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Mental Health in England

The British Psychological Society

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

Final Report of the New Roles Project Group

Department of Health

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A. Summary

The New Roles Project Group set out to consider what roles, career structures, training and supervision arrangements should be available to psychology graduates working in (mental) health services, taking into account the available evidence concerning the effectiveness of existing pre-qualification roles and emerging new roles. In addition, the capacity available in terms of supply and training resources to significantly increase the numbers of psychological practitioners through new roles was considered. Based on its work and discussions with a range of stakeholder groups, and with reference to a vision for the development of psychological services that takes into account health policy determinants, a strategy for delivery and organisational structures, the Project Group has concluded that there needs to be significant investment in pre-qualification roles and supporting systems. This includes the establishment of a distinct career pathway incorporating three levels of pre-qualification psychologists that are appropriately remunerated, supported and regulated. A pre-doctorate academic framework will need to be developed in partnership with the providers of current doctorate in applied psychology programmes to support this expansion of new roles. The Project Group also recommends the development of a new professional grouping of 'Psychological Therapist', along with a career pathway, to be located within established psychological services departments to help meet the demand-supply gap for psychological therapies.

B. Preamble

The New Roles Project Group is a sub-group of the joint British Psychological Society (BPS) and National Institute for Mental Health for England (NIMHE) Core Group for the New Ways of Working for Applied Psychologists (NWW-AP) project that was established in July 2005. NWW-AP is part of a wider NIMHE/ Care Service Improvement Partnership (CSIP) New Ways of Working Programme. The roots of this project are clearly linked to the English NHS and related social care contexts. This has meant that those applied psychologists whose work is mostly involved with the Health and Social Care sectors (namely Clinical, Counselling, Health and Forensic) have been at the forefront of the work.

This background means that the NHS context dominates much of the thinking and considerably more work is required to think through in depth, the implications for the applied psychologies working predominantly in other contexts (e.g. education, prison services, and independent sector). It is also worth noting that the origins of the project arose from concerns about mental health services and this has influenced the scope of the work. However, there have been active attempts to adopt an inclusive approach and involve all the applied psychologies including representatives from Scotland, Wales and Northern Ireland so that lessons could be shared and the wider implications considered.

The NWW Programme is concerned with ensuring clinicians with the most experience and skills work directly with service users with the most complex needs and to supervise and support other staff to undertake less complex or more routine work (Care Services Improvement Partnership, 2006). It is anticipated that this approach will help staff groups to extend their practice and provide opportunities for new people to come into the workforce at various levels of the career framework. NWW aims to develop services that meet the needs of service users and their carers by making the best use of the current workforce, providing job satisfaction and career development for staff and ensuring value for money. More information on the NWW project can be found at: www.newwaysofworking.org.uk

The work of the New Roles Project Group is distinct to, but overlaps with that of other NWW-AP project groups – in particular the Training Models and Career Pathways groups. The New Roles Project Group was formed in December 2005 and its membership reflects the range of stakeholders involved in considering the development of new roles for applied psychologists in the context of the aims of the NWW programme. The membership of the Group can be found at Appendix 1.

C. Scope and Work of the New Roles Project Group

The brief and scope of the New Roles Project Group involved the following:

i. What roles, career structures, training and supervision should be available to psychology graduates working in health and social care and in particular in mental health services?
ii. What roles can Assistants and Associates play in ensuring improved user access to safe and effective psychological therapies services and what are the implications for training?
iii. To what extent is there capacity available in terms of supply and training resources to significantly increase the numbers of psychological practitioners through new roles?

In order to carry out its remit, the Project Group undertook the following work-streams:

1. To develop a vision for the development of new roles supported by an underpinning model.
2. To review roles Primary Care Graduate Mental Health Workers have played and may play in the future.
3. To review work in Scotland regarding development of Clinical Associates.
4. To review pilots of other new roles including Psychology Associates and Mental Health Practitioners.
5. To consider training and career frameworks for new roles.
6. To consider developments concerning regulation and registration of psychologists/psychotherapists and implications for emerging and new roles.
7. To explore ways of testing out new roles.

D. The Need to Develop New Roles

There is insufficient resource available in the NHS to meet current demand for psychological therapies and services (Department of Health, 2006; Lavender & Paxton, 2004; Sainsbury Centre for Mental Health, 2006). A recent survey of the applied psychology workforce (British Psychological Society/Department of Health/Home Office, 2005) showed that despite both demand for services and the supply of trained psychologists growing steadily at around 10 per cent per annum in recent years, there is an annual supply-demand gap of between 10–15 per cent. Based on the estimate of psychological therapists required for a typical catchment area of 250,000 conducted by Boardman and Parsonage (2005), around 12,000 additional therapists would be required in England to provide primary care mental health services. Layard (2004) estimated that 10,000 additional therapists would be required to adequately deliver the NICE guidelines.

Estimating workforce requirements is, however, problematical due to different epidemiological approaches used and assumptions about referral rates, patient throughput, and therapy modality and service models considered. The Improving Access to Psychological Therapies (IAPT) cross-government department programme Workforce Group is currently developing a model that will enable a sophisticated estimate of the number of psychological therapists required nationally to implement the stepped-care model of service provision (Turpin, Hope, Duffy, Fossey & Seward, 2006). It is anticipated that this review will corroborate the growing demand for applied psychologists and psychological therapists in the NHS and the difficulties in narrowing the demand-supply gap.

An example of the difficulty in closing the supply-demand gap is illustrated by waiting times. In early 2004 the Management Faculty of the DCP undertook an e-mail survey of its membership on the waiting times for first appointment. Sixty-seven services responded from NHS organisations in the Southern, Northern, London, Midlands and Eastern regions. The results of this survey showed that waiting times for first appointments ranged from 0 to 26 months. Forty-eight per cent (48 per cent) of the responding services had some patients waiting longer than six months for their initial assessment appointments. Waiting time pressures were most acute in learning disability, primary care, and children's services.

It is anticipated that demand will continue to increase due to a number of factors including: the increasing numbers of elderly, chronically ill and disabled people; NHS policy developments focusing on health promotion, prevention of disease, amelioration of chronic disease and disability, caring for carers, and increased access to services; efforts to reduce workplace stress; and the availability of an increasing range of evidence-based psychological interventions. For example, recent NICE guidelines on anxiety, depression, OCD, panic, schizophrenia, and eating orders have also stressed the effectiveness of psychological therapies. Further, it anticipated that the Government's new mental capacity legislation and the agreed reforms to the Mental Health Act that will involve consultant psychologists taking on 'responsible clinician' responsibilities will result in significant increases in demand. Thus, there is a clear need to consider new roles for applied psychologists as a means of meeting the increasing demand for psychological therapies and services.

E. A Vision for the Development of Pre-Qualification New Roles

Along with nutrition and genetics, behaviour is a key influence on health and well-being. In this way the science and practice of psychology can be seen as central to health and well-being. It is important, therefore, to consider how new roles in applied psychology contribute to prevention of mental health and disability problems, and the treatment and care of those who experience them. To do this it is helpful to explore current and future health policy determinants, the strategic purpose of psychological services delivery, and how these services might be organised.

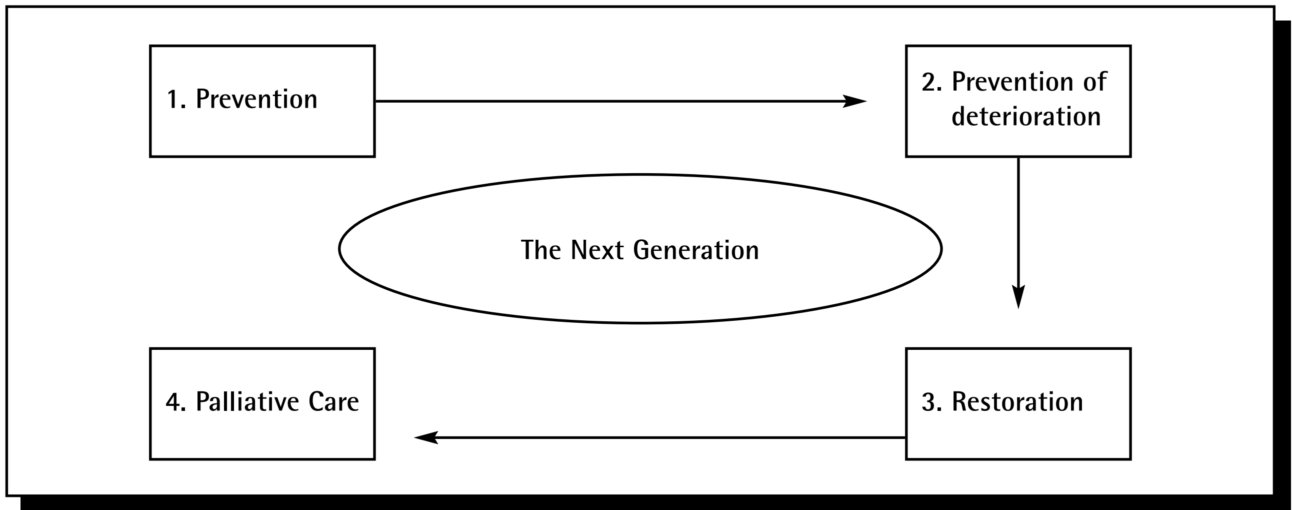
The determinants of health policy include factors such as demographics (particularly an ageing population), globalisation, scientific and technological advances, and lifestyle. Psychological theory and practice could have an impact in each of these areas through research, clinical practice, service and systems development, change and leadership. However, to have an impact on these factors, psychological services would need to move beyond the delivery of direct clinical services, and this requires the liberation of those applied psychologists with greatest skills and experience from the delivery of routine services.

Figure 1 shows health care intervention points that can guide the strategic purpose for psychological services. The purpose of prevention is to prevent people from requiring services and preventing deterioration is about ensuring that once a person requires service, no deterioration occurs from that time. Restoration relates to interventions designed to help the person re-gain their pre-morbid level of independent functioning. Palliation is concerned with maintaining the highest level of quality of life knowing that the person is deteriorating. Interventions for the 'next generation' are designed to ensure that carers are sufficiently well supported not to require further services, or to become themselves service-users in future.

Little psychological work is currently undertaken in the area of prevention. It is possible that the potential explosion of therapists will address the issue of preventing deterioration, but present waiting times for psychological services might result in this strategic purpose remaining unmet. Most activity carried out by psychological services in health and social care settings focuses on restoration, and some attention given to palliation. Virtually no activity is undertaken in 'next generation' where an increase in the amount of psychological support available could yield significant benefits in terms of health, social and economic outcomes. For applied psychologists to be more involved in a range of intervention points there would need to be a significant increase in workforce capacity and the establishment of new roles could assist with this development.

To achieve the strategic aims of increasing the psychological resources available to work on an increased range of health determinants and intervention points, the organisation of psychological services will require some re-engineering. Looking at the organisational architecture of psychological services within the health care system, currently there is an inverted pyramid configuration with the majority of posts placed towards the top of career structure (Agenda for Change grade 7 and above). There are relatively few applied psychologists populating the lower part of the structure at Agenda for Change grades 4, 5 or 6. In order to increase capacity to work in new and innovative ways, there needs to be significant developments in new 'pre-qualification' roles so that the base of the pyramid is widened.

Figure 1: Health Care Intervention Points (Mowbray, 2006).



F. Existing Pre-Qualification Roles and Emerging Roles

Since the Trethowan Report in 1977 there have been recommendations that applied psychologists should be assisted in their work by psychology graduates employed as psychology assistants. Assistant Psychologist posts have existed in many services but, in the main, tend to be funded from vacancies or short-term monies. These posts are an important part of the workforce and are easy to recruit to, but they are time-limited and are rarely considered as part of workforce establishment. In addition, the training of people in these posts is not regulated or accredited with subsequent risks to standards and qualities.

In recent years a number of new roles have been, or are being developed. These include the Graduate Primary Care Mental Health Worker (PCMHW; Department of Health, 2003), the Psychology Associate (Modernisation Agency, 2004; Taylor & Mowbray, 2004), and Clinical Associate in Scotland (Smyth, 2006). Despite funding being provided to PCTs to support PCMHW employment and training, and employment to these posts being performance managed, the target of 1000 posts in primary care by 2004 was not met. Harkness, Bower, Gask and Sibbald (2005) evaluated the effectiveness of the PCMHW development. They concluded that the scheme was successful in parts but found there to be a number of difficulties with the approach. Most significantly, the sustainability of the role is questionable with apparent issues with retention of post-holders related to poor career progression, remuneration levels, quality of support and supervision, and integration/embeddedness into host services. There is evidence that university courses supporting the training of PCMHWs are closing down as PCTs are not funding training places and cohort numbers are falling (Lavender, 2006).

The Clinical Associate scheme in Scotland, and the Psychology Associate project being piloted in the North of England, both include masters-level training for graduate psychologists. The initial one-year Clinical Associate training scheme sponsored by NHS Education for Scotland (NES) was developed by Stirling and Dundee Universities. This masters training focuses on psychological therapies for common mental health problems in Primary Care services. The scheme has not been fully evaluated to date. However, early indications are that the role is popular with no difficulties encountered in recruiting good quality candidates with just under four applicants for each place across the first two cohorts (Smyth, 2006). A high proportion of the first cohort (25/26) successfully completed training and all those completing training took up employment in NHS Scotland as Clinical Associates. A second development has recently been implemented for Clinical Associates specialising in early interventions for children and young people with mental health problems. The masters-level academic training to support this new role has been developed by the University of Edinburgh. Like the training for Clinical Associates specialising in work in Primary Care settings, this training is popular with the number of expressions of interest in this course was very high (approximately 14:1).

The small two-year pilot of eight Psychology Associates is still running but nearing completion. Five NHS Trusts in the north of England participated in this pilot, funding two-year fixed posts for 'Trainee 'Psychology Associates' at Agenda for Change band 5. In all, eight departments from the five partnership Trusts were involved offering psychological services to a range of service-user groups (working age adults, older adults, children and families, learning disabilities and offenders) in a number of settings (community, hospital out-patient, in-patient, day hospital and secure services). The in-service Masters level training model was developed in partnership with Northumbria and Newcastle Universities. The fees for the trainees' two-year part-time university training were funded by NIMHE.

Interest in the Psychology Associate posts was high, with over 400 applicants received for the eight available places – a ratio of 50:1. The training programme appears to have been largely successful with Trainee Psychology Associates reporting high levels of satisfaction with the course, and the cohort making good academic progress overall. However, feedback from trainees and work-place supervisors, corroborated by the results of placement assessments using competency checklist evaluation approach, suggests that the masters-level research component is probably not necessary for trainees to become competent and 'fit-for-role' post-training. It is likely that training could be shortened to an 18-month post-graduate diploma programme whilst maintaining standards and competencies to practice.

A survey of Trainee Psychology Associates and their workplace supervisors after 11 months of training demonstrated high levels of satisfaction with the role, supervision provision and contribution to service delivery (Jervis, 2007). The post-holders reported having experienced a mix of direct work with clients involving both assessment and therapeutic interventions, and a range of indirect work including audit and evaluation, and development of information and materials for clients and carers. They indicated high levels of satisfaction with this workload mix and balance. The Trainees were less satisfied with their remuneration (Agenda for Change band 5), and uncertainty about the establishment of role in the NHS and post-training career prospects.

The New Roles Project Team also considered the (Associate) Mental Health Practitioner ((A) MHP) scheme developed by the Hampshire Partnership NHS Trust in collaboration with Southampton University (Hampshire Partnership NHS Trust & University of Southampton, 2006). The (A) MHP scheme was introduced to help to alleviate a serious shortage of staff to work in mental health services in the Trust and the role was designed to work with people with serious and enduring mental health problems. As for other new roles, the (A) MHP scheme has been popular 100 applicants interviewed for the 25 places available in the last intake in Autumn 2006. The Trust had recruited 42 (A) MHPs in two earlier cohorts who had enrolled on the two-year part-time post-graduate diploma in 'Mental Health Studies' at Southampton University that is structured around the 'Capable Practitioner' framework (Sainsbury Centre for Mental Health, 2001). At the beginning of training (A) MHPs are placed on Agenda for Chane band 3, rising to band 4 in the second year and band 5 on successful completion of the diploma. After a further two years of practice, post-holders have opportunity to undertake a Masters level qualification following which they would become 'Mental Health Practitioners' (MHP).

The (A) MHP scheme has been successful in many respects, with post-holders in training reporting good levels of satisfaction with the clinical support they have received and the clinical activities in which they have been engaged (Barkley, 2005). There have been some difficulties, however, host service staffs' understanding and acceptance of the new role, variable management support and access to clinical supervision. It is also unclear to what extent the (A) MHP role can be viewed as a new role in applied psychology as whilst the clinical responsibilities included involvement in the delivery of psychologically informed interventions, they are accountable and report to team or ward managers, work as care co-ordinators within the CPA framework, administer medications and 'act-up' for charge nurses or senior nurse/practitioners. The main learning points for the development of future new roles drawn from the review of existing and emerging pre-qualification roles are set out in Figure 2.

Figure 2: Key requirements for safe, effective and sustainable pre-qualification new roles.

- Fit within a clear career structure;
- Be actively supervised and supported witin an appropriate professional accountability framework;
- Be integral to the design and aims of the local (mental) health service, and;
- Have reasonable levels of remuneration and prospects for personal/professional development and career progression.

G. Career Framework for Pre-Qualification Applied Psychologists

The New Roles Project Group considers the most effective way forward to increasing pre-qualification capacity to deliver psychological therapies and services safely, effectively and in a sustainable fashion, is to bring together the current assistant psychologist role and the most useful aspects of the new and emerging roles into a more systematic and coherent career framework for pre-qualification applied psychologists (see Appendix 4). This would allow the recruitment and retention of a workforce able to help meet current and future increasing demands and significantly improve access to psychological therapy and psychological services more generally.

The Project Group proposal is to develop three levels of pre-qualification workers:

- Psychology Assistants*
- Senior Psychology Assistant*
- Psychology Associates*

There are sufficient psychology undergraduates to fill such positions in that between 14,000 and 15,000 psychology graduates are produced in the UK each year, many of whom would welcome an opportunity to work in health and social services as demonstrated by the high numbers of applications to the pilot new role schemes described above. At present only a small proportion of these graduates take up Psychology Assistant posts. While a proportion of Psychology Assistants go on to take up places on clinical psychology training programmes, many are lost to the NHS as there are only around 550 funded doctorate in clinical psychology training paces each year.

It is envisaged that the creation and establishment of these new pre-qualification roles and an associated training pathway will attract more and a greater diversity of these graduates into the mental health workforce. In effect, a new attractive alternative career pathway will be available to those graduate psychologists who are not, for a range of reasons, able, ready or willing to embark on a minimum 11-year path to the consultant clinical/applied psychologist career grade; but who *are* interested in delivering psychological services and therapies directly to clients. While it is anticipated that the Psychology Assistant role will continue to be a temporary, transitional role for the great majority of people in this career pathway (although new training standards and awards will apply that the individual can carry forward), the Senior Psychology Assistant, and more particularly the Psychology Associate roles could become career grade posts for some who wish to remain in this pathway. Hence, the Psychology Associate role is designed such that the knowledge, skills and experience required, responsibilities for patient/client care, and the freedom to act (autonomy) are such that these posts will attract Agenda for Change band 6/7. This will help those who are making significant contributions to the delivery of psychological services to have a role and remuneration that enables them to remain in this career pathway if that is their preference.

It is proposed that these posts are made available to psychology graduates because they will have already completed a BPS-accredited first degree that provides a good grounding in psychological theory and concepts which are key to developing a modern mental health service. Also these graduates are available in sufficient numbers to expand the workforce rapidly and their undergraduate training requires no additional funding – that is, it is already HEFCE funded. There are, however, likely to be non-psychology graduates wishing to undertake these roles at pre-qualification levels. If it is concluded that having the equivalent of a psychology degree provides the type of grounding in psychological theory and models that enables people to perform more effectively and quickly in the new roles, then they could undertaken psychology conversion programmes available at many universities and in distance learning format from the Open University.

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*These terms adopted above have been replaced in the NWWAP Summary Report with Trainee Psychology Assistant, Psychology Assistant and Psychology Associate. This was specifically at the request of the Board of Trustees of the BPS who wished to ensure that a clear distinction was made between fully qualified Applied Psychologists, and the suggested new roles that might be developed below the current status of Chartered psychologists. This issue is discussed more fully in the Summary Report.

It is proposed that these posts and career pathways could be applied to a range of client groups (i.e. adult mental health, children's' services, older people services, services for people with learning disability, forensic services, etc) and in a range of settings (e.g. primary care, acute in-patient services, early intervention services, child and adolescent services, community mental health teams, etc.). The specifics of the roles at different levels would be dependent on the nature of the particular services where the posts are to be located. In order to illustrate how this might work, examples of main responsibilities of the three different levels of posts in are given in Appendices 2 and 3 for primary care mental health and specialist forensic learning disability services.

It is important that these posts exist within services designed to deliver psychological therapies and services. All three proposed roles in this pre-qualification career pathway are non-chartered, and thus post-holders will require on-going supervision and support from qualified colleagues. While we can expect those in the senior and associate roles to develop their ability to manage their caseloads with a fair degree of independence over time, they cannot be considered to be autonomous practitioners compared with, say, qualified clinical, counselling or health psychologists. It is crucial, therefore, that these pre-qualification posts are located within established psychological services departments/directorates in order that they are appropriately accountable and receive support and supervision from qualified staff. Not only are these arrangements important in terms of post-holders' job satisfaction, and thus retention and sustainability issues, they are imperative to ensure that proper clinical governance systems are in place to set and maintain professional practice standards and protect service-users.

The advantages of the proposed pre-qualification career framework, which would overcome some of the major problems encountered with the PCMHW and other pilot new roles schemes, include:

- The provision of a clear career structure with progression routes – this would mean the excellent pioneering work and experience of PCMHWs, Clinical Associates and Psychology Associates could be built on.
- There is a large pool of able psychology graduates wishing to work in mental health services enabling these new posts to be filled rapidly.
- It would be possible to increase relatively quickly the capacity to deliver better access to psychological therapies and the psychological services.
- Complex registration and regulation issues could be managed by developing the provisional registration status that already exists within the BPS. Alternatively, proposals for the registration and regulation of psychologists to be via the Health Professions Council should take into account the need for these pre-qualification roles to be properly regulated.

H. Training Framework for Pre-Qualification Applied Psychologists

It is proposed that the education required for pre-qualification new roles would correspond to post-graduate certificate (Assistant level), post-graduate diploma (Senior Assistant level) and a masters-level qualification for the career grade Psychology Associate role (see Figure 3). The relationship and distinctions between pre-qualification and doctorate-level training for applied psychologists is described in Appendix 5.

The capacity to develop and deliver pre-qualification training courses is a potentially limiting factor on the speed with which the proposed new career pathway can be established and posts filled. Each of the pre-qualification pilot schemes described in this report (PGMHW, Psychology Associates, Clinical Associates, and (A) MHW) established *de novo* training courses to support threes developments relatively quickly in collaboration with partner higher education institutions. It is suggested that if each of the current 31 NHS-funded doctorate in clinical psychology programmes was encouraged and supported to develop a masters-level course to complement and articulate with the doctoral programmes, and each masters course offered an average 15 to 20 places per annum, then between 450 and 600 pre-qualification posts could be created each year. This would potentially have a very significant impact on the demand-supply gap for psychological therapies in the NHS, and with use of existing doctoral programme structures, materials and networks then a rapid expansion in these terms might be feasible.

If the proposed pre-qualification career framework is developed then it should be anticipated that a proportion of post-holders are unlikely to want stay in these roles for prolonged periods and will want to step-off this pathway. Modularised programmes would need to be developed to meet the needs at each level and for the different roles. Individuals could then progress through the levels, or could step-off at any level and remain at the level for as long as the posts exist. These individuals could also step-off this pathway at any level and apply for admission to applied psychology doctorate programmes (e.g. doctorate in clinical psychology courses). Thus, ways in which existing doctoral-level courses can take into account theses people's prior training and education (AP(E)L)should be explored. The Training Models Project Group has explored these issues as part of its detailed review and proposals for integrated training models.

Figure 3: Post-graduate Educational Framework for Applied Psychologists.

	Awards	*CATS*
● Training for Chartering	Doctorate	540
● Psychology Associate	Masters	180
● Senior Psychology Assistant	Diploma	120
● Psychology Assistant	Certificate	60

I. Evaluation of New Roles

Based on the approaches previously utilised in evaluating pre-qualification new roles and pilot schemes, a core set of criteria for judging the effectiveness of any new roles is proposed, that includes the extent to which the new role(s):

- Increases the resources available to deliver (stepped care) levels 2 and 3 psychological services and therapies.
- Increases the resources available to deliver (stepped care) levels 4 and 5 stepped care psychological services and therapies.
- Supports and adds value to the work of chartered psychologists working at (stepped care) levels 4 and 5.
- Can address the issues of demand and supply for psychological resources quickly and without compromising the quality standards of delivery provided by chartered psychologists.
- Can be supported and regulated by the BPS and/or and Health Professions Council regulatory systems.
- Encourages diversity, flexibility and accessibility and creates an alternative career pathway for those who not wish to pursue a career involving training to be a post-qualification chartered psychologist.
- Contributes to the development of psychology as a science by supporting research, development and evaluation.

It is suggested that an evaluation of the new pre-qualification training and role in relation to the criteria listed above should at a minimum include a basic comparative analysis and structured case studies. Some outline ideas on how these evaluations could be shaped are set out below.

Comparative Analysis

A comparison of the costs and benefits of the new role and training with roles that are conceptually located just above and just below the new grade in terms a 'skills escalator' would be helpful with the evaluation. In addition to the criteria for evaluating effectiveness listed above, other issues that could be addressed in this part of this analysis include:

- Ease of recruitment and retention to the new roles.
- The impact of new roles on waiting list times and other relevant service-specific performance indicators.
- The effectiveness of the new roles in terms of clinical outcomes.
- The extent to which the new roles can address the issues of demand and supply for psychological resources quickly and without compromising the quality standards of delivery provided by chartered psychologists.
- Sustainability of the new roles in the workplace.

Comparison groups that might be used in this analysis include Trainee Clinical/Health/Counselling/Forensic Psychologists and existing PCMHWs and (Higher) Psychology Assistants. Study participants could be a range of stakeholders including trainees, trainers, service managers, workplace supervisors/line managers, service and training commissioners, service users, and workplace colleagues. Methods and procedures would involve:

- Survey questionnaires including rating scales conducted with a range of stakeholders;
- Detailed structured interviews with a sample of stakeholders, and;
- Quantitative data: demographic data; selection data; training process and outcomes; caseload/mix; clinical outcomes; waiting lists; etc.

Dependent measures would include:

- Recruitment ratio applicants: places;
- Training completion/attrition;
- Waiting list times;
- Clinical outcome measures;
- Other performance indicators, and;
- Survey questionnaire and structured interview coded data.

Multiple Baseline Single Case Studies
Within an N=1 design, a staggered baseline could be recorded across a series of competencies within the new role trainee's training programme. This could consist of either a series of teaching workshops, and/or clinical experience whilst on placement. In terms of the former, discrete aspects of the training programme could evaluated within this multiple baseline design. Alternatively, a series of significant clinical competencies that are to be developed on placement could be similarly entered into a multiple baseline design. In this design, enhancements in competence demonstrated in relation to 'skill 1' are controlled for by the anticipated absence of changes in the proficiency in relation to 'competencies 2 and 3', etc. After obtaining a steady baseline, competence 2 then becomes the target of the intervention while competence 3 is left again as a control for the individual's development. Lastly, competence 3 is manipulated and ideally a step-wise enhancement in proficiencies is demonstrated. As this is a rigorous design, it has the potential to enable causal inferences about the effectiveness of the training programme(s) to be drawn.

J. A Psychological Therapist Career Pathway

The Project Group's discussions about pre-qualification posts led to consideration of the interface of this career pathway with the career pathways for post-qualification applied psychologists and others involved in the delivery of psychological therapies. A potential model was developed and is illustrated in Appendix 4. This proposes an applied psychology pathway, a parallel pre-qualification career pathway, alongside an additional career pathway for staff whose work focuses on delivering psychological therapies. This model involves the development of a new professional grouping of 'Psychological Therapists' and a career pathway for those specialising in the delivery of psychological therapies. This proposed arrangement would help with the significant resource issue of non-psychologists staff with training and qualifications in psychological therapies not having the organisational support, supervision or opportunity to deploy their skills (Turpin *et al.*, 2006). These difficulties result in the loss of a potentially significant resource in terms of psychological therapy capacity being lost in the system that could be harnessed to increase access to psychological services. For example, Brooker and Brabban (2004) surveyed graduates from a psychosocial interventions programme and found that only a proportion of those with these newly acquired and valuable skills were employing them in the workplace.

This new career pathway would be open for the (Senior) Psychology Assistants and Psychology Associates but would also be open for those with other professional trainings (e.g. nursing, social work, OT) who wished, after the appropriate training, to become Psychological Therapists. Psychological Therapists are likely to be competent in one particular type of therapy (e.g. CBT, systemic therapy, etc.). It is envisaged that these staff would sit organisationally within established psychological services department/directorates with appropriate remuneration under Agenda for Change and with the infrastructure designed to support their therapeutic work, provide appropriate levels of supervision and ensure adherence to clinical governance standards. Staff would only be nominated for specialist psychological therapy training, or employed from training programmes as Psychological Therapists when there was a clear and agreed role within the service/ organisation for them to take up.

This proposed Psychological Therapist career framework and organisational positioning could help to solve a number of problems faced by the NHS and provider Trusts, including:

- Increasing the number of people with appropriate training offering psychological therapy.
- Avoiding staff being funded on training programmes only to return to services where they cannot practice the therapeutic approaches they have been trained to use (i.e. ensuring more effective use of training monies).
- Helping Psychological Therapist staff in the development of a professional identity and link them in to structures where they can receive appropriate clinical supervision and support.
- Helping with regulation and patient safety issues through creating a coherent staff group that would relate to agreed practice standards and appropriate clinical governance structures.
- Helping align specialist Psychological Therapist staff professionally, organisationally and for remuneration purposes.

A debate is still needed with the other professional groups about whether the existing professions, once qualified to deliver psychological therapies, would wish to remain as a specialist within their original profession or move to being within a psychological therapists' career framework. However, in the spirit of increasing choice, diversity and career development opportunities in the mental health workforce, this framework might be available on a voluntary basis to those who have already trained as psychological therapists but who wish to retain their core professional identity – with an expectation that those developing these skills through NHS supported training programmes in future will move into the psychological therapist career framework on completion of their training.

K. Recommendations

Based on its work and discussions with a range of stakeholder groups, the New Roles Project Group makes the following recommendations for consideration:

i. A distinct career pathway for pre-qualification psychologists should be established that is linked to and articulates with the pathway for applied psychologists.

ii. A broader base of three levels of pre-qualification psychologist posts should be developed within this career framework: Psychology Assistant, Senior Psychology Assistant, and Psychology Associate (Footnote 1, page 13).

iii. These new roles should be regulated within the proposed regulatory framework under the auspices of the BPS and/or Health Professions Council.

iv. The new roles should be realistically and fairly remunerated in order to provide attractive, alternative career pathways that are stable and sustainable and encourage diversity and inclusion.

v. A training framework incorporating awards at post-graduate certificate, post-graduate diploma, and masters-level should be provided to support the pre-qualification career framework.

vi. The training framework should be developed, as far as possible, in partnership with institutions currently accredited by the BPS to provide applied psychology programmes.

vii. A potentially new professional grouping of Psychological Therapist along with a career pathway should be developed that is located within established psychological services departments/ directorates.

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Appendix 1: New Roles Project Group Membership

Name	*Affiliation*
Professor John Taylor	Project Group Lead/Psychology Associate Pilot Project Lead
Professor Tony Lavender	Project Group Co-lead/British Psychological Society
Professor Ian Baguley*	NIMHE/CSIP
Professor Ann Smyth	NHS Education for Scotland
Laura Hamilton	BPS Division of Forensic Psychology
Dr Tony Cassidy	BPS Division of Health Psychology
Yvonne Walsh	BPS Division of Counselling Psychology
Dr Bruce Gillmer	Psychology Associate Pilot Project – Training Course Programme Lead – Northumbria University
Professor Derek Mowbray	Director, Ympactgroup
Rod Holland*	British Association for Behavioural and Cognitive Psychotherapies
Dr Greg Chowanec	BPS Division of Clinical Psychology – Managers Faculty
Rosalind Mead	Department of Health – Professional Regulation
Dr Anne McAreavey	AMICUS – The Union
Professor Ann Crosland	PCMHW Trainer – Sunderland University
Andrew Lee	BPS Division of Education and Child Psychology
Dr Judith Sheahan	PCMHW Programme Leader – Teesside University
Dr Angela Carter	BPS Division of Occupational Psychology
Robert Kidd	BPS Welsh Branch
Dr Kate Gendle	Psychology Associate Pilot Project – Workplace Supervisor
Nicola Gale*	UCL Hospitals NHS Trust
Isabel Battye	BPS Division of Clinical Psychology – Pre-Qualification Group
Diane Woods*	East Surrey PCT

**Corresponding members*

Appendix 2: Exemplar of Roles for Three Levels of Post in Primary Care Services

1. Psychology Assistant

Direct Work

- Mild mood disorders, anxiety and depression
- Facilitated self-help and CBT computerised programmes
- Exercise
- Screening for psychological health – screening instruments
- Development and facilitating the use of bibliotherapy materials
- Medication – compliance – telephone support

Indirect Work

- Signposting
- Development of resources
- MH promotion – programmes
- Facilitating patient community involvement
- Improving liaison with and between statutory and voluntary sector (patients and carers aware of access)
- Auditing projects and reviewing treatment
- Promoting patient involvement in services

2. Senior Psychology Assistant

Direct Work

- All psychology assistant work as above, taking more responsibility
- Protocol guided CBT, supervised
- Initial level of contact psychological assessment (basic CBT problem formulations)

Indirect Work

- All psychology assistant roles above, taking more responsibility
- Negotiating with secondary services – continuity of client's journey
- Linking with work related project schemes (advocacy role)
- Pathway support to other services (advocacy role)

3. Psychology Associate

Direct Work

- All previous roles increasing responsibility
- Running leading groups (anxiety, mixed mood disorder problems)
- Introduction to systemic work (programmes) protocol work children and family therapy
- More complex formulations to share with patient, GP and specialist services

Indirect Work

- All previous roles with increasing responsibility Supervision of facilitated self-help
- Implement service quality improvement
- Raise awareness about evidence (educative role)

Appendix 3: Exemplar of Roles for Three Levels of Post in Specialist Services (Forensic Learning Disability Services)

1. Psychology Assistant

Direct Work

- Screening for psychological health - screening instruments
- Supporting the work of Senior Psychology Assistant and Psychology Associate

Indirect Work

- Signposting
- Development of resources
- Auditing projects and reviewing treatment
- Promoting patient involvement in services

2. Senior Psychology Assistant

Direct Work

- All psychology assistant work as above, taking more responsibility
- Less complex mood disorders and challenging behaviour
- Protocol guided CBT and behavioural interventions, supervised
- Initial level of contact psychological assessment (including basic CBT problem formulations and basic analysis of test batteries)
- Gathering patient data for risk assessments
- Drafting of reports on assessment, formulation and interventions

Indirect Work

- All psychology assistant roles above, taking more responsibility
- Negotiating with relevant primary, secondary and tertiary services – continuity of care pathways
- Supporting work of chartered psychologists and psychology associate

3. Psychology Associate

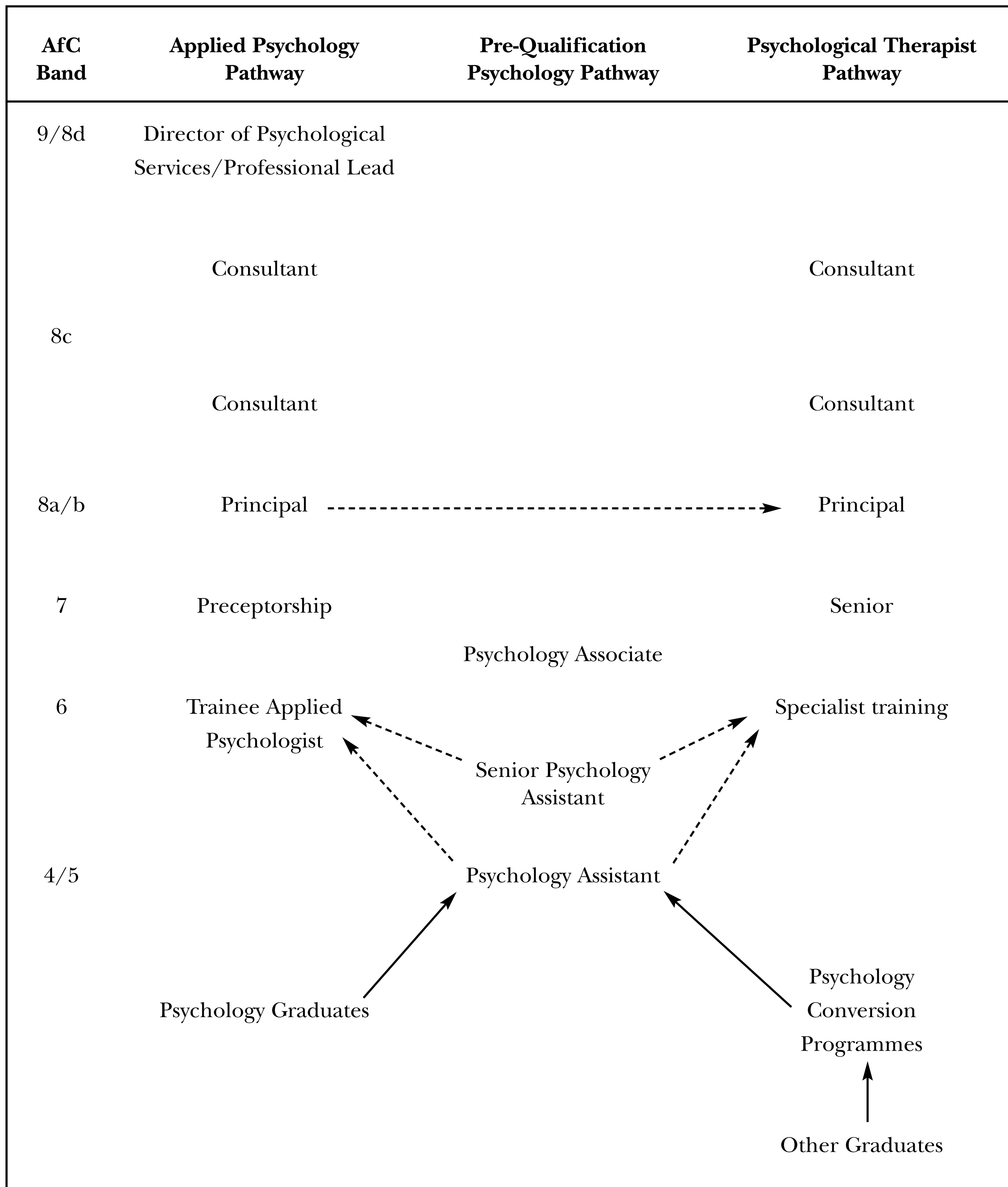
Direct Work

- All previous roles increasing responsibility (work more managed than directly supervised)
- Running and supporting groups (anger, sexual offenders, personality disorder problems)
- More complex programmatic protocol-guided work: using a range of models
- More complex formulations to share with patient, Consultant and MDT

Indirect Work

- All previous roles with increasing responsibility
- Supervision of certain psychology and senior psychology assistant responsibilities
- Implement service quality improvement
- Disseminates evidence on audits and outcomes (educative role)
- Participates in the development of new protocols for assessment and intervention

Appendix 4: Career Pathways for Applied Psychologists, Pre-Qualification Psychologists and Psychological Therapists



Appendix 5: Key Distinctions between Pre-Qualification and Doctorate Levels of Training in Applied Psychology (adapted from Taylor & Milne, 2005)

Criterion	Pre-Qualification	Doctorate
1. *Underpinning model*	'Practitioner-scholar'	'Scientist-practitioner'
2. *Range of work*	One clinical specialism ('Specialist')	4-5 clinical specialisms ('Generalist')
3. *Type of work*	Level 2: Protocol-guided, supervised practice. ('Delimited')	Level 3: Develops and adapts protocols; tackles emergent problems in systematic and innovative ways ('Unlimited')
4. *Competencies*	Four or five of six defined core competencies, to 'competent' level of proficiency	All six (i.e. inc. 'research'), to 'proficient' level
5. *R&D role*	'Implementation', especially service evaluation/audit/ benchmarking activity; 'Consumes' and 'utilises' research	Both R&D, especially 'development'; consumes, 'produces' and utilises research
6. *Degree level required to practice*	Up to Masters	Doctorate
7. *Duration of training*	Average of 18 months	3 years
8. *Lifelong learning*	Achieved through reflective practice, feedback from service implementation role, and pragmatic CPD updates and training (workshops, etc.); 'singularly self-critical' (i.e. learning impacts primarily on self and on local service: 'narrow' dissemination)	Reflective practice plus R&D linked CPD (i.e. informal methods of learning, such as from own research activity); workshops, conferences and 'master-classes' (i.e. education plus training); Contributes to national/ international service developments (e.g. through dissemination of research), and across professions-wide dissemination

Appendix 6: Guiding Principles on the Evaluation of Training Process(es) and the Value of the Pre-Qualification New Role(s) (after Milne & Taylor, 2004)

1. Context

- The evaluation should use and be guided by an explicit and widely accepted model, e.g. Quality Assurance (QA).
- The evaluation needs to be conducted in the context of, and with reference to the background, overall purpose, and aims of the new role.

2. Consistency

- The training evaluation should be consistent and comparable with competency evaluation methods used in applied psychology doctoral training programmes, e.g. training competency checklists, training logs, supervisor's feedback forms.
- The evaluation content should take into account the BPS accreditation criteria for doctoral courses in applied psychology.

3. Design of the Evaluation

- A Pre- to post-training A-B design should be used as far as is feasible in each of the areas of assessment set out in 4 below.
- Trainee competence should be evaluated in a minimum of two to three core areas of practice (e.g. assessment, psychometric testing, professional practice) using the range of assessment methods as suggested.
- Where possible the inter-rater reliability of these measures should be checked.

4. Measures

- To measure trainee competence a suitable range of creative and flexible measures should be used, e.g. essays, tutorials, quizzes, trainee presentations, video/audiotapes, behavioural analogues.
- The effectiveness of the training process needs to be evaluated by investigating the experiences of the trainees, users, supervisors and relevant others using suitable qualitative approaches to be specified by the bidder.
- An audit of the training methods should be included, e.g. checks on the fidelity of the training process, adherence to the curriculum.
- The sustainability of the role should form part of the evaluation, including investigation of the views of the graduates and employers.

5. Infrastructure and Resources

- The resources available to support the training and the role should be assessed as part of the evaluation. This would include supervision and support arrangements, assessment materials, the physical environment and management arrangements.