PETER KINDERMAN *calls for big changes in training and career structures.*

The applied psychology revolution

THE training and career structure of applied psychologists must change radically. And the structure of the governing professional body – the BPS – must change too. There should be a single three-year doctoral training programme in applied psychology, with specialisation into the current branches of applied psychology in the third year; a coherent pathway for career progression from undergraduate level to consultant level; and the establishment of a College of Applied Psychology within the BPS.

Demands and challenges for applied psychology

Policy makers increasingly stress the importance of psychology within the health and social care system (for examples see the website of the Cabinet Office Strategy Unit – *www.strategy.gov.uk*). In consequence, the Department of Health suggested that the annual growth in commissions for clinical psychology training alone should be increased to 15 per cent per year – from a baseline in 2002 of around 500 training places per year (British Psychological Society, 2004a). Instead of the 15 per cent annual increase, however, recent statistics indicate a growth in the profession closer to 4 per cent a year. There have been various recent initiatives designed to meet the need for psychological services by recruiting, for instance, graduate mental health workers in primary care and Support, Time and Recovery workers. Within the 'family of psychology', there are currently discussions about possible transformations of the assistant or 'associate' role. Nevertheless, the demand for staffed services far outstrips supply (Layard Report – see weblinks).

There are also difficulties within the professional and career structure of psychology. There are around 10,000 psychology graduates in the UK each year. Perhaps as a result of this effectively inexhaustible supply, recent graduates in psychology tend to be poorly paid, poorly supported and left without a sensible career structure. Despite the pressure on delivery of services at the 'practitioner' level, most psychology assistant posts are designed to be temporary. There is no single coherent career structure, but rather psychology assistants are tacitly assumed to be collecting work experience before becoming trainee clinical psychologists. There is little emphasis on the more junior – more 'practitioner' – level of the profession. Recently qualified clinical psychologists tend to wish to progress up the career structure as rapidly as possible to become consultant psychologists. This is unlikely to meet the demand for the delivery of 'on-the-ground' psychological services.

'The diversity of training routes serves to foster envy and confusion'

There are also serious difficulties within the 'family of psychology'. Clinical psychologists, counselling psychologists, forensic psychologists, health psychologists and clinical neuropsychologists work in very similar manners, and certainly in ways that reveal their overlapping areas of competence. But their routes of training, remuneration and even professional practice guidelines are very different. This diversity leads to very significant problems. Commissioners, colleagues, employers and (most importantly) the public are confused about what different psychologists do and how they work. The diversity of training routes serves to foster envy and confusion, and discourages many valuable applicants from approaching the profession. It also seems inequitable. Finally, applied psychologists may receive different levels of remuneration under different contractual arrangements.

These difficulties are exacerbated by the fact that each BPS Division produces discussion documents, professional guidelines and recommendations for service delivery and workforce planning. Each Division has a powerful influence on training and jealously defends the distinctiveness of that particular 'brand' of applied psychology. This is confusing for our colleagues, employers and service users, which must be regrettable.

This professional schism is also intellectually unsatisfactory, because all applied psychologists share much more than they differ in. Elsewhere (Kinderman, 2005) I describe the central aspects of a psychological model of mental disorder, placing emphasis on the disruption or dysfunction of psychological processes, and the role of psychological formulation.

A solution

There should be a single route of training, and a single career path for applied psychologists in health and social care. This plan is:

- *holistic* – incorporating the training and career paths of all the current applied Divisions of the BPS
- *straightforward* – simple for observers (students, psychologists, consumers and clients) to comprehend
- *unitary* – a single career path would aid compliance with equal opportunities employment law and good practice in addressing diversity and discrimination in employment
- *suitable for lateral transfer* – people trained as one form of applied psychologist

WEBLINKS

Layard Report: *www.strategy.gov.uk/seminars/mental_health/index.asp*

National Institute for Mental Health in England: *www.nimhe.org.uk*

Department of Health mental health information: *tinyurl.com/aq6jp*

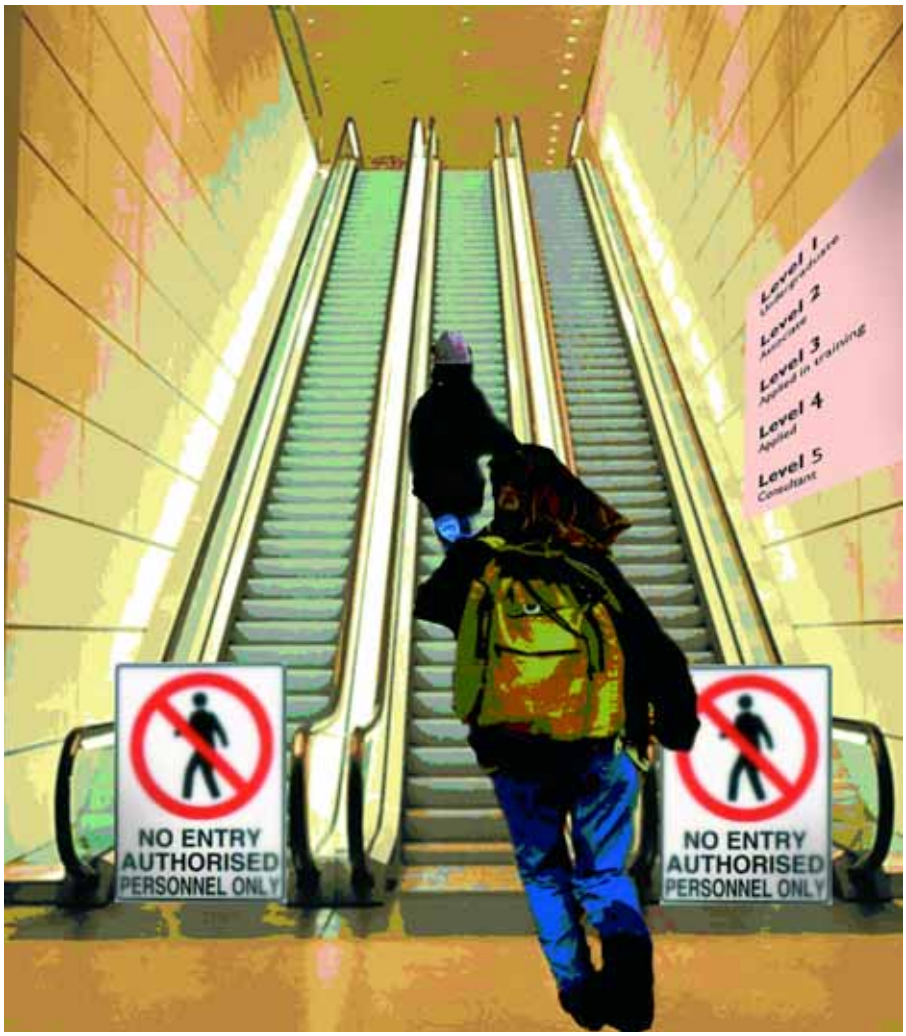
and a member of a particular Division of the BPS could become fully accredited as a different 'type' of psychologist, or a member of a different profession may be able to become thus accredited

- *escalatory* – students entering the profession at undergraduate level would see an unbroken escalator of skills and training (and responsibility and remuneration) ahead of them
- *plain* – reflecting the currently opaque truth that applied psychology is distinctive and unified, with important distinctions between specialists but with a dominance of shared rather than disparate competencies.

Commissioners, colleagues, patients and the public would 'know what they are getting'. The unified training route would enable commissioners to 'buy' what they need, while psychologists would get the structure they have always wanted. The career ladder would have the following steps.

Undergraduate psychologists (Level 1) An undergraduate education is essential in developing the knowledge base and theoretical background for the profession. Psychology education is also highly popular (the second most popular subject at undergraduate level: British Psychological Society, 2004b).

It may be beneficial to consider increased coverage at undergraduate level of applied psychology, clinical psychology or abnormal psychology. However, a major strength of the applied psychology professions comes from the application of psychological theory and knowledge base to clinical problems – rather than training in therapy. Although many psychology graduates want to work as applied psychologists in health and social care, most do not. Undergraduate education in psychology should remain pure – this education is, itself, a valuable preparation for future work as applied practitioners.



Students entering the profession at undergraduate level would see an unbroken escalator of skills and training ahead of them

Associate psychologists (Level 2) All present 'assistant psychologist' posts should be replaced with associate psychologist posts. These would be 'practitioner'-level, limited by the requirement of direct supervision, and limited to protocolised interventions. All associate psychologists would be required to complete master's level training including the '10 Essential Shared Capabilities' (Sainsbury Centre for Mental Health, 2001), including partnership working, respect for diversity, ethical practice, promoting recovery, and identifying people's needs and strengths, and providing service-user centred care.

Associate psychologists will be established professionals, and therefore be on a conventional career path. In the NHS this will be on an appropriate Agenda for Change pay band, with the consequences for career development and remunerative progression.

Applied psychologists in doctoral training (Level 3) The doctoral training programme in clinical psychology is clearly both a success and a model for other branches of applied psychology. We should build on this success with a three-year doctorate in applied psychology. This doctorate will lead, for some, to the qualification of 'Clinical Psychologist', with identical competencies to present. But the structure of training should be radically changed. Although all three years should continue to combine academic modules and 'clinical' placements – to ensure the highly valued theory-practice links – such doctoral applied psychology courses should be generic for the first two years and specialist in the third. This would offer a single route to training in clinical, counselling, forensic and health psychology. Clearly, such a development would have major implications for existing BPS Divisions. These Divisions would remain important and distinctive, but would have to work collaboratively to develop such unified training and career development. The implications for the Divisions and the wider BPS are discussed below.

This is a very challenging proposal. But a clinical psychologist should emerge with a doctorate in clinical psychology after having studied a generic applied psychology year 1 and 2, and then a specialist 'clinical' year 3. Counselling, health and forensic psychologists should emerge with doctorates in their appropriate specialities after having studied generic applied psychology years 1 and 2 and then a specialist 'counselling', 'health' or 'forensic' year 3. This element is key to the unification of the profession.

The issue of practical placements needs to be examined. First, placements in areas other than clinical psychology would need to be integrated into a training scheme. This may be difficult, and certainly would require discussions with both health and forensic and social care providers. It would also be highly beneficial to organise 'intern' places in the NHS and the other placement venues.

Planning for training placements should also be top-down. The number of generic and specialist placements in each area of psychological practice should be determined on the basis of established professional and educational need. The managers and placement supervisors offering training placements should establish, in consequence, the required number of 'intern' posts in the service. In other words, in the NHS, senior managers should liaise with the training higher education institutes to determine how many year 1, year 2 and year 3 training placements in both generic and specialist work would be required. Similar arrangements should exist for forensic and other services.

These requirements would be translated into a set number of 'intern' posts. These would be established posts, reorganised in the service, under managerial governance and with appropriate resources – rooms, desks, secretarial support. Thus a reasonably sized Department of Psychological Therapies in the NHS might have two generic year 1 intern posts, three generic year 2 intern posts and three specialist year 3 intern posts (one in counselling psychology and two in clinical psychology). Trainees would rotate into these intern posts. This idea has been proposed before (Kinderman, 2002).

'state funding should equitably be offered to all applied psychologists'

The MSc in applied psychology gained by associate psychologists should allow accreditation of prior education and learning. This will have implications for from the first generic year of the doctoral programme.

Finally, clinical psychologists' training fees and salaries are paid by the state. Forensic, health and counselling psychologists often pay their own fees for a variety of poorly coordinated training courses. A unitary training system implies that state funding should equitably be offered to all applied psychologists on the same basis as that received by clinical psychologists. Clearly this is not a trivial matter.

Clinical psychologist/health psychologist, etc. (Level 4) Following successful doctoral training, an individual would practise as a clinical psychologist, a health psychologist, a counselling psychologist or a forensic psychologist. Psychologists are proud of these titles and they do reflect different competencies as substantiated in the QAA and NOS statements.

Applied psychologists thus trained would be employed on the appropriate NHS Agenda for Change pay band (or equivalent in other settings), and progress accordingly. It is here that additional training will also be undertaken – for instance training in clinical neuropsychology. Key targets for continuing professional development (CPD) would be leadership, management and clinical governance. These will be explicitly intended to prepare the individual for the role of consultant.

Consultant (Level 5) The term 'consultant' has currency with the public and especially in the NHS. Senior and experienced (and properly trained) psychologists are expected to fulfil a range of key roles with statutory responsibilities – psychologists will be 'Lord Chancellor's Special Visitors' with powers under the Mental Capacity Act 2005 and 'Clinical Supervisors' with powers under the draft Mental Health Bill. The Department of Health's 'New Ways of Working' programme (DoH, 2004) is moving swiftly towards guidance for the employment of consultant psychiatrists (and other staff) that will effectively remove all statutory and other demarcations between medical doctors and other professions, and thereby distribute responsibilities more equitably between staff. Consultant psychologists will therefore expect considerable changes in status and working practices.

What needs to happen next?

This plan builds on the best in our profession. It will prove advantageous for the Society if a coherent and unitary training and professional career route were to foster better cross-divisional structures. A necessary next step would be to create a College of Applied Psychology within the BPS, itself comprised of Divisions (of clinical, counselling and forensic psychology, for instance). This college could act as an authoritative professional body for a development such as this.

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DISCUSS AND DEBATE

Are these proposals wise or necessary?

Do people see themselves as 'psychologists' or 'applied psychologists' or as (for example) 'clinical psychologists'?

Do we need a College of Applied Psychology?

Have your say on these or other issues this article raises. E-mail 'Letters' on psychologist@bps.org.uk or contribute to our forum via www.thepsychologist.org.uk.

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