2014). Meaning-making, mattering, and thriving in community psychology: From co-optation to amelioration and transformation. *Psychosocial Intervention*, *23*(2), 151–154.

Reich, S. M., Bishop, B., Carolissen, R., Dzidic, P., Portillo, N., Sasao, T., & Stark, W. (2017). Catalysts and connections: The (brief) history of community psychology throughout the world. In M. A. Bond, I. Serrano-García, C. B. Keys, & M. Shinn (Eds.), *APA handbook of community psychology. Theoretical foundations, core concepts, and emerging challenges* (Vol. 1, pp. 21–66). American Psychological Association. https://doi.org/10.1037/14953-002

Rethink Mental Illness. (2021). *Demand for mental health advice soars in year after first lockdown*. https://www.rethink.org/news-and-stories/news/2021/03/demand-for-mental-health-advice-soars-in-year-after-first-lockdown/

Thompson, M. (2007). Exploring the trainees' view of a socio-political approach within UK clinical psychology. *Journal of Community & Applied Social Psychology*, *17*(1), 67–83. https://doi.org/10.1002/casp.878

Thompson, M., Parker, H., & Cave, J. (2021). Exploring which aspects of a low-intensity CBT intervention were found to contribute to a successful outcome from the service user point of view: A mixed methods study. *Counselling and Psychotherapy Research*, *n/a*(n/a), capr.12433. https://doi.org/10.1002/capr.12433

Turner, J., Brown, J. C., & Carpenter, D. T. (2018). Telephone-based CBT and the therapeutic relationship: The views and experiences of IAPT practitioners in a low-intensity service. *Journal of Psychiatric and Mental Health Nursing*, *25*(5–6), 285–296. https://doi.org/10.1111/jpm.12440

Walker, C., Speed, E., & Taggart, D. (2018). Overrated: Our capacity to impact policy. *The Psychologist*, *31*, 40–45. https://thepsychologist.bps.org.uk/volume-31/june-2018/overrated-our-capacity-impact-policy

Wilkinson, R., & Pickett, K. (2010). *The spirit level: Why equality is better for everyone*. Penguin.

Williams, C. H. J. (2015). Improving Access to Psychological Therapies (IAPT) and treatment outcomes: Epistemological Assumptions and Controversies. *Journal of Psychiatric and Mental Health Nursing*, *22*(5), 344–351. https://doi.org/10.1111/jpm.12181