The NHS is channelling research activity into topic areas that are ‘centrally determined’, based on national priorities (Paxton, 2006). The government regulatory standards strive to produce high quality, peer reviewed research projects with greater accountability, paving the way for large-scale, multi-centered trials that are dependent on being funded and coordinated by research networks.

As clinical psychology is the ‘only profession in the NHS for whom demonstrable research skills are an essential to their qualification’ (Harvey, 1999, p.55), clinical psychologists have the responsibility of seeking opportunities where high levels of research knowledge and skills can be utilised. This does not just mean being involved directly with a research project. There are different ways of thinking about research activity, which have been highlighted in the literature, such as reviewing the literature (consumption), applying research findings to clinical practice (utilisation) and research publication (production) (Milne, 1999).

Other competencies, such as consultation, supervision and training could be applied to research as a means of getting it on the agenda in departments where research has not yet taken priority. For example, Leach (1999) explored the role of weekly advice ‘surgeries’ as a means to provide supervision and support to staff undertaking degrees with a research component. Training others in research methodology and critical appraisal is another activity clinical psychologists could participate in which, if provided externally, could possibly generate income for local services.


The continuing struggle:

Hassall and Clements (if you want to read this article you find it in this volume of Clinical psychology forum) do point out very clearly that there is no room to be complacent and indeed the above is not intended to be an overly defensive response - an accusation sometimes aimed at psychologists. They raise a number of significant problems with which psychologists need to continue to struggle. To name but four:
All of the interventions listed above have been shown to be efficacious relative to a variety of comparison or control conditions. For instance, there is evidence from multiple clinical trials that CT and CBT for depression yield more durable benefits than does antidepressant medication; that is, once treatment is discontinued, relapse rates for CBT are about half those for medications (DeRubeis & Crits-Christoph, 1998; Gloaguen, Cottraux, Cucherat, & Blackburn, 1998; Hollon et al., 2005). Similarly, CBT for panic disorder is either similar or superior to pharmacotherapy in efficacy (Otto, Pollack, & Maki, 2000), and its effects appear to be more durable (Craske, Brown, & Barlow, 1991; Pollack & Otto, 1994). With regard to CBT for bulimia nervosa, a systematic review of 47 studies suggested that whereas both medication (fluoxetine) and CBT exerted comparable short-term effects, only CBT yielded long-term effects (Shapiro et al., 2007). On the basis of strong support from multiple well-conducted randomized trials, the NICE (2004) guideline gave a 16- to 20-session course of CBT for bulimia nervosa their highest (“A” grade level) recommendation. This was the first time that NICE concluded that a psychological intervention is the treatment of choice for a psychiatric disorder (Wilson, Grilo, & Vitousek, 2007). There is little evidence that adding pharmacotherapy or any other treatment augments the effectiveness of CBT for bulimia nervosa (Wilson et al., 2007).

Many of the listed interventions have been shown to be more effective and/or cost-effective than pharmacotherapy and alternative psychosocial interventions. For instance, evidence shows that CT and CBT for depression compare favorably to medication and other psychosocial approaches (Antonuccio, Thomas, & Danton, 1997; Revicki et al., 2005). CBT is cost-effective relative to existing community intervention resources (Revicki et al., 2005). CBT and CT may be most cost-effective in the treatment of severe depression when used with an antidepressant adjuvant (Simon, Pilling, Burbeck, & Goldberg, 2006). Similarly, the long-term cost and cost–benefit profiles of CBT for panic disorders are more favorable than those of pharmacotherapy (McHugh et al., 2007; Otto et al., 2000). Recent research with primary care patients shows that the combination of pharmacotherapy and CBT for panic disorder produces increased quality adjusted life years saved at a cost that is comparable to that achieved by such common preventive interventions as the pharmacologic treatment of hypertension and hypercholesterolemia (Katon et al., 2006; also cf. Heuzenroeder et al., 2004). The listed interventions also have been shown to be cost-effective relative to alternative psychological interventions. Fals-Stewart, Klostermann, Yates, O’Farrell, and