



**The
Management
Advisory
Service**

The development of a role of
Associate Clinical Psychologist¹

A feasibility study

August, 2003

¹ This study was commissioned by the Department of Psychological Therapies & Research, Northgate and Prudhoe NHS Trust in 2002. It has been conducted by Professor Derek Mowbray with the support of a Reference Group (Appendix I) whose members have included practising and teaching chartered clinical psychologists and senior managers from the Northern Region. During the study advice and information was obtained throughout the UK from psychologists working in the health services, senior managers, professional trainers, and others engaged in workforce development and planning.

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1. FEASIBILITY STUDY CONCLUSIONS

The demand for professional psychological services within the health care system is growing and consistently outstrips supply. There is a ready resource available to meet this service shortfall in the form of graduate psychologists. Other approaches available to meet this need, such as training qualified nurses as psychological therapists, have a role, but shortages in most mental health care professions mean that this is a limited option.

The study concludes that it is feasible and desirable to develop a role of 'associate clinical psychologist' (ACP). The role is one which undertakes psychological assessment and treatment using approaches and techniques that can be described by procedure and protocol, and are applicable to individuals, couples, groups, families and their context. The role and posts work in partnership with, and under the supervision and management of chartered clinical psychologists. The posts are permanent (once training is completed), they are career positions in clinical psychology and they are open to graduate psychologists. It is intended that completion of training for the role will enable associate clinical psychologists to seek chartered status with the British Psychological Society. Also, should they so wish, they could progress to chartered clinical psychology status through application for further accredited training, e.g. a university based doctoral training course in clinical psychology.

2. PROPOSAL FOR A PILOT SCHEME

It is proposed that:

- Workforce Development Confederations (WDCs) in the north of England should sponsor and project manage a pilot scheme for the role of ACP in 3 settings initially (Northgate & Prudhoe NHS Trust, Tees and North Yorkshire NHS Trust, and North Cumbria Mental Health & Learning Disabilities NHS Trust) in order to trial the role in practice, and to evaluate the efficacy and effectiveness of the proposed role and training programme.
- The WDCs should seek the required resources for these pilot scheme posts (a minimum of 8 in total) from its own development funds as well as from those participating NHS organisations that have supported, in principle, this development.
- The WDCs should tender for the provision of training for this role, using the training programme in outline in section 5 below.
- The WDCs should tender for an independent evaluation of the role. The evaluation would determine the degree of efficacy and effectiveness of the role and training against its own stated purpose and objectives. It is proposed that the evaluation should include the impact of the ACP role on issues of, for example, increasing capacity to provide psychological therapies, the impact on chartered clinical psychologist roles and responsibilities, value for money, recruitment appeal, career structure, retention, and the perceptions of service users.

3. BACKGROUND TO THE FEASIBILITY STUDY

The demand for psychological interventions in the National Health Service (NHS) is high and is likely to continue to increase in the future (see section 8. Feasibility Study Report). Currently there are not enough qualified clinical psychologists to meet this demand, and it is unlikely that the shortfall between supply and demand will improve markedly in the near future. In the NHS vacancy census of March 2002 there was a vacancy rate, for that month, amongst chartered clinical psychologists of an average of 3.5%, with the majority of regions outside of the south-east experiencing rates of 5% (or 180 vacancies in total approximately).

One option to meet demand is to train other health disciplines, e.g. nurses, to be competent in the delivery of psychological interventions. However, given the vacancy rates found in the above census for qualified nurses and health visitors (3.1%) and allied health professions (5%) this would appear to be a very limited solution. Involving meaningful numbers of non-psychologists in the delivery of psychological interventions would simply place additional pressures on existing manpower problems within these disciplines. There is, therefore, a need to explore longer-term solutions that deal with some of the structural problems in building effective psychological services into the fabric of healthcare in the UK.

It is estimated that each year some 13,000 students graduate in psychology from universities in the UK. A modest number of these graduates are able to pursue careers in clinical psychology. Greater numbers are constrained by the limitation on the number of 3-year doctoral level clinical training places available to them. Competition for these training places is intense. Those hoping to gain a training place often show their interest by seeking posts as assistant psychologists in the NHS. Competition for these posts is also intense. An advertisement in the local press will routinely result in 40-50 applications for one post. This role is generally time-limited, relatively low paid (starting salary of £12,978), does not require any formal training in clinical activities, and is largely unregulated. During the course of this study a number of assistant psychologists were consulted. Around 50% had been successful in gaining clinical training posts over a 24-month period. The remainder faced an uncertain future. There are limited alternatives to clinical psychology training if an assistant psychologist wishes to have a career in clinical practice in the NHS. The majority of those who are not able secure clinical training places are lost to the NHS as they seek careers and pay commensurate with their qualifications elsewhere. It seems obvious to consider the development of alternative career pathways to prevent the ongoing loss of these valuable people from the Service.

The proposal in this study for the development of a new role of associate clinical psychologist is based on utilising a readily available,

well qualified and highly motivated resource (psychology graduates) to help meet the (increasing) demand for effective and professional psychological interventions within an appropriately trained, supervised and remunerated career structure.

The history of clinical psychology in the UK is relatively short. It is still very much a developing profession. The first comprehensive review of the efficacy and effectiveness of the application of psychological theories and principles to clinical issues only took place in 1989². As a profession, clinical psychology has espoused the idea of 'scientist-practitioner' from its earliest days in the 1950s. In the 1990s, in a context of a developing emphasis on the evidence-base in the NHS as a whole, the university-based training programmes extended the training period from two to three years and translated masters level into doctorate level courses with the inclusion of research as a significant aspect of each programme. Following successful completion of these British Psychological Society (BPS) accredited courses, graduates are eligible to become chartered clinical psychologists on the BPS *Register of Chartered Psychologists*. Normally people will then work for a minimum of six years as a Grade A clinical psychologist before they are able to apply for externally assessed consultant clinical psychologist posts. Assuming an average of two years in assistant psychologist positions, a minimum of 14 years training and experience is required to achieve a career-grade consultant post within the profession.

The MAS (1989)² review of clinical psychology services defined the purpose of clinical psychology within the NHS as 'to improve, either directly or indirectly, the standard and quality of life of people who are served by and provide health services, and to alleviate disability, through the application of appropriate psychological theories'. The report proposed that consultant psychologists should work with other psychologists as supports, the 'consultant plus' model. One reason for proposing this model was a delineation and definition of levels of psychological activities. The different levels equated, broadly speaking, with psychological knowledge and skills. Level 3 was the level at which a psychologist would be eclectic in knowledge and skill and be able to apply the broadest range of psychological therapies and principles to any (appropriate) presenting health problem or issue. This was the defining uniqueness of clinical psychologists. Level 2 was the level where specific techniques, described by procedure or protocol, could be applied under the supervision of someone with level 3 knowledge and skills. In this relationship, level 3 psychologists would undertake some assessments, formulation and some therapy. Level 2 psychologists would be responsible for some prescribed assessments and therapies, and would have an understanding of formulation.

² Review of Clinical Psychology Services. May 1989. MAS Cheltenham

The range of psychological therapies that can be described by procedure or protocol is expanding as more outcome research is completed and the effectiveness of interventions is being demonstrated. In effect, therefore, there is an expanding need for skills at level 2 working in partnership with those with level 3 skills. Associated with these developments, there is an expanding need for skills at level 3 to advance the use of psychology, to support an increasing number of people using psychological therapies, to supervise clinical psychologists at the junior end of the career structure, to be engaged in service improvement initiatives, and to further develop psychology services across the range of patient groups and clinical specialties.

It is envisaged within this study proposal that associate clinical psychologists will function broadly at level 2 and so will release chartered clinical psychologists from undertaking work at this level. This in turn will enable chartered clinical psychologists to meet the expanding need at level 3 for which they have trained and are qualified. In addition, an attractive alternative career will be available to those psychologists who are not able, ready or willing to embark on an 11 year plus path to a consultant clinical psychologist position, but *are* interested in developing skills and experience in delivering psychological interventions directly to clients.

4. THE ROLE OF THE ASSOCIATE CLINICAL PSYCHOLOGIST

With respect to research, the observation of Milne and Paxton³ that an important aspect of the psychologist's interest in research is as an "empirical clinician – someone who consumes and applies research, including participation in audit" is compatible with psychologists working at level 2.

Within this evidence-based framework, the application of psychological theories and principles will involve administration of assessments and delivery of therapy using procedures that can be described by protocol.

The range of activities undertaken by ACPs includes the following:

- Recognising when to refer a person or a problem to a chartered clinical psychologist.
- Direct and indirect clinical services (assessment, therapy and training).
- Disseminating and promoting wider appropriate use of psychology in health and social care (advice and support to other disciplines).
- Supporting clinical research and service evaluation.

The range of competencies to undertake these activities is described in section 5. below.

³ Milne, D.L, and Paxton, R., *A psychological analysis of the scientist-practitioner, in the light of the R&D initiative*. Clinical Psychology and Psychotherapy, 1998, 5, pp.216-230

5. TRAINING FOR THE ROLE OF ASSOCIATE CLINICAL PSYCHOLOGIST

It is proposed that training for ACP will mirror closely the key components of the training of chartered clinical psychologists who they will be supporting. However, in addition to the length of training, there are important distinctions between the training programmes. There are clear differences in the comprehensiveness and depth of the academic curricula, as well as distinctions in the range and levels of skill competencies expected. For example, while associates will be expected to be aware of and have an understanding of the formulation process, unlike their chartered clinical psychologist colleagues they will not need to demonstrate high degrees of competence in this sphere. Similarly, it is anticipated that by the end of their training associates will have an appreciation of research, evaluation and service development, however, they will not be expected to be highly skilled in these activities.

It is proposed that associate training will take place over an 18 month period, mainly based in a clinical setting, with academic modules being provided by a higher education institution, with the whole forming a masters level degree qualification. A workbook for each module could be prepared which could be used as the guide for teaching in clinical settings. A workbook would be useful also to the clinical supervisors as a means of reinforcing the academic teaching.

The 18 month training period could be divided into:

- 6 months of general clinical training supported by teaching modules
- 12 months of clinical training within a specialty supported by teaching modules

Throughout the 18 month period each associate clinical psychologist should be assigned a training co-ordinator responsible for overseeing their training plan, and one or more clinical supervisors could be involved in providing a range of training experiences in clinical settings.

Assessment will be continuous using a range of approaches (essays, case-studies, examination, diaries, etc.) to determine competence.

The proposed outline training is as follows:

Module 1. Induction

This module aims to introduce the associate to working in the NHS.

Employment briefing

Contracts of employment. Confidentiality. Data Protection Act. Discrimination Acts. Health and Safety. Conditions of Service. Patients consent. Working practices. The organization of the NHS. Latest personnel initiatives and workforce planning developments. The role of other disciplines. The nature of supervision. Respect for people.

Clinical Practice

Contact with patients. Information gathering. Assessment and therapy. The referral processes. Formulation skills. Psychometrics in outline. Communication and report writing. Ethics. Working in different settings. Change management. Therapeutic skills in outline. Personal development. Demands of clinical working. Safety. Competence. BPS Code of Practice.

Module 2. Introduction to Clinical Practice

This module introduces some of the basic approaches to clinical practice.

The competences for this module are:

- Ability to develop and maintain an effective working alliance with clients
- Ability to choose, use and interpret a broad range of assessment methods appropriate:
 - To the type of intervention which is likely to be required
- Assessment procedures in which competence is demonstrated will include
 - Formal procedures (use of standardized instruments)
 - Structured interviewing procedures
 - Other structured methods of assessment (eg observation or gathering information from others)
- Ability to ask questions in an appropriate manner
- Ability to tailor the style and range of questions asked to the client's presentation and emerging story, accommodating their wishes and ideas within a psychological framework
- Ability to engage clients, to listen actively and establish a good and responsive working relation with them. This includes service users, families and carers, and people who are disengaged from services.
- Ability to relate empathetically to clients, to communicate an understanding of the client's experience and to establish rapport.
- Ability to adopt an appropriate professional manner which is responsive to the client but which is neither too distant or too over-familiar.

- Ability to respond appropriately to clients from differing cultural and ethnic backgrounds.
- Ability to communicate effectively and sensitively with people with expressive and receptive language difficulties, where these difficulties reflect underlying functional or organic problems.
- Ability to help memory impairment or disorientated clients maintain an interaction, through sensitivity to the underlying feelings of disorientated clients.
- Ability to adapt verbal communication style to individuals of different developmental levels.
- Ability to adapt verbal communication style to individuals across the spectrum of difference-specifically in relation to gender, sexuality, ethnicity, culture and social class.
- Ability to write reports and letters clearly
- Ability to identify material which will aid effective coordination between professionals in writing reports.
- Ability to discuss the theoretical issues underpinning a technique.
- Ability to write reports and letters tailored to the needs of the reader.
- Ability to write reports using language that is not pejorative or derogatory towards other professionals, the client or the carers.

Module 3. Assessment

This module introduces and develops methods of assessment to be used by associates. The competences to be assessed are:

- Ability to describe a rationale for the overall process of assessment and hence the relevance of specific information sought during the process of assessment.
- Ability to structure an interview appropriately (neither too loose, nor too structured)
- Knowledge of the range of questions appropriate for the initial interview or assessment
- Ability to make accurate and structured behavioural observations
- Ability to assess families and systems and to take account of the social context in which problems arise.
- Ability to take into account factors such as physical illness and the impact of medical interventions when planning and interpreting assessments.
- Knowledge of the ways in which cultural factors may influence assessment procedures, and a capability to adapt practice to ensure clients are not disadvantaged.
- Understanding of the limitations of assessment procedures and when it is inappropriate to use them.

Module 4. Psychometric Testing

This module covers the statistics required for psychometric assessments, together with the selection and use of appropriate tests, together with test administration. The competences to be assessed are:

- Ability to select and administer standardized tests appropriate to the assessment being conducted
- Ability to apply knowledge and the principles of psychometric assessment in order to accurately interpret the results of testing.
- Ability to use appropriate statistical methods in psychometric testing and marking
- Ability to feedback psychometric assessments
- Ability to administer psychometric tests.
- Ability to integrate information from interviews or assessments within a sound and coherent framework.
- Ability to give appropriately tailored verbal, written or other feedback regarding the assessment to clients, carers and professionals.

Module 5. Formulation

This module develops the associate's understanding of formulation, within limited systemic thinking models, with a view to enabling the associate to understand the appropriate therapeutic framework to the patient. The competences to be assessed are:

- Capacity to think flexibly across more than one approach, demonstrated by a coherent integration of their ideas or the ability to consider more than one strategy for intervention.
- Ability to identify, prioritise and agree expectations, needs and requirements of clients.
- Ability to communicate a formulation to other professionals in a clear and concise manner.

Module 6. Therapies

In this module the associate is taught the psychological therapies they will use in practice. In the main, the therapy will be Cognitive Behaviour Therapy as the base therapy. The competences to be assessed are:

- On the basis of a formulation, the ability to implement psychological therapy techniques appropriate to the presenting problem and to the psychological and social circumstances of the client(s), and to do this with:
 - Individuals
 - Couples, families or groups
- Ability to implement an intervention through and with other professions and/or with individuals who are formal (professional) carers for a client, or who care for a client by virtue of family or partnership arrangements.
- Capacity to be appropriately flexible in the approach to intervention (ie. An ability to adapt therapy to client's needs)
- Capacity to be appropriately flexible in the approach to intervention with clients from varying cultural and social backgrounds.
- Ability to take into account the physical and social characteristics of the client's environment (eg. Material resources or social support), and legal and statutory frameworks, and to adjust interventions accordingly.

- Capacity to be clear about the role and limits of each person involved in an intervention.
- Ability to decide on the appropriateness of implementing or withholding an intervention.
- Competence at negotiating with the client before proceeding with formal intervention.
- Competence in managing breaks and ending of therapy
- Ability to manage difficulties within the session constructively.
- Ability to recognize and manage therapeutic impasses.
- Ability to negotiate specific change targets with the client and other stakeholders.
- Ability to create a secure, safe and reliable therapeutic 'frame' (eg. Ensuring clarity about timing of sessions, and the location and duration of therapy)
- Ability to work with more than individual clients (eg. Families, groups or couples)
- Ability to undertake triadic work, to work jointly with other staff and to work with staff teams.
- Ability to work directly with patients in long-term care.
- Knowledge of all three of the following intervention frameworks and competence to work in at least two:
 - Behavioural (eg using anxiety management techniques, functional analysis)
 - Cognitive (eg explaining the links between thoughts and emotions, enable clients to identify NATS, enable clients to generate alternative thoughts)
 - Systemic (eg by thinking in terms of interactive systems regarding individual, family and organizational issues, using circular questioning, interviewing at a systems level with families and/or organizations)

Each formal teaching session/module will be reinforced in the practical setting with practical work being developed on the basis of the module programme.

A workbook for each competency will be developed providing all the required information and supporting material for continuing professional development.

Module 7. Evaluation

In this module the associate will develop the ability to identify and evaluate research evidence relevant to clinical practice. The associate is expected to become competent in evaluating the appropriateness, effectiveness and impact of the chosen therapy as applied to an individual, couples, group, family and context. The associate is, also, expected to gain competence in the aggregation of evaluation evidence to inform his/her practice.

The competences to be assessed are:

- Ability to analyse and interpret data.
- Ability to locate, access, and consult relevant sources of information in journals.
- Ability to critically evaluate and systematically review literature.
- Ability to identify research and service evaluation questions.
- Ability to understand and apply the evidence base for a treatment approach or model of service provision used.
- Ability to critically evaluate clinical work and to adapt or change the approach taken where this is indicated.
- Ability to evaluate the effectiveness and outcome of interventions.
- Ability to conduct audit and/or service evaluation.
- Ability to tailor the method of evaluation to the intervention being evaluated.
- Awareness of ethical considerations in evaluation, and how to apply for ethical approval.
- Ability to disseminate the results of evaluation and to implement service changes in the light of evaluation outcomes.

6. MANAGEMENT, SUPERVISION AND CONTINUING PROFESSIONAL DEVELOPMENT FOR THE PROPOSED ROLE

Wherever possible, ACPs would be located within established psychology departments or services with clear line management accountability to qualified clinical psychologists. These arrangements would be consistent with the BPS guidance on the management of clinical psychologist services³.

Supervision of associate clinical psychologists will be in keeping with NHS goals as an organisation committed to supporting the learning and development of its staff as its most valuable asset. The supervision of associates, its purposes and the level of supervision should be consistent with guidance provided by the BPS⁴. At a minimum, all associates should have access to regular and planned supervision for their clinical work from a named chartered clinical psychologist.

It is expected, in common with all other NHS staff, that the associate will be engaged in continuing professional development (CPD) once trained and undertaking a substantive role. The recommendation of the BPS⁵ on this matter is that each psychologist should have available 10 days per year for CPD. It is further recommended that a CPD logbook be maintained to ensure that psychologists maintain a record of their personal development.

³ Guidelines for Clinical Psychology Services. 1998. British Psychological Society.

⁴ Policy Guidelines on Supervision in the practice of Clinical Psychology. February 2003. British Psychological Society.

⁵ Guidelines for CPD. September 2001. British Psychological Society

7. INDICATIVE COSTS OF A PILOT SCHEME

There are national discussions concerning the assimilation of clinical psychologists into the pay spine for healthcare professionals under *Agenda for Change* proposals. These include seven job profiles representing the psychology career structure – assistant, trainee, psychologist, specialist psychologist, consultant psychologist, psychology manager and senior consultant psychologist. It is proposed that the associate clinical psychologist role in training will equate with the psychologist, and that the associate clinical psychologist once trained will equate with the specialist psychologist.

Details of the precise figures involved are unknown. For the purposes of the proposals to pilot the role it is proposed that (based on current equivalent assistant, trainee and clinical psychologist salary scales):

- The associate in training will cost **£18,000-£20,000 salary plus on-costs**.
- The trained associate will cost **£22,000-£38,000 salary plus on-costs**.
- The salary costs per annum will, therefore, be **£18,000 salary plus on-costs** for an initial period of 12 months.
- The costs of training will equate to standard charges for Masters degrees. It is proposed that for illustrative costing purposes the Masters programme should be priced at **£7,000 per person**.
- The costs of supervision in the workplace will be consumed within the supervising department.
- A budget of **£1,000** per trainee should be available for travel, accommodation and learning materials, where charged.
- **Therefore the Total amounts to approximately £26,000 plus on-costs per post in the first year; £27,500 plus on-costs in the second year.**

Costs of Preparing and Developing Training

The material for the proposed training programme requires collation. In addition, the preparation of useful and informative workbooks for the entire training programme will require an estimated 100 days. On the basis of £500 per day this would involve a total cost of approximately **£50,000**.

In addition, the costs of producing materials for training, the negotiations with supervisors and the incidentals involved in launching pilot studies needs inclusion in the costs. A further **£10,000** should be budgeted for this.

Therefore, the Total cost of preparation and developing the training course equates to the cost of a full time course director, with additional costs for materials i.e. circa £60,000.

Pilot Scheme Evaluation Costs

These have been calculated on the basis of 10 days per training place, based on an initial cohort of 8 places.

- On the basis of £500 per day, the estimated cost for evaluation is **£40,000 excluding VAT**. The budget for tendering purposes would, therefore, need to be around the £40,000 figure.

Overall Costs of a Pilot Scheme

Based on the estimated figures provided above:

- The start-up cost per training place (based on 8 places) for the scheme is therefore **£38,500 plus on-costs**.
- In the second year the costs per place reduce to **£27,000 plus on-costs and material costs**.

8. FEASIBILITY STUDY REPORT

Policy Context to the Study

The purpose of the feasibility study was to test the feasibility of establishing a role of 'associate clinical psychologist' (ACP). The method employed has been largely consultation together with a review of the background and an examination of the issue that the role should be open exclusively to graduate psychologists. This issue arises from the current NHS context that is encouraging the development of new roles and the exploration of the contribution of staff with different academic and professional backgrounds to existing roles.

The service context for the initiation of this feasibility study was the service to those with learning disabilities (LD). These are services that, nationally, have found difficulties with recruitment and retention of chartered clinical psychologists. The overall picture varies, with some locations having fewer difficulties in recruitment than others. The picture also changes over time. Therefore, whilst the focus has been LD services, the feasibility study has considered throughout a general application of the associate role.

There are a number of government and NHS policies that provide a context for this study and directly influence the proposals emerging from it. These include, amongst others, *The New NHS - Modern and Dependable*⁴, *The NHS Plan: A Plan for Investment, A Plan for Reform*⁵, *The National Service Framework for Mental Health*⁶, and *Valuing People. A New Strategy for Learning Disability for the 21st Century*⁷. An extended and annotated list of relevant policies and strategic plans is provided at Appendix II.

Background and Rationale for an Associate Clinical Psychologist Grade

The last ten years has seen growth and strengthening in both the science and practice of clinical psychology, and ever-increasing demand from service-users for access to psychological therapies. At the same time there has also been a growth in the number and variety of people, other than clinical psychologists providing psychological interventions and therapies.⁸ Part of this growth, one could argue has been attributable to the shortage of

⁴ The New NHS. Modern. Dependable. Cm.3807. 1997. *The Stationery Office*

⁵ The NHS Plan: A Plan for Investment; A Plan for Reform. Cm 4818. 2000 *The Stationery Office*

⁶ National Service Framework for Mental Health. *Sept. 1999. DoH*

⁷ Valuing People. A New Strategy for Learning Disability for the 21st Century *March 2001 DoH*

⁸ Milne, D, Baker, C, Blackburn, M, James, I and Reichelt, K 'Effectiveness of Cognitive Therapy Training', *Journal of Cognitive Behaviour Therapy and Experimental Psychiatry*, 1999. 30, pp81-92

qualified clinical psychologists, which was recognised in the recent National Service Framework for Mental Health⁹.

The shortage of qualified clinical psychologists, coupled with other factors, has resulted in some NHS Trusts (Mancunian Community Health NHS Trust first and foremost) establishing a new grade of psychologist, an 'associate psychologist'. This grade is an enhancement over the established assistant psychologist role, in areas of practice defined on the basis of training, experience and demonstrated competence¹⁰. This particular role requires post-holders to have an undergraduate degree in psychology.

The NHS largely employs three main grades of professional psychologist: qualified Grade A and consultant clinical psychologists, and assistant psychologists. Between the qualified and assistant points on the pay spine is the trainee clinical psychologist grade. This grade is only available however, to those people on postgraduate clinical psychology programmes. There are many psychology graduates seeking assistant psychologists posts, very often with a view to progressing to postgraduate training as a clinical psychologist. Between 1998 and 2000, for example, there were an average of 15 applications for each of the 392 annual training places in the UK¹¹. The Mancunian Community Health NHS Trust argued therefore that, "there is a bottleneck for experienced assistant psychologists seeking entry to postgraduate training."

In addition, the situation in the Mancunian Community Health NHS Trust up until 1998, typical of other NHS Trust LD services, was one where there was a long pay spine for qualified clinical psychologists from point 20 up to point 53. In reality this resulted in points 20 to 30 rarely being used, with the effect that only half of the Grade A spine was in effective use. The result, the Trust argued was one where, "Newly qualified clinical psychologists are relatively costly, as they typically engage in individual pay bargaining with competing, prospective employers who often appear to take little responsibility in containing either unnecessary expenditure of premature rocketing through a negotiated career structure."

The resultant effect of this situation for the Mancunian Community Health NHS Trust was one where they had been repeatedly unsuccessful in filling vacancies for qualified clinical psychologists at Grade A level. Further, the Trust had no way of facilitating the career development or acknowledging the increasing levels of skill of the four assistant psychologists that they

⁹ Department of Health. *National Service Framework for Mental Health*, 1999. London: HMSO

¹⁰ Burton, M and Adcock, C 'The Associate Psychologist: Developing the Graduate Psychologist Workforce,' *Clinical Psychology Forum*, 1998. 121, pp 7-12

¹¹ Huey, D and Britton, P 'A Portrait of Clinical Psychology' *Journal of Interprofessional Care*, 2002. 16 (1), pp69-78

employed, whom, they believed, “were working well beyond the level expected of an assistant psychologist.”

This led the Trust to develop a scheme to appoint ‘associate psychologists’ in their learning disability service. The following points were developed by the Trust to guide the development of the role of associate psychologist:

- Such posts would not substitute for all round skills of qualified clinical psychologists, but would allow an enhancement over the assistant psychologist role.
- Within the person-specific “area of additional autonomy” not every piece of work would have to be supervised in detail, although there would be periodic reviews of all work with a supervisor.
- These posts would still require supervision by a qualified clinical psychologist.
- These posts would be established, using NHS Trusts’ freedom to establish their own pay scales and conditions.
- Progression from assistant psychologist to the new grade would be on the basis of assessment of capability, rather than time served.

Staff would need to have a minimum of two years’ experience at the assistant psychologist grade before being considered for progression to associate psychologist posts, and would also have to submit a portfolio to a panel which demonstrated that they met certain competency domains. The proposed grade of ACP is a further development of the approach pioneered by the Mancunian Community Health NHS Trust.

Study Consultation Procedure

Consultation on the proposed associate role took the form of interviews with individuals and small stakeholder groups. In addition, a reference group comprising chartered clinical psychologists (senior clinicians and trainers) and NHS service managers were asked to contribute to the definition of competencies required. These competences were also presented to a group of assistant psychologists representing the Northern Region Graduate Psychologists Group to determine those which they considered important to their roles. They were asked to consider themselves as performing in an associate role. Telephone interviews were used in limited circumstances and only to discuss the role of associate with people who were engaged in this type of role already. An examination of the diary of one associate psychologist was undertaken to explore the range of activities and amount of supervision provided.

Interviews were held with chartered clinical psychologists and psychology managers in Northumberland, Cumbria, Teesside, Manchester, Edinburgh, Fife and Northern Ireland; psychologists working in an associate-type roles; assistant psychologists; and those responsible for the training on doctorate programmes in Newcastle-upon-Tyne, Teesside and Edinburgh.

Personal interviews were also conducted with the representatives of the Northern England Workforce Development Confederation; the Northumberland, Tyne & Wear Strategic Health Authority, and with the Executive Director team at Northgate & Prudhoe NHS Trust. Liaison was maintained throughout the project with the Changing Workforce Programme and with those involved in the development of the Graduate Primary Care Mental Health Worker initiative locally.

In total 55 people participated in interviews and group discussions over a 10 month study period (see Appendix III), with some being interviewed more than once.

Results of Consultation Exercise

There was widespread support for the development of the ACP role. Several NHS Trusts indicated support in principle to sponsor up to 8 pilot posts across the region. All of these are subject to further consultation on the detail of the proposal with Trusts, relevant WDCs and Strategic Health Authorities and identification of required funding.

The comments in support of the ACP role tended to be referenced to the role of the current assistant psychologist grade, and the need for that role to be reviewed and made more stable and better regulated, supported and paid. Therefore it might be concluded that the proposed ACP role is seen by many as a substitute for, or a development of the existing assistant psychologist grade.

The main concerns expressed about the proposed ACP role tended to relate to anxiety that the chartered clinical psychologists role would be eroded in favour of the less well qualified associates. For some this concern went deeper, in that if the role of the chartered clinical psychologist was to be eroded by ACPs, then the chartered psychologist role could be at risk to non-psychologists offering level 2 skills.

Amongst the assistant psychologists interviewed, there was a split between those who wanted a career at level 3 and those who were not seeking that level of expertise and responsibility, preferring instead the associate-type, direct therapy delivery role. However, all involved in this discussion recognized and acknowledged a need for, and the potential benefits of the proposed associate grade.

Some practical concerns were expressed which piloting the role would seek to address. These included the amount of time ACPs would spend on direct clinical activities, and the amount of supervision required. Other issues related to the extent to which an ACP would be able to function independently; whether the work would overlap with that of Chartered

Clinical Psychologists; and whether entry to doctoral courses would be possible.

There was some discussion and debate amongst contributors to the consultation process concerning the suggestion that many Grade A chartered clinical psychologists appear to work mainly at level 2. Therefore, the proposed ACP grade might be used as cheaper substitutes for more junior clinical psychologist posts. On the other hand, in a modest survey¹² of recent graduates from the Newcastle University doctoral training programme, 8 out of 10 newly qualified clinical psychologists reported that they were in fact working at level 3. These reports need to be set against additional self-reports in the same survey that 64% the study cohort provided "direct service provision under the guidelines of a more senior psychologist".

Further research on this issue would be helpful. However, the concern about the proposed ACP grade simply being a way of replacing Grade A chartered clinical psychologists 'on the cheap' is misplaced for several reasons. While it is likely that there will be some overlapping of level 2 work between the two grades, it is not envisaged within the proposal that the work of ACPs will be in place of Grade A clinical psychologists, or at reduced cost. Rather, the primary aim of the development of the ACP grade is to add to and increase the amount of level 2 psychological services available to clients, and the salary scale proposed for this new grade has parity with the pay of Grade A clinical psychologists. The key difference between the two grades is that Grade A clinical psychologists will in general be moving through this grade, honing their level 2 skills and developing level 3 skills in complex case formulation, service development and evaluation, clinical leadership, consultancy, etc. before moving into the consultant clinical psychologist career grade where they will be operating almost exclusively at level 3.

Within the study consultation process the other side of this debate was raised and discussed. That is, to what extent is it a necessary to have a first degree in psychology for effective level 2 work? This discussion prompted a review of the available literature on associate-type roles, including international perspectives. A detailed account of this review can be found at Appendix IV. In summary, the review suggests that the evidence that level 2 practitioners benefit from having a psychology degree is equivocal. This is, however, a largely academic debate. Anecdotal evidence and the experience of most experienced clinical psychologists suggest that people from other academic and professional backgrounds can become very accomplished psychological therapists. The same sources of evidence also indicates that graduates who have completed a solid undergraduate psychology course can also become competent therapists and can bring something extra in terms of critical and evaluative psychological thinking. The pragmatic point is that there are plenty of psychology graduates available and highly motivated to take on level 2 work in the guise of the proposed ACP grade. Therefore, there

¹² Milne, D *Follow-up of recent graduates* in Bulletin Issue 3 October 2002 Univ. of Newcastle-upon-Tyne

is little to be gained by concerning ourselves about whether other types of graduate could, with additional preparation, be as able as psychology graduates; or whether psychology graduates will be as good as those from other health professions at level 2 skills.

In conclusion, the proposed ACP grade was supported by a wide range of people consulted representing chartered clinical psychologists, psychology managers, assistant psychologists, health service commissioners, providers and strategists. Some of those whose work focuses on training clinical psychologists have concerns about the potential impact of the new grade on the Grade A clinical psychology role. Surprisingly few significant problems with the proposed role were identified or anticipated by those consulted, and the consensus concerning the potential value of the role was broad.

Appendix I Reference Group Members

Dr John Taylor	Head of Psychological Therapies and Research, Northgate and Prudhoe NHS Trust, and Northumbria University
Dr Ann Galloway	Director, Doctorate in Clinical Psychology Course, University of Teesside
Dr Derek Milne	Director, Doctorate in Clinical Psychology Course, University of Newcastle-upon-Tyne
Dr Roger Paxton	Director of Psychological Therapies and Research, Newcastle, North Tyneside and Northumberland Mental Health NHS Trust
Paul Davies	Executive Director, Northgate and Prudhoe NHS Trust
Moray Allan	Executive Director, Northgate and Prudhoe NHS Trust
Steve Manders	Changing Workforce Programme, DoH
Professor Derek Mowbray	Director, MAS and Northumbria University

Appendix II Policies and Strategic Plans Relevant to the Development of the Associate Clinical Psychologist Grade

i. The New NHS - Modern and Dependable

The current strategic focus for health and social services first detailed in *The New NHS – Modern. Dependable*¹³, sets out the Government's vision for the National Health Service (NHS) in England. This NHS white paper and subsequent quality consultation document identified requirements for consistent, high quality care throughout the health service and all health organisations. The Government's plans for NHS modernisation are intended to ensure a high quality, national service that is clinically sound, evidence-based, cost-effective and equitable.

ii. The NHS Plan: A Plan for Investment, A Plan for Reform

The NHS plan, published in 2000¹⁴, is the detailed blueprint for reform of the health service. The NHS Plan establishes a set a "core principles" for the NHS, which reaffirm the NHS traditions of free access to services on the basis of clinical need and enshrines commitments to:

- ✓ Improved standards of care.
- ✓ More investment in staff development.
- ✓ Increased partnership working between the NHS and social care.
- ✓ A renewed commitment to improving the health of the nation.

iii. Modernising Mental Health Services

The task of improving mental health services requires both vision and commitment. The Government published a new Mental Health Strategy – *Modernising Mental Health Services*¹⁵ in December 1998, which outlined a new direction for mental health. The new vision is to provide safe, sound and supportive mental health and social care services so as:

- ✓ to protect the public and provide effective and safe care for those with severe and enduring mental illness;
- ✓ to meet the needs of those with mental health problems who can appropriately and safely be managed within primary and social care; and
- ✓ to promote good mental health in the population and help build healthier neighbourhoods.

iv. The National Service Framework for Mental Health (NSF)

The NSF¹⁶, published in 1999, sets out a vision of a better service in its seven standards, spanning the full range of mental health care.

¹³ The New NHS. Modern. Dependable. Cm.3807. 1997. *The Stationery Office*

¹⁴ The NHS Plan: A Plan for Investment; A Plan for Reform. Cm 4818. 2000 *The Stationery Office*

¹⁵ *Modernising Mental Health Services - Safe, sound and supportive. 1998. DoH.*

¹⁶ *National Service Framework for Mental Health. Sept. 1999. DoH*

Addressing the roles of mental health promotion, primary care and specialist secondary care, the NSF was a major milestone in recent policy development.

In 2000 a Workforce Action Team was set up, in support of implementation of the NSF and NHS Plan, to provide useful and practical information, which will enable local health and social care communities to take forward this very challenging agenda, working in partnership with a wide variety of agencies.

The key NSF recommendations pertinent to clinical psychologists are as follows: -

- ✓ Employing NHS Trusts should ensure they provide clear overarching professional leadership and accountability structures for psychologists.
- ✓ Employing NHS Trusts should put in place proper arrangements for clinical supervision and continuing professional development activities for psychologists, supported with funding and appropriate allocation of time.
- ✓ The number of psychology assistant posts should be increased, to improve the current service, and enable more people to acquire the relevant professional experience prior to entering training.

There should be a continued increase in the number of funded clinical psychology training posts;

v. The Review of Mental Health Act (MHA)

The framework of law within which mental health care operates is also being reformed. The current 1983 MHA is based broadly on the 1959 Act that preceded it. The new White Paper *Reforming the Mental Health Act*¹⁷, moves away from the presumption that compulsory treatment needs to be provided in institutions and promotes new models of service delivery.

A major proposal of the MHA reforms is for clinical psychologists to take on the role of 'Clinical Supervisors' which would include involvement in compulsory assessment and treatment, detention and discharge, and responsibility for co-ordinating patients' treatment plans.

vi. Learning Disabilities

The most recent LD strategy document, *Valuing People*¹⁸ emphasises that local services must develop competencies to provide treatment and support to clients with severely challenging behaviour. Approximately 5% of the population of people with learning disabilities has severely challenging behaviour. This small proportion of clients use a high proportion of resources

¹⁷ Reform of the Mental Health Act 1983. Cm 4480. Nov. 1999. DoH

¹⁸ Valuing People. A New Strategy for Learning Disability for the 21st Century March 2001 DoH

within the community and on occasions community services cannot maintain these clients within their current placements.

With the increased emphasis on community integration and the intention of hospital services to provide brief, focused interventions for circumscribed specialist needs, rather than emergency management, it is increasingly important for community services to develop in ways which enable them to cope with clients who engage in challenging behaviour. These clients often require complex multi-level interventions and highly individualised and responsive services.¹⁹

Opportunities to deliver such sophisticated psychological interventions vary widely depending upon the availability of clinical psychologists within both mainstream learning disability services and specialist challenging behaviour services, particularly specialist peripatetic support teams. It is only when LD services are sufficiently resourced with staff skilled in the implementation of effective psychological and behavioural interventions that community services will be better able to cope with the most challenging clients and that hospital services will be used more sparingly and appropriately.

A recent review of clinical psychology services in Northern Ireland makes the following recommendations with respect to challenging behaviour²⁰:

- ✓ Mainstream LD services must develop expertise in the delivery of effective interventions for clients with severely challenging behaviour. Such services must be highly individualised, flexible and responsive to client need.
- ✓ It is essential that services are designed by staff with specialist knowledge of these interventions. In the main clinical psychologists are the providers of such assessment and treatment services and are involved in development of services to meet the needs of this client group.
- ✓ Specialist challenging behaviour services should be headed by consultant clinical psychologists supported by a team of staff from a range of professional backgrounds but with a shared model of challenging behaviour.
- ✓ At present, numbers of clinical psychology posts do not approach the levels recommended for mainstream LD services. Thus it is essential

¹⁹ Kiernan C and Quereshi H “Challenging Behaviour” in: Research to Practice? Implications of Research on the Challenging Behaviour of People with Learning Disabilities Ed. C Kiernan. British Institute of Learning Disabilities 1993

²⁰ Personal communication

- to develop, resource and attract appropriately qualified psychologists to LD services.
- vii. Mental Health Services – Workforce Design and Development – Best Practice Guidelines (February 2003)
These guidelines²¹ set out non-prescriptive guidelines for the development of workforce plans. The documents refers to new roles, such as “Support Time and Recovery Workers”, and “Graduate Primary Care Mental Health Workers”.
- viii. “Meeting the Challenge” – A strategy for the Allied Health Professions
This strategy²² (Department of Health, 2000) focuses on issues relevant to the Allied Health professions and refers to the value of protocol-based care.
- viii. Agenda for Change
Agenda for Change²³ is the Government’s initiative to rationalise pay spines into three main spines, based on job evaluation.

²¹ Mental Health Services – Workforce Design and Development. Best Practice Guidance. *March 2003. DoH*

²² Meeting the Challenge – A strategy for Allied Health Professions *Nov. 2000. DoH*

²³ Agenda for Change – Modernising the NHS Pay System. *2001 DoH*

**Appendix III List of Individuals Consulted as part of the
Feasibility Study
(unless indicated otherwise, those listed below are Chartered
Clinical Psychologists)**

Kate Barnes and colleagues – Assistant Psychologists from the Northern Region Graduate Psychologists Group.
Mark Burton
Tom Butler – Northern England Workforce Development Confederation
Tim Cate
Greg Chowanec
Daniel Collerton
Andrew Cuthbertson
Hilary Dawson – Head of Personnel, Northgate & Prudhoe NHS Trust
Andrew Donovan
James Duncan – Director of Finance and Performance Management, Northgate and Prudhoe NHS Trust
Brian Foley, DoH Changing Workforce Programme
Hugh Firth
Jenny Firth-Cozens
Teresa Fundudis – Training Manager, Northgate & Prudhoe NHS Trust
Ian Gale – Consultant Child Psychologist, Northgate & Prudhoe NHS Trust
Bruce Gillmer
Derek Gorman – Associate Clinical Psychologist
Denise Johnson
Bernard Kat
Peter Kinderman
Alison Knights
Alison Lancaster – Associate Clinical Psychologist
Bill Lindsay
Jake Lyne
Heather McVittie – Clinical Governance Manager, Northgate & Prudhoe NHS Trust
Anthony Perini – Medical Director, Northgate & Prudhoe NHS Trust
Nigel Roberts
Lois Savage – Assistant Psychologist
Herde Schand-Borgschulte
Geraldine Scott-Heyes
Yvonne Sewell
Judy Sheahan
Jackie Sochocka – Northumberland, Tyne & Wear Strategic Health Authority
Paul Smith

Hugh Toner
Rod Webster

Members of the D. Clin. Psych. Tutor group – University of Teesside
Members of the D. Clin. Psych. Tutor group – University of Edinburgh
Members of the Study Reference Group.

Appendix IV A Review of the Development and Effectiveness of Associate-Type Roles in Clinical Psychology Services²⁴

Introduction

The Mancunian Community Health NHS Trust pioneered the role of 'associate psychologist'. As candidates for these posts were required to have a minimum of two years' experience as an assistant psychologist then, de facto, they had to have a first degree in psychology, recognised by the BPS, and thereby be eligible for graduate membership of the BPS. But is a degree in psychology a necessary prerequisite to entrance to the role of associate clinical psychologist? Or, given the growth in alternative professions providing psychological therapies and interventions, could this role be carried out by these professions if they are trained in psychological techniques? The main focus of this review is to examine the arguments for requiring the associate clinical psychologist grade to be a psychology graduate, as opposed to a professional such as a nurse or social worker who is trained in psychological techniques.

In order to explore this issue, a systematic search of the professional literature (clinical psychology, social work, nursing) was undertaken to retrieve reports of all studies that examined psychological intervention and assessment by clinical psychologists and other professional staff. Computerized database searches of Medline, Cinahl and PsychInfo were undertaken using key words such as 'clinical psychologist', 'associate clinical psychologist', 'nonpsychologists', 'nursing', 'social work', 'psychology', 'psychological assessment', 'education', 'training' and 'cognitive behavioural' and 'therapy.' The search was limited to publications between 1966 and 2003. In addition there was concurrent monitoring of relevant journals, references cited in review and original articles, and searches for key authors' names.

Does the Associate Psychologist Need to be a Psychology Graduate?:

The Argument Against

Strategic Thinking.

The single most comprehensive review of clinical psychology services in the British National Health Service (NHS), proposed a 3-tiered framework of psychological skills- Level I to Level III through which clinical psychology services should be developed. Level II skills were described as:

²⁴ The Author acknowledges the support of Jena Muston, Beeches Management Centre, Belfast, in undertaking the literature searches and review.

"skills required to undertake circumscribed activities entailing psychological interventions for which one is qualified and/or has had specific training (such as behaviour modification, as undertaken by mental handicap nurses).....At this level it is necessary to recognise the constraints/limits of one's contribution." ²⁵

This proposal therefore, although put forward in 1989, did not exclude the prospect of other professional staff members operating at Level II in the psychological skills framework.

More recently, proposals under *Agenda for Change* espouse a philosophy in which the development of the new pay system in the NHS is being promoted within a culture of demarcation. *Agenda for Change* proposes that 'new working practices' will "sweep away old-fashioned demarcations, as the opportunity of extra pay encourages staff to take on new responsibilities." Furthermore, it is proposed that a more sensible division of labour based around direct patient care will allow staff to develop into new roles through a 'skills escalator.' Arguably, therefore the culture of *Agenda for Change* promotes erosion of traditional demarcation lines.

In the area of clinical psychology itself, Routh²⁶ summarises some informed 'crystal ball gazing' regarding the future of clinical psychology between 1937 and 1984, by a number of prominent clinical psychologists. These predictions include a reduced role in many standard level II (MAS) assessment and treatment protocols, which will be taken over by technicians.

The Empirical Debate.

An analysis of the research literature revealed an absence of empirical studies comparing the effectiveness of associate psychologists who are graduates vis-à-vis other professionals trained in psychological techniques. One could argue that this is owing to the fact that the concept of an associate psychologist grade is recent. There are perhaps other reasons. In part, there may be little evidence comparing outcomes and effectiveness of psychologists and other professionals because it is logistically and ethically complicated to survey consumers about experiences with providers. A recent article by Milne et al²⁷ also provides a further explanation for the dearth of empirical evidence.

Therapy process research is the study of interaction between patient and therapist systems. In experimental terms, the task is to establish the functional relationship between therapy (the independent variable) and its clinical outcomes (the dependent variables). These outcomes are influenced by

²⁵ Review of Clinical Psychology Services. 1989. MAS. Cheltenham

²⁶ Routh, D.K. *The field of clinical psychology*. Journal of Clinical Psychology. 2000. 56(3) 275-286

²⁷ Milne, D, Claydon, T, James, I, Blackburn, I, Sheikh, A 'Rationale for a New Measure of Competence in Therapy', Behavioural and Cognitive Psychotherapy, 2001. 29, pp21-33

other factors classed as 'moderators' and mediators.' A moderator effects that direction or strength of relation between independent and dependent variables, for example, the therapists' level of experience. Therapy process research is not yet in a position to identify the key variables in therapy, as there remains considerable conceptual and methodological disarray.²⁸

Empirical Evidence From Comparative Studies of Professional and Paraprofessionals.

One way of addressing the research void is to examine research on comparisons between paraprofessionals and professionals. Again however, there have been very few well-designed studies comparing the effectiveness of psychological services provided by paraprofessionals to services delivered by professionals.²⁹

The two main reviews of the literature on this issue,^{30 31} have been controversially received. Both reviews analysed the same set of studies. Using a simplistic 'box score' tallied across a broad range of services, Durlak concluded that professionals may not possess demonstrably superior clinical skills when compared to paraprofessionals. Hattie et al re-analysed Durlak's data using meta-analysis methodology, drawing conclusions similar to Durlak. It appears however, that both reviews failed to exclude obviously inappropriate or egregiously flawed studies. Nietzel and Fischer³² considered that only 5 out of 42 studies considered by Durlak were acceptable as actual psychotherapy outcome studies. In addition, because most of the studies (65%) in Durlak's review did not find an advantage of paraprofessionals, Robiner et al argue that:

"it would be inappropriate to assume that paraprofessionals' services were proven to be equal or superior to those of professionals."

Empirical Evidence from Uni- Discipline Research.

Whilst there have been limited systematic efforts to compare the effectiveness of associate psychologists who are graduates vis-à-vis other professionals trained in psychological techniques, there have been several studies highlighting the effectiveness of disciplines in their own right.

²⁸ Milne, D, James, I, Blackburn, I and Reichfelt, F 'Moderators of Trainee Therapists' Competence in Cognitive Therapy' British Journal of Clinical Psychology, 2001 40, pp131-141

²⁹ Robiner, W, Arbisi, P and Edall, G 'The Basis of the Doctoral Degree for Psychology Licensure', Clinical Psychology Review, 1994.14 (4), pp227-254

³⁰ Durlak, J 'Comparative Effectiveness of Paraprofessional and Professional Helpers', Psychological Bulletin, 1979. 86, pp80-92

³¹ Hattie, J, Sharply, C and Rogers, H 'Comparative Effectiveness of Paraprofessional and Professional Helpers', Psychological Bulletin, 1984. 95, pp534-541

³² Nietzel, M and Fisher, S (1981) 'Effectiveness of Professional and Paraprofessional Helpers: A Comment on Durlak', Psychological Bulletin, 1981. 89, 555-565

The National Service Framework for Mental Health (1999) attests, cognitive behaviour therapies (CBTs) are the best validated treatments for psychological distress³³. However, despite the consensus regarding the effectiveness of CBT, the number of trained expert therapists is small. Other than Nurse Behaviour Therapists (NBTs) the only other significant source of trained CBT therapists are clinical psychologists. The English Nursing Board 650 (Behavioural Psychotherapy) course was initiated in 1972, in order to address the lack of therapists to deliver the emerging behaviour therapies. The first course was rigorously evaluated and the data, according to Gournay et al "showed clearly that NBTs were at least effective as their colleagues from other disciplines."

A recent 25-year follow-up by Gournay of British Nurses in Behavioural Psychotherapy has continued to highlight the central role that NBTs have in the administration of psychological interventions for mental health problems. The study showed that the two most common states for which NBTs were involved were obsessive-compulsive states and depression. The study also showed that the autonomy of NBTs was considerable, and very frequently no other professional was involved in the treatment provided. The study concluded that:

"the literature on nurse therapy outcome and practice compares very strongly with the very sparse literature on the effectiveness of clinical psychology and an absence of any systematic study of outcomes of the other professions. Perhaps the time has come for clinical psychology, in particular, to examine its own practice and justify any further expansion with surveys and outcome research."

The American Perspective

The current US Mental Health workforce is composed of professionals who have been variously trained in the fields of clinical social work, clinical psychology (masters and doctorate levels) education and counselling, and medicine (including psychiatrists and nurses). As managed care and other cost-containment strategies become central features of the American Health Care System, it has been argued that "an army of new masters-level mental health professionals has now joined clinical psychologists in the consulting room."³⁴ Perhaps then it is fruitful to examine the developments in America.

Masters-level psychologists are being produced at a rate of 6,000 per year. These professionals once were, but are no longer licensed as full

³³ Gournay, K 'British Nurses in Behavioural Psychotherapy', Journal of Advanced Nursing, 2000. 32, (2), pp343-351

³⁴ Humphreys, K 'Clinical Psychologists as Psychotherapists' American Psychologist, 1996. 51 (3), pp190-197

independent practitioners of psychology. These 'psychology associates' are, one could argue, conceptually equivalent to the associate psychologist adopted by Mancunian Community Health NHS Trust. Christensen and Jacobsen's³⁵ review of studies of professional training in psychotherapy designed and conducted by doctorate-level psychotherapists, provides evidence supporting the view that replacing doctorate-level psychotherapists with masters-level and paraprofessional counsellors will not decrease the effectiveness of psychotherapy. No distinction is drawn in this summary review between the effectiveness of masters-level and paraprofessional counsellors.

A 1996 survey of 26 Community Mental Health Centre Directors in the South of America looked at CMHC master's level employment requisites, and compared them with the same study undertaken fifteen years earlier. Likert-type scale data were analysed and means computed. CMHC Directors believed that certain skills were relevant for master's level professionals. The requisite skills included: a good foundation in basic psychological theory, training in basic individual, group and family counselling, training in testing and diagnosis, and such personal qualities as communicating a high degree of warmth and good oral and written communication skills³⁶. Of most interest were the findings that items moving into the 1993 high ranking category were those regarding training as a clinical social worker and trained in a social work department. Furthermore, moving out of the high-ranking category were items related to holding a degree from a psychology department and trained in clinical psychology. Therefore, evidence from experience over 15 years in America indicates that in community mental health at least, the prominence of clinical psychology and holding a degree from a psychology department is not a necessary pre-requisite to employment.

Until recently little has been done to examine the credentials of the hybrid nurse-psychologist or psychologist-nurse role that has developed as part of the supply dynamics within America. Thomas³⁷ undertook a survey of 107 Division 38 (Health Psychology) members of the American Psychological Association. This research indicated that 88% of nurse psychologists held a PhD in psychology, and clinical and counselling psychology, were the most common foci of respondents' PhD preparation. Furthermore, nurse-psychologists were found to be often involved in research as well as provision of direct/mental health services and teaching. This therefore shows the high

³⁵ Christensen, A and Jacobsen, N 'Who (or what) can do Psychotherapy: The Status and Challenge of Non-Professional Therapies', *Psychological Science*, 1994. 5, pp8-14

³⁶ Randolph, D and Davis, S '*CMHC Master's Employment Requisites Fifteen Years Later*', *Psychology- A Quarterly Journal of Human Behaviour*, 1996.33 (1), pp10-19

³⁷ Thomas, S '*Nurse Psychologists: A Unique Group Within Health Psychology*' *Journal of Clinical Psychology in Medical Settings*, 1996. 3 (2), pp 93- 101

academic credentials and strong research focus of nurse members of the American Psychological Association.

Empirical Evidence on the Influence of Training

Gournay³⁸ argues that in cognitive behaviour therapy training at least, the core tasks in skill training are exactly the same for nurse, psychologist or doctor, and the challenge lies in integrating training amongst these professions. Nearly two decades ago an article co-authored by three psychologists and a nurse in the *American Psychologist* highlighted the same issue. The authors described many commonalities between psychology and nursing, reviewing the parallel evolution of the two professions including the development of their scientific knowledge bases and specialized clinical expertise. Thomas³⁹ argues that the focus on both professions on client behaviour change and symptom management, more so than the cure of physical and mental disease, unites them and differentiates them from medicine. Benefits of greater interdisciplinary collaboration in training, practice and research arenas were espoused.

Indeed, some recent research has highlighted the effectiveness of training on treatment efficacy specifically in clinical psychology. Milne et al⁴⁰ examined moderators of trainee therapists' competence in cognitive therapy. Twenty screened outpatients who had been routinely referred to the Newcastle Cognitive Therapy Centre, were assigned to 20 postgraduate trainees receiving training in CT. Expert raters assessed trainees' competence at three points over a 12-month period. The 20 trainee therapists were all mental health professionals undertaking further training in CT on a post-qualification course – 6 were Psychiatrists/GPs, 6 psychologists and 8 nurses. Three therapist factors were found to be related to competence: time (trainee therapists improving over the trainee period, previous experience with CT (those with most experience were most confident) and gender of the therapist. The discipline of the mental health professional therefore does not appear to be a factor related to competence.

Perhaps therefore the argument as to whether the associate clinical psychologist needs to have a psychology graduate, as opposed to a professional such as a nurse or social worker who is trained in psychological techniques, should focus on what competencies are required of the grade and what training can assist in acquiring such competencies, irrespective of profession.

³⁸ Gournay, K 'British Nurses in Behavioural Psychotherapy', *Journal of Advanced Nursing*, 2000. 32, (2), pp343-351

³⁹ Thomas, S 'Nurse Psychologists: A Unique Group Within Health Psychology' *Journal of Clinical Psychology in Medical Settings*, 1996. 3 (2), pp 93- 101

⁴⁰ Milne, D, James, I, Blackburn, I and Reichfelt, F 'Moderators of Trainee Therapists' Competence in Cognitive Therapy' *British Journal of Clinical Psychology*, 2001 40, pp131-141

The Therapeutic Alliance

Supporting the competency argument, is empirical evidence on one such factor affecting clinical outcome, that of positive therapeutic alliance. A positive therapeutic alliance, defined as a positive and collaborative relationship between patient and therapist, has been found to be associated with clinical outcome across a range of psychological therapies and clinical conditions⁴¹. Recently Krupnick et al⁴² for example, have found therapeutic alliance to predict outcome in placebo and clinical management control trials of psychological and drug therapies, suggesting therefore that alliance may be significant in the treatment of emotional problems by other than specialist psychological therapists.

The paragraphs above have highlighted some of the issues against the argument that the associate clinical psychologist needs to be a psychology graduate as a pre-requisite, but what of the case for the psychology graduate?

Does the Associate Psychologist Need to be a Psychology Graduate?

The Argument For

Lewis⁴³ is one of the main clinical psychology authors who has pointed out the disadvantages of operating through, and thus sharing psychological skills with non-psychological professions. These include problems of quality control, supervision and authority, the degradation of skills resulting from highly selective training without an adequate base, premature autonomy in psychological work and the potential loss of standing of the training professions.

Breakwell and Rowett⁴⁴ argued that:

⁴¹ Cape, J 'Patient- Rated therapeutic Relationship and Outcome in General Practitioner Treatment of Psychological Problems' British Journal of Clinical Psychology, 2002. 39, pp383-395

⁴² Krupnick, J, Sotcky, S, Simmens, S, Moyer, J, Elkin, I, Watkins, J and Pilkonis, P 'The Role of Therapeutic Alliance in Psychotherapy and Pharmacotherapy Outcome: Findings of the National Institute of Mental Health Treatment of Depression Collaborative Research Program, Journal of Consulting and Clinical Psychology, 1996. 64, pp532-529

⁴³ Lewis (1984) quoted in Nichols, K 'Psychological Care by Nurses, Paramedical and Medical Staff: Essential Developments for the General Hospitals', British Journal of Medical Psychology, 1985. 58, pp231-240

⁴⁴ Breakwell, G and Rowett, C 'Collaboration Between Social Workers and Psychologists', Bulletin of the British Psychological Society, 1982. 35, pp65-66

“There are dangerous drawbacks, even dangers in some instances, to the free accessibility which non-psychologists have to psychological methods. The dangers thereof have been eloquently described thus: others sometimes “treat psychology like a supermarket where theories fill the shelves like cans, they take the can, open it (often without understanding the cooking instructions), devour the contents and all too frequently suffer the indigestible consequences. One of the after-effects of antiperistalsis can be abandonment of all theory.”

It appears that the arguments against other professionals being involved in psychological intervention, advanced by clinical psychology and others, have largely a philosophical base. These arguments are identified below.

The Unique Features of Clinical Psychology

It has long been recognised that psychological principles are relevant to all health professions, and various professionals routinely apply psychological techniques in their practice. As the MAS independent review of clinical psychology services suggests:

“There would be few interventions, if any, which are unique to the clinical psychologist. Any psychological approach one can think of is probably also undertaken by someone, somewhere, who is not a clinical psychologist. Their distinctive contribution comes not from any single task that they undertake, but the base from which they work and their overriding perspective.”

So what is this distinctive base and overriding perspective? Their distinctive perspective, is one that is widely known as the ‘Scientist-Practitioner’ approach, in which they use scientific method and systematic scientific enquiry to determine the way in which they practice. Characteristics of this approach are hypothesis-testing, collection of evidence to confirm or deny a hypothesis and a thorough evaluation of an intervention.

Huey and Britton⁴⁵ extrapolate this approach further to conceptualise it as using deductive and inductive approaches, when dealing with client’s presenting problems, i.e. intervention is guided by a variable integration of general principles of human functioning with more idiographic client information. Philosophically, this way of working is compatible with viewing science as an approach, rather than as a collection of facts.

The clinical attitude of this profession is described as open-minded and objective. Objectivity stems from the scientific approach to analysis and the

⁴⁵ Huey, D and Britton, P ‘A Portrait of Clinical Psychology’ Journal of Interprofessional Care, 2002. 16 (1), pp69-78

ability of clinical psychology, unlike other disciplines not to be “involved with the minutiae of day-to-day patient.” (MAS)

It has been argued that another distinctive feature of clinical psychology is the fact that these professionals are research-based practitioners, with training and more active interest in research. The reciprocal link between theory and practice means that research and theory inform and are influenced by clinical practice.

These are the main philosophical arguments for arguing that the associate clinical psychologist should be a psychology graduate as a pre-requisite, as opposed to a professional such as a nurse or social worker who is trained in psychological techniques. But is there any empirical evidence for this argument?

Empirical Evidence from Comparative Studies of Professional and Paraprofessionals

Again there appears to be a dearth of evidence comparing the significance of an academic background in psychology being a pre-requisite to the grade of associate psychologist. Perhaps the only study to compare statistically significant differences in treatment outcome of professionals over paraprofessionals was that of Carey and Burish⁴⁶. The authors compared the administration of relaxation techniques to cancer chemotherapy patients administered by professionals and paraprofessionals. It was found that professionals administered relaxation techniques with more positive results such as less gastrointestinal distress and physiological arousal and increased food intake, than the paraprofessionals.

Empirical Evidence of the Influence of Training

There has been some research evaluating the impact of therapist training on outcomes. This has largely focused on psychotherapy, and again does not directly compare psychology graduates with graduates of other disciplines such as social work or nursing. Rather it focuses on therapist training generally. Variables such as therapist personality, therapeutic style, and the therapist’s professional background have been examined. Robiner et al argue that therapist experience plays a positive role in a) decreasing the rate of clients premature dropout from treatment; b) effective treatment of difficult patients; c) administration of complex and intensive interventions.

⁴⁶ Carey, M and Boorish, T ‘Providing Relaxation Training to Cancer Chemotherapy Patients: A Comparison of Three Delivery Techniques’ *Journal of Consulting and Clinical Psychology*, 1987. 55 (5), pp732-737

Variations in therapist training levels may also influence therapists' effective use of specific techniques. Luborsky et al concluded that differences among therapists affect the process and outcome of psychotherapy. These differences, they argued appeared in part to be related to the 'purity' of the therapists' technique: that is the technical expertise of the therapist.

Although the data and quality of studies is limited, therapists' technical skills, which derive in part from training and experience, appear to influence treatment efficacy. However, to date there has been no research to indicate that this is exclusive to the profession of psychology.

Conclusions

Clinical psychology's effort to resist other professions' ascendancy in psychology on the grounds that it is dangerous to the public interest is an example of an often noted feature of professional guilds: an assumption of isomorphism between their own interests and the welfare of the society at large, even when there is no data to support such a view. From the evidence presented above it appears that the question as to whether the associate clinical psychologist grade should be a psychology graduate or other professions such as nurses, trained in psychological techniques cannot yet be answered.

Research highlighting the unique features of clinical psychologists has a philosophical, yet not empirical base. An analysis of the research literature has revealed an absence of empirical studies comparing the effectiveness of associate psychologists with a graduate degree in psychology vis-à-vis other professionals with training in psychological techniques. Research evaluating the efficacy of paraprofessionals has been equivocal: some researchers have argued that paraprofessional therapists can achieve clinical outcomes equal to or better than those obtained by professionals, whereas others have concluded that methodological weaknesses, which are characteristic of much of this research, limit the conclusions that can be drawn.

This review shows that the training in psychological techniques does not require a degree in psychology. However, psychology is more than a collection of techniques, and the role of the associate includes an understanding of formulation following an assessment. The role, also, calls on the associate to be able to refer cases onto a chartered clinical psychologist in situations beyond the competence of the associate or in situations of doubt. Whilst this may be described as a skill, it is more in the way of knowledge. It is in the knowledge of psychological theories and principles which draws the distinction between a graduate psychologist and others. It is, equally, the perspective of the psychology graduate which draws the distinction, a perspective which is embedded with an inquisitiveness to understand how and why a person thinks, feels and behaves. It is this inquisitiveness which will place the psychologist on alert for cues to matters not necessarily obvious to others.

There is a wider issue of duty of care. This concept, difficult to define, places a personal responsibility on everyone in a position of trust over others to have a wider awareness of the implications of actions. The application of psychological techniques in the absence of a wider awareness of the implications may place individuals at risk of failing in their duty of care. Psychology graduates are educated to a level of understanding about a broad range of psychological theories that form an umbrella for the application of specific techniques. This provides them with a wider understanding of implications when compared to those without a similar academic background.

Evaluating the contribution of knowledge to the work of an associate compared with the knowledge of other disciplines undertaking level 2 work is a line of enquiry which needs further investigation.