

The Associate Psychologist: developing the graduate psychologist workforce

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Introduction

The Mancunian Community Health NHS Trust has established a new (Trust specific) grade of psychologist, the *Associate Psychologist*, between the Whitley grades of Assistant Psychologist and Qualified Clinical Psychologist. This now seems to be general knowledge within the profession, and this article explains how and why we have taken this step, as well as discussing wider implications for psychologists in the NHS.

Why a new grade?

The NHS employs two main grades of psychological worker: the Qualified Clinical Psychologist (QCP) and the Assistant Psychologist (there are also counselling psychologists in some Trusts). Between these two grades on the pay spine, is the Trainee Clinical Psychologist grade. This is only available to people on postgraduate clinical psychology programmes.

There are many psychology graduates seeking jobs as Assistant Psychologists, usually with a view to eventual postgraduate training: our last advert resulted in 156 applications. In contrast, there is a scarcity of QCPs, especially in the less popular areas which include learning disability. There is also a bottleneck for experienced Assistant Psychologists seeking entry to postgraduate training. This situation has recently worsened with the conversion of the former Masters or Diploma level postgraduate courses to three year practitioner doctorates.

In theory there is a very long pay spine for qualified clinical psychologists from point 20 up to point 53. In reality, given the scarcity of QCPs, points 20 to 27 are rarely used. This means only half the A grade spine is in effective use. It also means that newly qualified QCPs are relatively costly. They typically engage in individual pay bargaining with competing,

prospective employers who often appear to take little responsibility in containing either unnecessary expenditure or premature rocketing through a negotiated career structure.

For our service the consequences have been:

1. A relative shortage of A grade QCPs. We have been repeatedly unsuccessful in filling the vacancies, despite being a service with a national reputation and unique opportunities for interdisciplinary work.
2. The presence of assistant psychologists with varying degrees of skill and knowledge, broadly reflecting their prior experience and their time in the service. By the time we began working on the associate scheme, three had been in post for more than the three years advised in the grading criteria, and indeed, we had placed them on permanent contracts. Two were studying for (non-clinical) higher degrees. Three had also completed a Masters level module in the analysis and intervention with behavioural challenges. All four of the assistants employed then were working well beyond the level expected of an AP. Two had additional training in counselling. These staff are comparatively poorly paid, they are valued in the service, and the service had invested considerable resources in their supervision and training. The Trust had no way of facilitating career development or acknowledging increased levels of skill. Not all of them saw clinical psychology as their future career.

First steps

A proposal was drafted that we create an intermediate grade of psychological worker, on salary scale to be defined by the Trust. The following points were identified:

1. Such posts would not substitute for the all round skills of QCPs, but would allow an enhancement over the Assistant Psychologist role, in areas of practice to be defined for each worker on the basis of training, experience and demonstrated competence.

2. Within the person-specific 'area of additional autonomy', not every piece of work would have to be supervised in detail, although there would be periodic reviews of all work with a supervisor (as should be the case with all staff).
3. These posts would still require supervision by a QCP, and this implied a finite limit to the future substitution of QCPs by these posts.
4. The posts would be established, using NHS Trusts' freedom to establish their own pay scales and conditions.
5. Funding would be from the A grade vacancy, and this would mean ruling out the possibility of recruiting a further A grade post, in the medium term.
6. Progression from Assistant Psychologist to the new grade would be on the basis of assessment of capability, rather than time served.

Internal consultation

The proposal, was submitted to and agreed by my colleagues on the management team for the Joint Learning Disability Service. We had already discussed the possibility of such a development, and were also pursuing similar 'grade/skill mix' approaches to recruitment difficulties in the therapy professions. My B grade colleagues had involvement in the drafting of the proposal.

The next step was to consult with the Director of Human Resources, and the other psychologists in the Trust (in the learning disability service and in another service). Again, after explanation and discussion, the desirability of the development was agreed.

It was around this time that the label 'Associate Psychologist' was chosen, more by the lack of any better proposals than as a result of its intrinsic merits.

Refining the proposal

The next step was to identify the criteria for progressing people from the Assistant to the Associate grade. Several frameworks were studied, including that within the BPS criteria for granting a statement of equivalence, and the curriculum for the BPS Diploma in Clinical Psychology. Some work has been done on core competencies for various areas of clinical psychology practice, but in the end the following work-based approach was adopted.

Broad domains of work content (4) and conduct (2) were identified:

For progression, the candidate will have met criteria in 3 of the 4 content domains and both conduct domains, and will present evidence of advanced study in 3 areas from different content areas.

Assessment (5 from 8 criteria)	Intervention (4 from 7 criteria)	Ethical standards (4 criteria)
è	ì	ê
CONTENT		CONDUCT
í	î	ë
Implementing Change (2 from 4 criteria)	Research & Development (3 from 7 criteria)	Personal Organisation (1 Criterion)

Assessment for progression would be based on submission of a portfolio to a panel consisting of the person's manager, professional supervisor, and the most senior psychologist in the service. This would be supplemented by an interview with the panel.

The framework allows flexibility on the part of the candidate, who can chose areas in which he or she wishes to establish capability for more independent practice. The specific criteria are ones relevant to services provided by our Trust, but could be added to.

An example of the content is as follows:

2.	<u>Intervention</u>		[Require 2 from a-e, and f and g]
a)	<u>Behavioural</u>	è	Design and delivery of interventions based on behavioural theory and formulation.
b)	<u>Cognitive</u>	è	Design and delivery of interventions based on cognitive theory and formulation.
c)	<u>Counselling</u>	è	Delivery of counselling to Service Users and their allies.
d)	<u>Social/Ecological</u>	è	Design and delivery of interventions that alter physical/social environment. (Including systems and family intervention)
e)	<u>Psychotherapeutic</u>	è	Social skills training. Design and delivery of interventions based on psychodynamic theory/other recognised psychotherapy model relevant to a specific area of work.
f)	<u>General</u>	è	Relevance, practicality and sustainability.
g)	<u>Evaluation</u>	è	Evaluation of interventions.

Because the topic areas overlap and may be added to as work or service scope changes, specific criteria have not been stated for each domain. Instead the general method of assessment is set out, together with the criteria to be applied.

These are not tight competencies, which are difficult to state categorically for work that requires judgement, understanding, and flexibility of application. However, they are supplemented by guidance to the panel on the depth and breadth of experience and knowledge required.

Experience and Understanding

1. Experience

For each domain presented the worker provides :-

* Evidence of having used the methods specified, having produced pieces of work in the area concerned; or of meeting acceptable standards.

- Examples :
- a) Case notes and/or report based on one of the assessment methods (1a and b)
 - b) Supervisor's report stating that interventions have been relevant, practical and have tackled the issue of sustainability
 - c) Written account of the use of explicit frameworks for management of change in working with a staff group

How assessed : Panel considers extracts from case notes, reports and other written portfolio material, and report from supervisor.

2. Understanding

* The worker can describe methods and approaches used and available under each heading, and critically evaluates their use.

How assessed : Interview by panel.

CRITERIA TO BE APPLIED

- 1) The worker must be functioning largely independently - i.e. can identify and select between alternative causes of action in clinical work, and evaluate their appropriateness while implementing.
Formal supervision is required no more than monthly, although the worker seeks supervisor's advice and opinion when necessary.
- 2) The worker will be functioning at an intellectual and critical level equivalent to University Master's level
i.e. they can :
 - a) Demonstrate knowledge and understanding and critical and comparative evaluation of alternative approaches to the work
 - b) Critically appraise current literature that bears on the work
 - c) Understand methodological and ethical dilemmas underpinning assessment, the design and implementation of interventions and the evaluation of interventions and services
3. The worker will have sufficiently broad experience in each domain to enable an informed choice of methods.

Staff would normally have had a minimum of two years' experience at the level of the assistant grade before being considered for progression.

The details were refined in consultation with the qualified psychologists in the learning disability service, and the head of the primary care psychology service.

External consultation

At this point, and because of the common interest in assessing learning and practice, the proposals were circulated locally for comments to the clinical psychology training courses in the region and other interested parties. Somehow, the documentation appeared on the agenda of more than one BPS committee, and the first author was asked to contribute to a task group reporting to the 'Service Development Subcommittee' of the Division of Clinical Psychology (British Psychological Society 1997a). This in turn led to the 'Stakeholder conference' (British Psychological Society, 1997b, 1998), held in October 1997, at which a consensus seemed to recognise that radical solutions should be considered in meeting the shortfall in QCPs in the NHS.

From the limited consultation, and the reactions of others who heard about the scheme, we were surprised by the interest in and support for the approach we were taking. We had expected hostility from within the profession - especially from qualified psychologists who might be forgiven for seeing the advent of associates as a threat.

Not everyone was supportive: two arguments were voiced against the associate grade:-

- a) It will reduce the number of supervisors available for clinical training.
- b) It will create a two tiered profession.

The first seemed to misunderstand the nature of the problem: assistants are already in post, and if anything the proposal would have the opposite effect, by reducing the supervision demand from assistants. The second argument also seemed to ignore that the two tiered profession was already here. Moreover, developing the graduate 'part qualified' part of the workforce could (as we argue later) begin to address the problem of the training bottleneck.

However, the consultation indicated that if we went ahead with the proposal there would not be professional opposition, and indeed there would be substantial support.

Implementation

A pay point was identified commensurate with the responsibilities envisaged. Assistant psychologists with more than two years experience were sent the agreed job description and documentation on the criteria and process for progression. They were invited to apply for regrading, by means of submission of the portfolio of experience.

The first author then met individually with those who were interested to discuss the requirements, and what they would have to submit. Four people confirmed their intention to apply. One of these subsequently obtained a place on a clinical psychology postgraduate course. At the time of writing, three assistants have stated an intention to apply for progression. Of these, at the time of writing (March 1998) one has yet to submit a portfolio, one has just submitted a portfolio which is under consideration, while the third has now made the progression to the associate grade following submission of the portfolio, and a careful process of consideration which included a lengthy interview covering the areas covered in the portfolio.

It seems likely that within a year the Trust will have a more even mix of psychological workers: assistant psychologists, associate psychologists, and both A and B graded QCPs. Some of the assistants and associates will eventually gain entry to training in clinical psychology, but for at least half of the current group of seven, this is not their aim.

Implications

To some extent, the initiative of the Mancunian Trust does no more than recognise and work with current realities. Sooner or later one Trust was bound to do something similar, and the proactive and progressive management style of the Joint Learning Disability Service (Burton

and Kellaway, 1995, in press) helped catalyse this development. We are not alone in exploring more flexible grade/skill permutations in our workforce. This Trust, for example has done the same in physiotherapy, where similar difficulties affect recruitment and these solutions have been explored elsewhere (e.g. Saunders, 1997). We have also heard that other Trusts have done something similar 'on the quiet'. Similarly the employment of counselling psychologists in the NHS broadens the skill/grade mix of the psychological workforce.

Of more interest, given the bottleneck at entry to postgraduate training, are the potential implications for future pathways to qualification as QCPs. Higher Education is changing - many courses now give advanced standing for prior learning, accredit workplace learning, allow credit accumulation and transfer, have modular structures, allowing people to assemble a qualification through their own route, but underpinned by common standards. We could deal with the postgraduate bottleneck in Clinical Psychology by learning from this, and working with the training courses to open up entry, progression and qualification to a wider spectrum of psychology graduates. Up until 1997 the profession seemed uninterested or resistant to these possibilities. We can only speculate that this is at least in part because of memories of the old 'time-served' nature of in-service training which often had little in the way of proper supervision, or of academic requirements. There is no question of going back to that - the BPS Statement of Equivalence framework itself suggests a model for a bolder yet rigorous approach to accreditation.

To illustrate, here are some possible prior experiences that could be accredited as part of the Clinical Psychology postgraduate qualification:-

1. This service runs a course on assessment and intervention with people with learning disabilities who present behavioural challenges: this is accredited by a local University at Masters level (and also at first degree level depending on qualifications at entry - the

teaching and assessment requirements differ between the two levels). Nurses and Social Services staff have been awarded advanced standing on other courses: in contrast, Clin. Psy. Doc. courses seem to have no mechanism for doing the same thing with regard to their curriculum. Yet it could be possible to recognise this accredited qualification as part completion of the learning disability and behaviour analysis requirements of the clinical psychology degree. Similarly, assistants commonly take other courses, again with no recognition for clinical qualification.

2. Work under supervision of a qualified psychologist (with various requirements in terms of breadth, depth, psychological reference, to the work) could be exchangeable for at least some of the placement requirements of the postgraduate course.
3. Some people have Masters degrees (or higher) by research - why make them do a further dissertation and research study, if their research was broadly relevant to investigation in health service settings?
4. Some graduates keep career options open by undertaking independent training in order to register as one or other type of psychotherapist. Someone who achieved such registration might again be accredited with some of the requirements of training as a QCP.
5. A more clearly modular and (optionally) part time structure to postgraduate clinical psychology courses would help open training to a wider group of people. It might be that while some qualify in three years, others take ten years, picking up credits at their own pace, and others never acquire doctoral QCP status, but establish the kind of enhanced

autonomy within specific areas - based on established skill, knowledge, and experience - that we have established within the associate psychologist scheme.

We do not want to suggest that accreditation of prior learning, modular structure, and partial qualification are some kind of panacea for clinical psychology's ills. Indeed, the cautions of those commentators who take a critical view of professions and professionalisation are pertinent to any expansionary bids (e.g. Burton and Kagan, 1982; Illich et al., 1977; Newnes, 1996; Pilgrim and Treacher, 1992). Yet an opening up of routes to the elite rank of QCPs, and the recognition (financial and organisational) of the contribution of experienced psychology graduates to the NHS are unlikely to be bad things, and could help enrich psychological practice.

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