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National Institute for
Mental Health in England



The
British
Psychological
Society

New Ways of Working for Applied Psychologists in Health and Social Care

Models of Training

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The British Psychological Society

St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK

Tel: 0116 252 9568 Fax: 0116 227 1314 E-mail: mail@bps.org.uk Website: www.bps.org.uk

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Executive Summary

A Training Model Group was assembled with representation from all applied psychology Divisions and major Boards of the British Psychological Society as well as service users and commissioners. The remit of the group was as follows:

1. To review current training models in applied psychology, strengths and weaknesses, including current capacity and application rates, BME and gender ratios;
 2. To generate some radical alternatives which address overarching NWW themes such as inclusion, increasing access to psychological therapies and capacity building, service user perspectives, unification of applied psychology training routes, flexibility, Accreditation of Prior Experience and Learning, step-on/step-off pathways;
 3. To consider the undergraduate curriculum and what constitutes the Graduate Basis for Registration;
 4. To develop criteria for evaluating training models.
- Some of the drivers for change considered by the group included unification of training routes, increased inclusion of psychology graduates in health and social care roles, and integration of new roles into training pathways.
 - The group assembled summaries of current applied psychology training models associated with the Society's Divisions and evaluated these in terms of strengths and weaknesses.
 - By an iterative process of progressive consultation with Divisions and their training communities, the group developed a number of radical new training models. These were tested out through the process of robust debate and consultation. Ultimately this has resulted in the drawing out of a number of key principles:
1. A progressive, pre-doctoral training pathway for psychology graduates that populate NHS pay bands 4 to 6 needs to be developed, that leads directly into doctoral training (this should not serve to exclude other, flexible and diverse routes into doctoral training); such a development would make a significant contribution to the NHS workforce by providing capacity and competences relevant to Improving Access to Psychological Therapies and other health improvement programmes whilst creating inherent clinical governance, accountability and supervisory structures which would protect the public interest;
 2. Existing doctoral applied psychology training courses should offer training for this pre-doctoral pathway that is relevant to these roles and which provides a progressive, coherent curriculum integrating with doctoral training; commissioners of training should be encouraged to fund such developments, although *not* at the cost of reducing doctoral commissions;
 3. The Membership and Professional Training Board of the Society should develop accreditation mechanisms and criteria for such pre-doctoral training;
 4. The applied Divisions and their training committees should explore jointly areas of their curricula where generic or unified training might be feasible; and
 5. Existing applied psychology training courses should provide an increased emphasis on supervisory and leadership skills.

These principles should form the basis for further dialogue with the Boards of the Society, training commissioners and NHS employers.

1. Introduction

The psychological revolution in health and social care in the UK, which arguably began in the middle of the last century, is now well under way, such that psychological concepts, interventions and approaches are ubiquitous in health care policy and practice.

The NWW projects represent a range of proposals to address these substantial changes in the contextual topography of health and social care in the UK, and to modernise the applied psychology workforce relevant to health and social care with particular reference to adult mental health, so that it might be more 'fit for purpose'. Such proposals also imply review, if not modification, of training.

Change has also been taking place in applied psychology training: the postgraduate clinical psychology doctoral training model, established more than a dozen years ago, is being implemented (in some form) in other areas of applied psychology such as educational, counselling, health and forensic psychology; training routes have become more clearly specified and rigorous regulation by the professional body, the British Psychological Society, has raised standards of both training and practice. Recently the Society has promulgated the competency-based specification of training and benchmark standards, and this has clarified both the skills of the profession and the associated learning outcomes of pre-registration training programmes.

However, despite representations to central Government, funding for postgraduate training in applied psychology remains highly variable. Clinical psychology (the largest applied psychology grouping in health and social care) has generally been adequately resourced, although training commissions have consistently failed to meet the demand for qualified clinical psychologists. Despite the aspirations of a large number of highly qualified and high calibre psychology graduates, each year only a minority are successful in obtaining training places on doctoral courses. Although the rate of expansion of clinical training over the past 50 years has been exponential, there are currently clear indications of a plateau.

Counselling psychology and health psychology have arisen as independent applied psychology specialties in the last 15 years with their own training routes and evolving competency profiles, and although individuals from these emerging groups have gained access to NHS and other health care employment, conspicuously they have been unable to obtain funding for training. Counselling and Health Psychology presently are largely dependent on individuals funding their own training pathways.

Educational psychology has recently adopted a doctoral training model which has received government recognition, and has a funded training route the details of which are yet to be finalised in England.

Traditionally the prison service has been the main provider for funding within forensic psychology. The probation service has also funded training in recent years as has the NHS and health providers in the private sector.

Why change?

The current clinical doctorate model has been hard-won, enjoys a good deal of confidence, and has promoted high standards in clinical psychology training and professional practice. The model of a three-year postgraduate doctorate is being replicated in other applied psychology specialties. Negligible attrition rates through the postgraduate training pathway are unparalleled and the envy of other health care professions with 95 per cent of those entering clinical psychology training taking up NHS posts on qualification. This clearly represents good value for money from a training commissioning perspective. Thus many ask 'why change?' and invoke the old adage 'if it ain't broke, don't fix it'.

A number of difficulties that have become increasingly apparent in recent years and which might argue for a review of the current model are discussed below.

The need for greater inclusion of psychology graduates in training and career routes

Many more high calibre psychology graduates have been excluded from clinical psychology training courses than those who have been included, and no other viable careers in health and social care have been made available. Around 15,000 people graduate with a degree in psychology each year, and surveys suggest that up to 40 per cent of these would be interested in a career in health and social care if it was available to them. This is in stark contrast to the recruitment situation in other health care professions such as nursing which struggle to admit expected and required quotas of students.

In the face of a pool of such relatively untapped talent, increasingly we are witnessing the development of other training routes for psychology graduates such as Graduate Primary Care Mental Health Worker schemes. The relative lack of association with existing applied psychology services has meant in many cases there are problems of career progression, clinical governance, appropriate professional supervision and accountability. Moreover it is these individuals and their posts that are perceived to be a threat to doctoral psychologists since at least part of the motivation of commissioners is to create a cheaper service with a lower level of skill-mix.

Lack of coherent career and training progression for Psychology graduates wishing to work towards a professional career in Psychology

There is a hiatus in training for Psychology professions which often leaves Psychology graduates isolated, building up experience in applied settings in an ad hoc, piecemeal fashion often without ongoing support for their learning, without the opportunity to share the learning experiences of others working/volunteering in similar roles and without encouragement to reflect on the skills and competencies they are acquiring.

The need for governance and accountability irrespective of Division

An important secondary effect of the specification of training and career pathways is the intrinsic governance and accountability of training grades to qualified members of the profession. Although not the primary intention of training, nevertheless this affords a substantial measure of protection for the public and vulnerable client groups. This is of particular significance at the present time when the external regulation of pre-registration and training grades remains uncertain. Recent schemes involving the employment of psychology graduates who offer services to clients without direct reference to qualified applied psychologists have raised concerns about governance, accountability and the extent to which these individuals' graduate calibre is being properly exploited.

Absence of consideration of the connection between training pathways and service structures

Hitherto scant regard has been paid to the impact of clinical psychology training routes on service provision and the structure of services. Trainees have not been formally included in service contracts and no attention has been paid to creating planned service structures involving assistants with clear career pathways or progression.

Given the context of increasing recognition by NHS managers of the need to employ psychology graduates in relatively low-level, protocol-driven roles, it seems imperative that applied psychology services create coherent structures for such people which are led by psychologists rather than accepting the development of piecemeal graduate employment schemes without direct accountability to applied psychologists. Such structures would ensure appropriate clinical governance and accountability, and would enable the proper exploitation of the employees' postgraduate calibre.

Difficulties in attracting men and BME groups into the profession

The applied psychology profession has attracted a majority of women of heterogeneous backgrounds, age and life experience. However, many other groups are under-represented.

There is now emerging evidence that the uncertainty and ambiguity of the clinical and applied psychology training routes act as a deterrent to people from ethnic minorities and men to consider applied psychology as a serious career option, and inadvertently we may have institutionalised what is undeniably a largely white and female profession.

Applied psychology is predominantly female numerically (although like many other professions, males are well represented at the most senior levels). These demographic biases reflect to a degree the composition of undergraduate cohorts (Turpin & Williams, 2002). Nevertheless, generally people from ethnic backgrounds are less likely to be successful when applying for clinical psychology training, and a smaller proportion of the undergraduate cohorts actually apply (Turpin & Fensome, 2004; Phillips *et al.*, 2004).

Competence convergence in the context of bewildering complexity

Increasingly the competences of counselling, health, forensic and clinical psychologists have been converging. Many pre-qualification training courses in counselling psychology now boast training in psychometric testing, psychopathology and CBT, in common with clinical psychology training. This makes for a great deal of confusion for service commissioners, service users and the Department of Health, giving rise to questions about the unification of training and simplification of the denominations of applied psychologist. If it is true that several Divisions share a number of common competences which are practiced within the same or very similar health and social care contexts, then arguments for some degree of training unification seem strong. Indeed, the Society's National Occupational Standards Project and Committee have identified common competencies between applied psychology divisions, and these are far more numerous than the shrinking areas of distinctive competence.

The above represent some of the factors which have prompted and shaped the debate, and this has resulted in the development and consideration of a number of alternative models of training in applied psychology. These are described and evaluated in subsequent sections.

2. Scope, Purpose and Remit

The NWW in Applied Psychology projects represent the continuing evolution and implementation of the Department of Health's modernisation agenda, which seeks to update and modernise the structure, function and flexibility of the healthcare workforce. They follow on from the NWW for Consultant Psychiatrists Project and along with similar developments in other health care professions, contribute to the multi-disciplinary integration and modernisation of the workforce. In practice this means:

- The development of associate practitioners, access to traditional career pathways by nurses and others, step-on step-off career grades and routes.
- Client-centred care, improved access to services, incorporation of client views of training and career pathways.
- Workforce and training design that supports stepped care pathways.
- Better inclusion of minority groups.
- Simplification of training pathways in applied psychology and facilitation of non-clinical applied psychologists to work in health and social care.
- Clearer specifications of generic competences and correspondence with training and career pathway grades.

In addition, all seven project groups have been required to take account of the following general issues:

- Service User's perspectives.
- Diversity and social inclusion.
- Registration and regulation.
- Multi-professional perspectives.
- Life-long learning and CPD.

The NWW in Psychology projects are a joint enterprise between NIMHE/CSIP and the British Psychological Society. The Training Model Project Group includes representation from most applied Divisions and their training committees, and the major Boards of the Society. Although the Group has tried to be inclusive of all applied psychology specialties and their Divisions, because of the nature of the Department of Health sponsorship, specification of remit and consequent health care emphasis, inevitably some have felt that the project has been less relevant to their Division than others. Nevertheless, a key issue within the project group (and hence the inclusive nature of its constitution) has been the possibility of some degree of training unification across different applied psychology specialties.

The remit of the Group has been to:

- Review current training models in applied psychology and collect information on capacity, application rates, gender and BME ratios.
- Generate radical alternatives which address inclusion, access to psychological therapies, capacity-building, Service User perspectives, unification, flexibility, AP(E)L.
- Consider the Graduate Basis for Registration as specified by the Society and its associated curriculum in terms of its relevance to health and social care.
- Develop criteria for evaluating models of training in applied psychology and use these to evaluate both existing and new models.

This report represents the culmination of the NWW Training Model Project Group's deliberations and includes both alternative models and recommendations. Moreover, although this report is seen as the starting point for further consultation and dialogue with stakeholders, a good deal of iterative interaction with applied psychologists, Divisions and trainers has already taken place and this is reflected in what follows. Irrespective of the impact of the specific recommendations of the Group, ultimately it is hoped that the report will provide the basis for further debate within the profession and its applied Divisions, and also within the Boards of the Society. It may also provide a framework to assist commissioners of training in the piloting of innovative models.

3. New Models

The next section outlines a number of alternative training models to those that currently exist in applied psychology.

Some background issues

Modularisation

Given the potential overlap of competences between different branches of applied psychology referred to above, one approach might be to modularise to the point where specific skills are trained to a high level and examined within specific, self-contained modules, which are accessed within the context of pre-registration/pre-chartership training by the whole range of applied psychology professions. Thus for example, there might be a module on psychometric testing in a health care context, or one on cognitive behaviour therapy. Trainees from a variety of backgrounds such as health or forensic psychology might be able to undertake such modules alongside clinical and counselling psychology trainees. In effect, such modules would appear as options within an overall training framework, subject to the preferences and career aspirations of individuals. One problem with this approach is that it would be difficult to inculcate any sense of coherent professional identity and values within a specific applied psychology profession, or indeed to be clear about unique competences of any one profession.

Increased modularisation, however, does offer the advantage of increased flexibility of progression through training, and clearer pathways to instituting Accreditation of Prior Learning (APL) or Accreditation of Prior Experience and Learning (APEL) procedures. Such an approach is consistent with the 'skills escalator' model set out in the NHS plan which encourages free and flexible movement of individuals across professional career pathways.

Presenting a clearer and more coherent training pathway

One of the obstacles to diversity of intake is that clinical and applied psychology do not present a clear, coherent and unambiguous training pathway to young people, and this uncertainty counts against applied psychology as a serious option for many people from ethnic minorities where concrete vocational pathways such as those offered by medicine, law and engineering are valued by parents, families and communities (Arnold *et al.*, 2003; Morris *et al.*, 1992). These issues may also be relevant to men, who, rightly or wrongly, may feel the need to adopt career pathways that are associated with a degree of financial and career progression security since they may envisage being the primary provider for future dependents. The presentation and publicising of a common or typical training career progression does not have to be at the cost of current experiential and age diversity; it would be perfectly possible to promote a standard pathway whilst preserving a considerable degree of flexibility in admission routes.

Taking account of the link between training structures and pathways and service structure – Mushrooms and Christmas trees

Historically clinical psychology training structures and pathways have taken no explicit account of the impact on service provision and the structure of services. This is in marked contrast to, for example, our medical colleagues, where training routes are integrated in to service structures. The profile of clinical psychology has been likened to a mushroom, in which assistants and trainees form a narrow base which broadens out into a much larger number of qualified individuals employed on bands 7 through to 8, with fewer on band 9. It is arguable that this structure may not be best fit for purpose, and what is needed is a profile more like that of a Christmas tree in which there is a much broader base, with lower grades delivering more basic and protocolised interventions under the direction and supervision of more qualified applied psychologists. Conversely it might be argued that applied psychologists do not need to adopt pyramidal psychological service structures since their role is to advise and supervise other health and social care professionals such as nurses, occupational therapists, social workers, etc. However, applied psychologists have no formally recognised jurisdiction or mandate over other professions and have struggled for many years with service managers over the legitimacy of such activity. Despite the length and advanced level of training of the applied psychologist, there has been no automatic recognition within

services of psychological competence over and above other professions. At the same time, the Department of Health and primary and secondary care services have become aware of the large number of high calibre psychology graduates who seek a career in health and social care and have created new posts for such people without explicit reference to existing applied psychology services.

In addition, partly as a result of the implementation of Agenda for Change and the contribution to service delivery currently made by Applied Psychologists there has been recognition that Applied Psychologists at doctorate level should be integral to the provision of leadership, supervision and consultancy within mental health and specialist psychological services. As such there will be an increased expectation of newly-qualified applied psychologists to apply these competencies, thus requiring the training to adapt and incorporate these areas.

Taking account of different structures of service delivery in specialties other than Adult Mental Health, e.g. Learning Disability

In areas where Clinical Psychologists have been hard to recruit, other models of service delivery, using a wider range of Applied and Associate level psychologists, have developed, e.g. Learning Disabilities. In this speciality it is common for a Clinical Psychologist to be managing a team that might consist of other Clinical Psychologists, Counselling Psychologists, Challenging Behaviour Therapists and Assistant Psychologists. Any new proposals must be able to include and build upon this existing diversity of service delivery.

New Training Models Considered by the Group

The following four models are those that have emerged as alternatives worthy of further exploration.

The Kinderman Model

Peter Kinderman has put forward a model which substantially unifies current applied psychology training routes (Figure 1). Following the completion of an undergraduate degree in psychology, an individual may proceed immediately to an assistant or associate post in a variety of work settings including, for example, NHS, educational and forensic contexts. After one or more years, the individual might obtain a place on a postgraduate doctoral Course in applied psychology. If the individual had gained a Masters degree during their assistant or associateship (which might represent a combination of both academic study and practical placement work) this might be taken into account such that the length of the Doctoral course could be shortened by one year by means of accreditation of prior experience and learning (APEL). If the individual was following the standard three-year doctoral route, the first two years would include a generic applied psychology curriculum. This would emphasise common competences in applied psychology, and placements would be wide-ranging, for example including experience in health, educational and forensic settings.

Only the final year of the Doctorate would include specialisation of curriculum, competence testing and placement experience related to a specific type of applied psychology. This final year of training would dictate the career specialisation following qualification and chartership.

The Wang Model

This model (Figure 2) builds on the existing integrated six-year Clinical Psychology Doctoral training model at the University of Hull, in which candidates for the postgraduate phase of clinical psychology training are selected at the end of the second undergraduate year and then move, seamlessly, through into the three-year postgraduate training. More recently, Hull, in collaboration with York University, have developed a second intake arm in which selected York undergraduates enter a one-year internship following graduation before moving on to the Hull three-year doctorate. The internship year is funded by the Graduate Primary Care Mental Health Worker Scheme, and allows for York graduates to gain one year's experience in primary care under the supervision of a clinical psychologist. The Wang Model then borrows from the Kinderman Model in proposing a period of generic applied psychology training in the postgraduate phase, but this is limited to just one year, addressing the concerns of many current trainers in applied psychology that specialisation for just the final year of the Doctorate is not sufficient time to

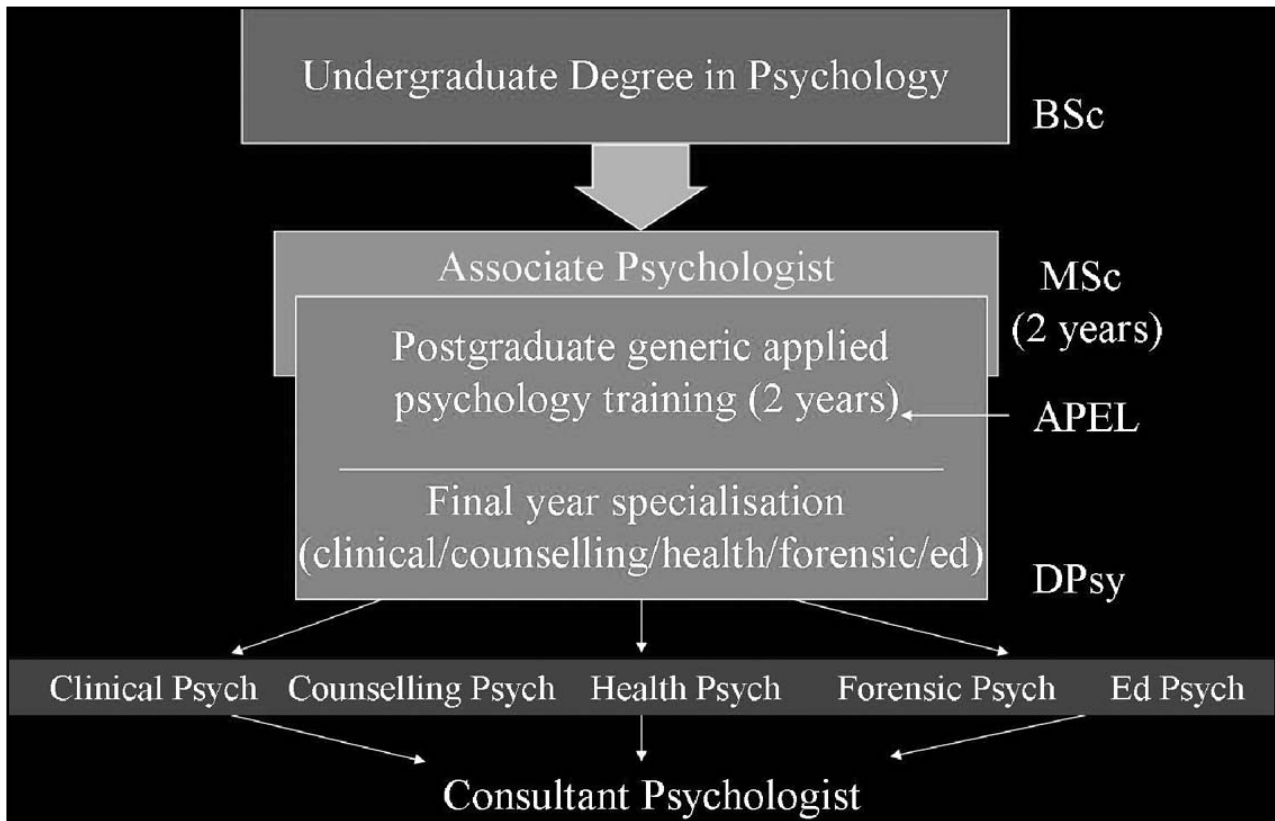


Figure 1: The Kinderman Model.

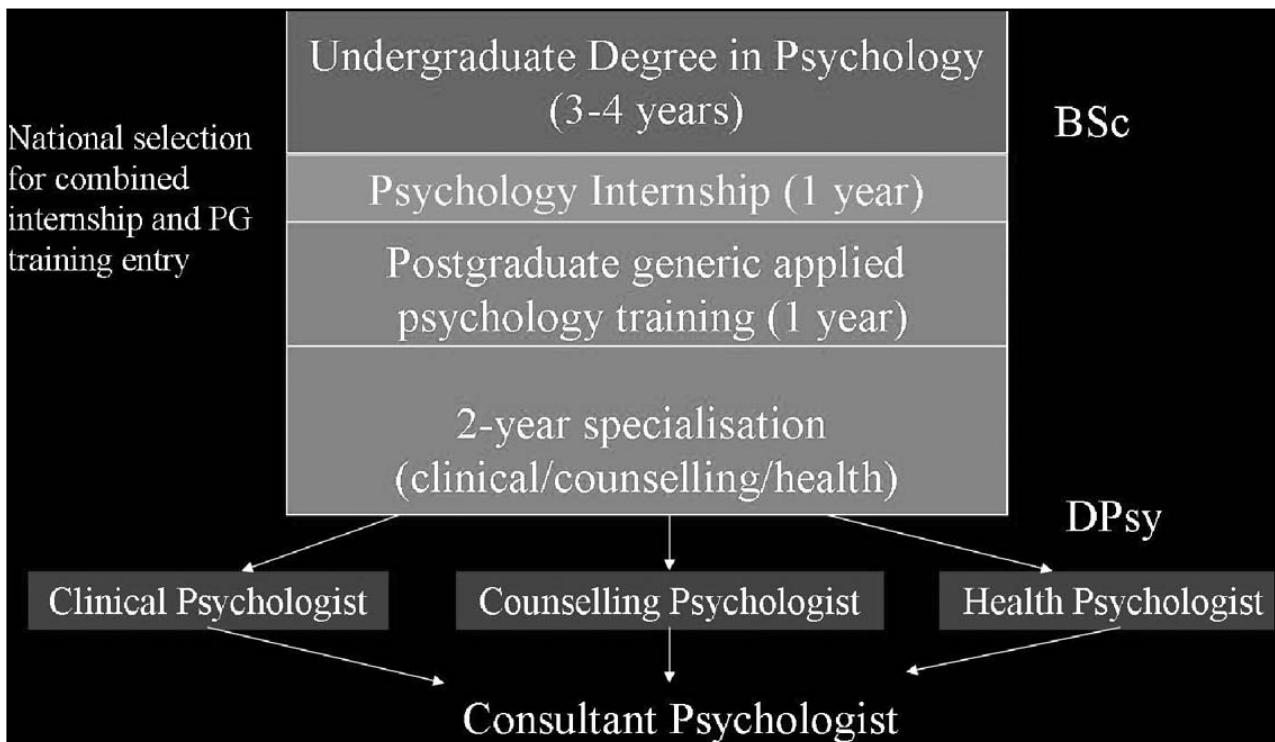


Figure 2: The Wang Model.

provide trainees with the required knowledge base and work setting-specific familiarity and competence. The Wang Model proposes a common although not necessarily inflexible training pathway which typically would take seven years with the average individual qualifying at the age of 25. It is perhaps, important to note that all three models (Hull, Hull-York and Wang) imply an earlier average age of qualification than is presently the case in applied psychology. Although this may reduce (but not eliminate) diversity in terms of age and experience, there is no reduction in gender or ethnic diversity – indeed these latter may actually be improved.

Although this is not essential to the model, Wang also proposes a national scheme of collective pooling of assistant, associate and Graduate Primary care Mental Health Worker funding and more nationally centralised control of selection to these internship posts. This would provide a means of controlling supply of recruits to the postgraduate phase training in applied psychology. The applied psychology courses might also have control of the training offered during the internship year and applied psychology elements of the final undergraduate year.

New Roles Models A and B

The NWW New Roles Project Group has been meeting in parallel with the NWW Training Model Group. The work of the New Roles Group was thought to be pertinent to the deliberations of the Training Model Group insofar as it has addressed the period between graduation and postgraduate doctoral training (whilst the New Roles have been seen as career grades in themselves, in reality many of those entering into existing graduate posts have subsequently sought and obtained entry into clinical psychology training courses). Thus the Training Model Group was kept informed of developments in the New Roles Group and these were incorporated into an integrated approach marrying the suggestions of both groups.

This proposes that there be a common (although not exclusive) training pathway moving from graduation through three pre-doctoral phases of psychology assistant, senior psychology assistant, psychology associate. Typically (although not invariably) each of these phases would last one year. Each phase would incorporate a study day training scheme in which psychology assistants would be working towards a certificate qualification; psychology associates would be working towards a diploma; and senior psychology associates would be working towards a Masters degree. It would be expected that each of these qualifications would be achieved at the end of one year of work (both academic and practice); that the Masters degree would *not* involve any research, but would simply be a taught degree; and that each qualification over the three years would represent a coherent progression of taught competences relevant to the roles. Ideally the taught component would be offered by the local Doctoral training course, thus allowing for potential integration and coherence of doctoral and pre-doctoral curricula. Thus, for example, pre-doctoral New Roles qualification curricula might include competences in protocolised brief interventions, including CBT; they might also include training in psychometric assessment under supervision, as defined in the Society's Level A specification of test competences. Such training, in addition to being highly relevant to assistant and associate roles in health and social care, would provide a very useful foundation for doctoral training.

Such a pre-doctoral training pathway, whilst being the *typical* route into doctoral training, would not exclude the possibility of individuals entering postgraduate applied psychology training from more diverse experiential backgrounds and at different stages of the progression outlined above.

Pre-doctoral New Roles posts would be funded and employed by NHS Trusts as part of their service provision. The training component would be funded by Strategic Health Authority Healthcare Workforce Directorates.

It is important to note that entry into each pre-doctoral phase (assistant, senior assistant, associate) would represent a selection point, and the progression would be characterised by falling numbers of available posts at each phase. Thus there would always be greater numbers of applicants for available posts from assistant to associate, and from associate to senior associate. Those who were not successful in moving to the next phase would occupy the same grade for an extended period – but may ultimately achieve their ambition in following years. However, the net effect would be to create a pyramidal pre-doctoral

workforce structure with a broad base. It would be important for the professional body (the Society) to regulate these pre-doctoral training grades to ensure that accredited posts had accountability, supervision and clinical governance from chartered applied psychologists. One implication is that doctoral training would allow us to include a heavier emphasis on supervisory, consultancy and leadership skills. Whilst purchasers might be tempted to create pre-doctoral posts outwith such professional structures, this could be largely obviated by Society selective accreditation of posts and training courses. Posts not meeting Society criteria would not be accredited, and these would become unattractive to psychology graduate applicants since they would not provide a route into doctoral training in applied psychology.

New Roles Model 'A'

In this model (Figure 3), individuals progress from the three predoctoral phases described above into the three-year doctoral training course. The first year of the doctoral course would be generic and shared between clinical, counselling, forensic and health psychology. It would emphasise common competencies. The second and third years would be specialised into one of the four disciplines.

Thus there are shared modules in year 1 of the doctorate; people then specialise into their chosen field of applied psychology for the following two years. Selection into the type of applied psychology could be at the start of the doctorate or towards the end of year one. Placements and teaching in year one could place greater emphasis on professional, organisational (leadership, supervision) and research skills – areas of shared competence. Years two and three would then see more emphasis on advanced clinical practice, whilst consolidating and practising the competencies acquired in year one.

Entry would be at the start of the three years, but with the facility to APL/APEL out of a limited number of modules. This process could be made co-terminus with the training supplied at the pre-doctorate level, or other entry routes (e.g. PhD), or from an entirely different route (e.g. career change) where individuals may complete the whole three year training (although GBR would need to have been obtained). This model could encompass the existing differences in funding but could also accommodate changes in this area.

New Roles Model 'B'

This constitutes an even more radical approach in which the four applied psychology specialisations of Forensic, Health, Counselling and Clinical would be entirely amalgamated, sharing a common training pathway and the doctoral phase be reduced to just two years. In this model (Figure 4) all go through the same training and share the same funding. No distinction is made between the different types of applied psychologist, thus simplifying the professional divisions, in line with the current Society emphasis on *harmonisation*.

Since the third and final New Roles pre-doctoral qualification is a Masters degree, it should be possible for this pre-doctoral training to be recognised and accredited by HEIs as contributing towards the doctoral qualification (as is the case with a research PhD). Thus individuals following this route might achieve certificate, diploma and MSc qualifications over three years and then move directly onto a two-year doctorate. Such a route would not extend the training pathway for doctoral applied psychologists: if anything, it may actually reduce the average age of qualification from around 28 as it is at present for clinical psychology to 26.

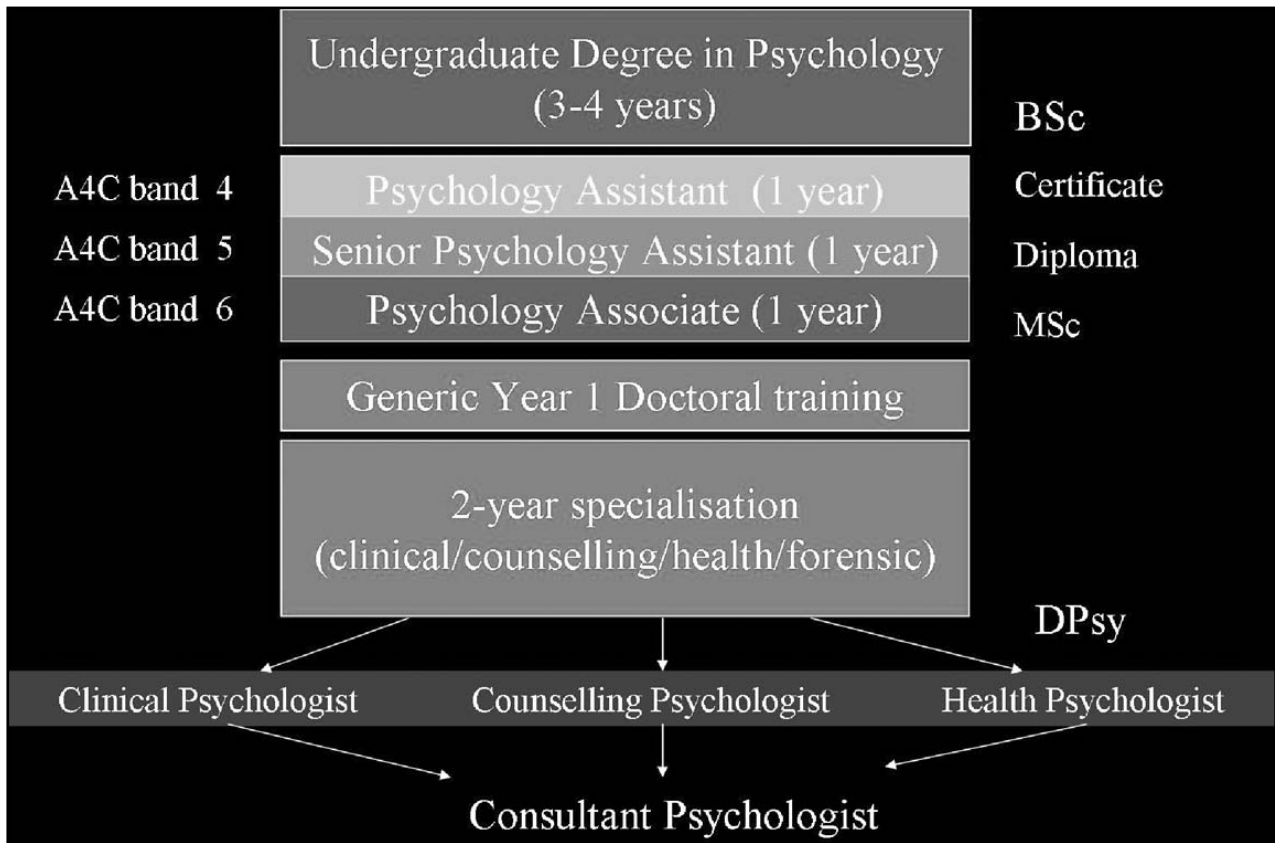


Figure 3: New Roles Model 'A'.



Figure 4: New Roles Model 'B'.

Addenda

More recent discussions have suggested the omission of the Senior Associate and Masters pre-doctoral phase, leaving a two-phase model of assistant and associate. This has the advantage of potentially shortening the pre-doctoral training period, but it would be difficult to argue for any APEL to shorten the three-year duration of doctoral training.

Which of the applied Psychologies might be integrated into this model of training is open for debate. It might be argued in the first instance that it has more relevance to Clinical, Counselling, Forensic and Health psychology training because of the degree of overlap of aspired and actual competencies, common occupational contexts and client groups in health and social care. Other applied psychology divisions might be included at a later stage, and this might require further modification of the model.

4. Evaluation of the Current and New Models

Criteria were set at the start of the NWW training subgroup by which to evaluate current and new models. The following table evaluates the current and each of the new models against these criteria. Additional criteria have been suggested as a consequence of the consultation and these have been added to the end of the tables.

These models have been discussed at a wide range of consultation meetings and circulations. The models and evaluations of them have been advanced and refined during these consultations. However, they have provoked wide debate and difference of opinion. Alternatives have been suggested mainly through GTiCP and these are presented in the sections which follow.

Table 1: Evaluation of current and new models against specified criteria.

Criteria	Models				
	Current model	Kinderman	Wang	New Roles Model A	New Roles Model B
1. Should maximise the benefits of psychology to society.	(a) Difficult to expand workforce. (b) Takes little account of previous training. (c) Competitive and difficult to get into (d) Complex. (e) Highly valued.	(a) High level of entry to postgraduate training (MSc) make it unattractive. (b) APEL makes possible shortening the Doctorate training route. (c) Does take account of experience before doctorate training.	(a) Provides increased workforce. (b) No training in internship year, although recognised that this could be addressed more at undergraduate level.	(a) Provides a larger trained workforce at bottom of the Xmas tree. (b) Fits with stepped care model.	(a) Provides a larger trained workforce at bottom of the Xmas tree. (b) Fits with stepped care model. (c) Shortens Doctorate training by APL/APEL route. (d) Makes better use of existing resources.
2. Should be inclusive of large nos. of psychology graduates.	(a) Produces very small workforce. (b) Many experienced, capable people lost to workforce.	(a) Unlikely to be funded at MSc level hence unlikely to expand workforce.	(a) Clearer pathway, but inflexible route. (b) No clear pathway for those completing internship but not getting on doctorate.	(a) More 'stepping on and off' points for graduates, with wider variety of psychology career opportunities. (b) Not just attractive to recent graduates but also those with life experience.	(a) More 'stepping on and off' points for graduates, with wider variety of psychology career opportunities. (b) Not just attractive to recent graduates but also those with life experience.

Criteria	Models				
	Current model	Kinderman	Wang	New Roles Model A	New Roles Model B
3. Should represent unified approach to applied psychology in health and social care.	(a) Trainings at Doctorate level are very 'stand alone' and un-connected. (b) Very different training pathways between divisions of applied psychology.	(a) Simplifies the process for the first part of training, but scepticism that there is enough generic content for two years, and that one year provides enough time for specialisation.	(a) One year generic training, unclear what it would involve. (b) Internships may vary considerably.	(a) Provides a unified approach through to year 2 of doctorate level. (b) Allows for specialisation for two years, (c) however, one year generic training, unclear what it would involve.	(a) Provides a unified approach throughout all levels of training. (b) Essentially does away with the different types of applied psychology, which is a profound change, requiring extensive consultation and a fundamental shift in how the profession of applied psychology is conceptualised.
4. Should not undermine quality and maintain standards of clinical governance.	(a) Good established standards and quality assurance. (b) No quality control of or coherence with graduate worker and new role developments.	(a) Problems at MSc level about how this experience might be mapped onto Doctorate programme to shorten programme through APL, given the experience might be specialist and the programme generic. (b) Content of generic two years might not allow current depth. (c) Require a lot of change and collaboration between Divisions.	(a) Unclear how internships would be regulated.	(a) Provides a clear structure of training, regulation and accountability at pre-doctorate level.	(a) Shift to generic training would require complete overhaul of all applied psychology training, governance and BPS structures. (b) Provides a clear structure of training and possibilities for regulation at pre-doctorate level. (c) Problems at MSc level about how APL/APEL might be applied to Doctorate to shorten programme.

Table 1: Evaluation of current and new models against specified criteria (continued).

Criteria	Models				
	Current model	Kinderman	Wang	New Roles Model A	New Roles Model B
		(d) However, would provide some standardisation			
5. Should equip trainees with different levels of competence within a developmental framework integrated into a service delivery model.	<p>(a) Not currently integrated.</p> <p>(b) Developmental within the trainings, but few 'stepping off points'.</p> <p>(c) Differences between trainings re: connectivity with NHS services.</p>	<p>(a) Does not map so easily onto IAPT agenda.</p> <p>(b) High level entry point.</p> <p>(c) May shorten the route to Doctorate but does not expand base much.</p>	<p>(a) No clear 'qualified' stepping off points.</p> <p>(b) High turnover of workforce as purpose of internships primarily focussed on entry to doctorate.</p> <p>(c) Does not map so easily onto IAPT agenda.</p>	<p>(a) More in line with IAPT agenda.</p> <p>(b) Provides a developmental model that might be better integrated with emerging service models.</p> <p>(c) Period between gaining MSc and Doctorate training may allow the consolidation of clinical skills allow more advanced practitioner skills, e.g. leadership to be developed.</p>	<p>(a) More in line with IAPT agenda.</p> <p>(b) Provides a developmental model that might be better integrated with emerging service models.</p> <p>(c) Simplifies the pathways to being an applied psychologist allowing greater flexibility to fit with changing service models, but some would argue oversimplifies and may result in 'dumbing down' and loss of higher level specialist skills.</p> <p>(d) Period between gaining MSc and Doctorate training may allow the consolidation of clinical skills allow more advanced practitioner skills, e.g. leadership to be developed.</p>

Criteria	Models				
	Current model	Kinderman	Wang	New Roles Model A	New Roles Model B
6. Should be inclusive of diversity.	(a) Problematic in that applied psychology professions do not tend to reflect demographic diversity of the client groups and are largely white, middle class and female.	(a) May attract more through possible shortened route, but provides few stepping off points into other possible careers. (b) High entry level into a career in psychology services.	(a) Represents a more coherent training and career pathway which may be more attractive to men and people from minority backgrounds, (b) but, may be less attractive to those coming from other careers or less traditional routes.	(a) Includes more selection steps into the process to Doctorate level, b) but represents a more coherent training and career pathway which may be more attractive to men and people from minority backgrounds.	(a) May put more steps, i.e. more selection steps into the process to Doctorate level, (b) but provides more alternative career opportunities, and more accessible qualifications, to a greater body of people. (c) Represents a more coherent training and career pathway which may be more attractive to men and people from minority backgrounds . (d) Shortened Doctorate may be more attractive to minority groups
Other Criteria					
Feasible and acceptable to NHS and HEI training providers	(a) Expectations re: expansion and new roles difficult to accommodate (b) current differences between funding, i.e. full to none. (c) Clinical psychology although fully funded perceived as expensive – but this is mitigated by extremely	(a) High costs to MSc training. (b) Some HEIs might not accept APL/APEL procedures to shortened Doctorate. (c) Not all Doctorates modularised. (d) Rationalises effort by combining elements of Applied psychology training.	(a) Some scepticism about content of a generic year. (b) Rationalises effort by combining elements of Applied psychology training.	(a) Pre-doctoral New Roles dependent on Trust investment at local level. (b) Rationalises effort by combining elements of Applied psychology training.	(a) Model only acceptable if entry to the Doctorate is still possible without going through the cert/dip/MSc route, e.g. career change. (b) High costs to MSc training. (c) Some HEIs might not accept APL/APEL procedures to shortened Doctorate.

Table 1: Evaluation of current and new models against specified criteria (continued).

Criteria	Models				
	Current model	Kinderman	Wang	New Roles Model A	New Roles Model B
	high retention rates.				(d) Not all Doctorates modularised. (e) Rationalises effort by combining elements of Applied psychology training. (f) Raises problems for how applied psychology programmes might adapt to this model where there are not other doctorate level applied programmes. (g) Likely resistance from HEIs to such large scale change.
Be affordable and attract funding into new roles.	(a) Currently worked out.	(a) Expensive and unlikely to be funded on its own, although shortened doctorate attractive.	(a) Less qualified, unregulated, transitory internship not so attractive. (b) Likely to lose all those people not successful in getting onto a doctorate from the workforce.	(a) Possibly expensive, especially MSc level, scepticism about availability of funding. (b) Fits with developing new roles, and existing pilot of associates.	(a) Possibly expensive, especially MSc level, scepticism about availability of funding. (b) Fits with developing new roles, and existing pilot of associates.
Be coherent with Agenda for Change.		(a) Problems that MSc qualification usually attracts band 7 and Doctorate training band 6.	(a) Degree level at internship does not pose a problem.	(a) Problems that MSc qualification usually attracts band 7 and Doctorate training band 6.	(a) Problems that MSc qualification usually attracts band 7 and Doctorate training band 6.

Some alternative models

The doctorate model of training has become the 'aspired to' position with many of the other divisions moving towards a three year minimum training, and it is also the only training that is fully funded. The clinical psychology doctorate is hence seen as well established, has high standards and has been seen as 'fit for purpose', producing valued professionals entering and expanding the workforce. It is, therefore, unsurprising that especially from the training community within clinical psychology there has been a strong defence of the current doctorate training along with suggestions that many of the objectives of NWW could be met whilst maintaining the doctoral programmes, and building better infra-structures around them. This has been endorsed by responses to the consultation from some clinical psychology services in Trusts. Hence, we must consider the costs of fundamental changes to a system that is seen by many as working well alongside no change but meeting these new demands by other means. A number of principles have been expressed very strongly by members of the Group of Trainers in Clinical Psychology (GTiCP) and others:

- There should be no shared pathway, and the distinct training associated with each Division should remain unchanged, i.e. the model of three-year Doctorate training.
- The current doctorate model should be evaluated alongside the new models.
- GTiCP members are not convinced there is extensive overlap between Divisions and propose that evidence should be gathered to support or refute this.

Specific alternatives have been suggested, all of which share a number of common elements that have received endorsement by the wider GTiCP and NHS clinical psychology community:

- The establishment of formal trained roles lower than the doctorate level training.
- Flexibility should be maintained so that people can enter the doctorate either through these pre Doctoral routes or straight onto the doctorate having had appropriate experience, e.g. clinical PhD, other career.
- The doctorate/applied psychology training is a developmental step between pre-registration training and post-registration continuing professional development and there is a need for this to be an integrated system.
- There is an acceptance that team functioning, leadership, supervision, and management skills need to be included in the higher levels of this framework.

5. Summary of Feedback from Initial Consultation

Funding

There is a danger that current funding might be spread across all applied psychology training and whilst giving access to other Divisions will reduce existing funding to clinical psychology.

Current training monies might be used to fund training at lower levels and reduce the overall number of doctoral commissions.

There is no guarantee that new funding for pre-doctoral training will be forthcoming.

The models assume expansion of psychological and other health care services, and this is now doubtful given the current financial circumstances of the NHS.

The new models rely on co-operation and funding from several different organisations.

Undermining of the Doctoral profession

Psychology services might be developed around pre-doctorate training grades and pay bands leading to less Doctoral level appointments.

Were any of the new models adopted, they might undermine the strengths of the current model.

Unification of training routes and Divisions

There is ambivalence and lack of clarity regarding the need to unify the different applied psychologies. This has led to variable views being held within and between the Divisions. Much more consultation is needed about this issue. There has been clear opposition to this from trainers in clinical psychology and from some NHS Trusts.

There has been strong opposition to the loss of adjectival titles and the adoption of a generic title of 'applied psychologist'. Clinical psychologists in particular have expressed much concern about this and feel it would undermine the role and profession.

Most of the models are premised on a belief that there is an overlap in training and rationalisation of this could bring greater efficiency and possibly other gains. Yet there has been no systematic investigation of overlaps in curricula.

Unification proposals ignore the importance of specific work context and knowledge base and overestimate the degree of similarity between areas of applied psychology.

Early versus late registration

A tension is emerging between the models of encouraging as many recent graduates into the profession as soon as possible and facilitating their progression through the doctorate quickly, versus another model where they are seen as consolidating their clinical experience in other mainly therapeutic roles and coming to the Doctorate later in their careers. The latter then allows them to build upon greater experience to undertake higher level, either specialist clinical or organisational skill development, and have the credibility to take on the roles of leadership and management currently being put forward in NWW. This needs to be debated and considered within the evaluation of the models.

Modularisation

Many of the suggestions being made are dependent upon programmes being modularised. In Clinical Psychology about a third are modularised. There is some reluctance to modularise Doctorate programmes for pedagogic reasons. To move to modularisation would also require another large shift and area of work for programmes.

Adult Mental Health focus

Much of the discussion and evolving ideas have been felt to be most applicable to adult mental health. There is concern that the project has been excessively driven by the Improving Access to Psychological Therapies agenda and insufficient attention paid to other areas such as learning disabilities and other minority specialisms.

Specific issues related to New Roles Models A and B

A two-year doctoral training model may not be practical: not all Higher Education Institutions (HEIs) will be able to accept APEL of MSc qualifications towards the doctoral award.

There may be A4C banding problems with MSc level training. MSc qualifications are associated with Band 7 (minimum) appointments, not Band 6. Progression through to Doctoral training might imply a demotion and pay-cut.

The assistant/associate route may actually deter BME people from a career in applied psychology.

There is a need to consider clinical governance and statutory regulation for pre-chartered levels.

General criticisms

The project is excessively focussed on the NHS context and does not take account of the more generic and broad nature of applied psychology and its Divisions.

A 'bottom-up' rather than 'top-down' review of training is needed which starts from the needs of clients and their care pathways.

6. Recommendations

There is widespread concern in the clinical training community that the NWW Training Model Project represents a significant threat to doctoral qualifications and appointments in clinical psychology. It is, therefore, important that such concerns are addressed. It is essential that NHS commissioners of training and NHS employers do not take the NWW project and its outcomes as a license to compromise future doctoral training commissions.

As indicated in section 4 of this document, of all the new models reviewed, New Roles 'A' was considered to have the most to commend it. However, although it represents even less unification of training than the Kinderman model, we recognise that at the present time there is substantial resistance to even a single year of applied generic training. This resistance arises not just from the clinical training community, but also from other applied Divisions. There appears to be less resistance to the general concept of the development of specific pre-doctoral stages and some are interested in the prospect of developing training programmes for such stages. Clearly the Divisions and their training communities need to be persuaded that there is significant overlap and that some degree of unification is justified. More evidence of the degree of overlap (or otherwise) could be obtained. The Membership and Professional Training Board of the British Psychological Society would be in the best position to undertake such a project. In the meantime, all applied training courses, and particularly those located within the same HEI, should be encouraged to explore joint training strategies in relation to both curriculum delivery and practice placements.

In view of the arguments for a more structured pre-doctoral pathway and associated training, existing applied psychology training courses should be encouraged to develop training programmes for assistant and associate psychologists, which are relevant to their roles, but which also represent a coherent training progression from undergraduate to doctoral level. NHS Commissioners of training should be encouraged to commission pilot projects of this kind. Ultimately the Society's Membership and Professional Training Board should be encouraged to develop curricula, learning outcomes and accreditation criteria for such pre-doctoral training. It is recognised by the project group that such pre-chartership training has hitherto been considered outwith the scope of MPTB's accreditation activity.

There has been much debate and a recent white paper addressing the issue of statutory regulation of applied psychology, and, in this particular context, pre-qualification and training grades. No clear proposals with regard to the latter have emerged. It is imperative that robust mechanisms for the regulation of pre-doctoral appointments in applied psychology are developed and implemented.

At the present time, Doctoral clinical psychology training courses are heavily (although not exclusively) dependent on a consistent supply of assistant psychologists from whom they select for postgraduate clinical training. There is no national oversight of the supply of such posts and this is a potential weakness. Equally, any move towards a staged pre-doctoral pathway into doctoral training would require a degree of central oversight and strategic planning to ensure supply. The Annual meeting of the NIMHE/BPS Workforce Planning Group would be an appropriate forum to consider how such central influence might be achieved.

The recent DfES document, *Review of the Functions and Contributions of Educational Psychologists (EPs)*, produced through the University of Manchester, recommends that 'professional organisations representing EPs should begin discussions about the possible eventual merger of the two professions, child clinical and educational psychologists'. Given that educational psychologists will be working alongside child clinical psychologists in the community and in educational settings, it would be helpful in the meanwhile to explore ways in which the two professions could work jointly and in a more complementary fashion.

In view of this the New Ways of Working in Applied Psychology Training Model Project Group recommends the setting up of a working group from the Division of Clinical Psychology and the Division of Educational and Child Psychology including representatives from both Training Committees to explore the possibilities of moving towards an integrated training.

The NWW Training Model Project Group has discussed the nature of GBR and its role as the gateway into applied psychology. GBR is strongly endorsed as an essential prerequisite for postgraduate training and post-qualification practice in applied psychology and it is imperative that the regulation and accreditation of the undergraduate curriculum is maintained by the Society. Nevertheless, concern has been expressed at the apparent absence of engagement between the QE Committee that reviews the curriculum and the applied Divisions. Much better representation from applied psychology should be included on this committee. Moreover, a specific project to explore the extent to which topics and competences relevant to pre-registration practice in health and social care settings could be included should be initiated.

7. Summary of Recommendations

1. The established three-year doctoral training model in clinical psychology and, more latterly, in other areas of applied psychology, is robust, has a proven track record and remains the flagship of applied psychology training; any alternative developments should not be viewed as a substitute for doctoral training.
2. Existing applied psychology training courses should be encouraged to explore shared, common modules and shared placement opportunities (where these are relevant) with other applied psychology training courses within their host institution.
3. The Society's Membership and Professional Training Board should be asked to initiate a project to identify commonalities, complementary areas of practice and differences between the applied Divisions in their training curricula and learning outcomes.
4. If significant differences emerge from such a project, these should be clearly articulated to the public and health care commissioners.
5. Existing applied psychology training courses should be encouraged to develop training programmes for assistant and associate psychologists, which are relevant to their roles, but which also represent a coherent training progression from undergraduate to doctoral level.
6. The Society's Membership and Professional Training Board should develop accreditation criteria and processes for such pre-chartership courses.
7. A joint DH/BPS project should be initiated under the aegis of the joint Workforce Planning Group to explore the strategic development of pre-doctoral posts in NHS Trusts, which is responsive to national workforce and training requirements as well as local need.
8. It is imperative that robust pre-registration regulatory mechanisms are pursued jointly by the Society and the DH, and implemented.
9. A Membership and Professional Training Board/GTiCP/Division of Educational and Child Psychology and Training Committee working group should be set up to explore joint training possibilities between Child Clinical and Educational Psychology.
10. The Psychology Education Board should be asked to initiate a working group with specific representation from all applied Divisions to review the objectives of GBR and the Qualifying Examination curriculum as a preparation for applied psychology training and practice.

8. References

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Appendix 1: NWW Training Model Project Group Membership

Members:

Prof. Ian BAGULEY
Dr Peter BANISTER
Dr Alan BELLAMY
Prof. Jan BURNS*
Mr Douglas CRIX
Dr Hazel DEWART
Ms Jacqui FARRANTS
Dr Mark FORSHAW
Mr Rob GOOD
Dr Ruth GREEN
Ms Nicola HART
Ms Suzi IYADURAI
Dr Andy KEEN
Ms Rachel MUIR-NELSON
Ms Shirley Murgraff
Dr David MURPHY
Ms Juliet REID
Dr Nicky RUMSEY
Dr Dave SHAW
Dr Ann SMYTH
Prof. Michael WANG*
Ms Fiona WILKS RILEY

Affiliation:

National Institute for Mental Health England/DH
Membership & Professional Training Board, BPS
Division of Counselling Psychology
Group of Trainers in Clinical Psychology
Graduate Primary Care Mental Health Worker
Heads of University Psychology Departments
Division of Counselling Psychology
Division of Health Psychology
Service User & Carer Liaison Committee/DCP
Psychology Education Board, BPS
Division of Counselling Psychology
Division of Educational and Child Psychology
Division of Health Psychology
Pre-Qualification Group/DCP
Service User & Carer Liaison Committee/DCP
Committee for the Scrutiny of Individual Clinical Qualifications
Division of Occupational Psychology
Division of Health Psychology
Division of Sport and Exercise Psychology
National Education Scotland
Division of Clinical Psychology
Division of Forensic Psychology

** Professors Wang and Burns co-chaired the group*