



# **Review of Clinical Psychology Services**

**MAY 1989**

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This review stemmed originally from concern over the serious shortage of clinical psychologists working within the Health Service. Subsequently it became a major review of the role of clinical psychology.

The review concludes that clinical psychology services, as they exist currently, fall grossly short of meeting the needs for a service. Based solely on the extant increases to clinical psychologist establishments contained within regional strategic plans, there is a firm case for expanding the supply of qualified practitioners.

However, having undertaken a detailed review of the role of psychology and its potential impact on the behavioural, as well as psychological health of individuals, the conclusions of this review extend beyond proposals for increasing the size of the profession to improve its services. We recommend that psychologists become fully independent professional practitioners, accorded equal status with medical practitioners and assuming responsibility for the psychological well-being of individuals served by and providing healthcare. We therefore propose a model of service delivery based on the principle of shared care.

This option emerges robustly from the appraisal process as the preferred direction for the profession and the Health Service. It entails independent, yet integrated practice, through the provision of: direct and indirect patient care, management and organisational advice and training and research (service evaluation).

Within the balance of service provision, we recommend that greater resources be allocated to primary care than are currently, in order to introduce the serious possibility of preventing illness and promoting and enhancing health.

To achieve these aims, the review proposes a significant increase in the number of psychologists working within the NHS.

## **Summary**

### **Background to this Review**

This review was commissioned in response to the major shortage of clinical psychologists within the NHS. This resulted from a significant expansion to clinical psychologist establishments, not accompanied by a commensurate increase in training places. The loss of qualified practitioners choosing to take up employment in financially more attractive sectors was another contributory factor. The shortfall is reflected in the significant proportion of all posts which remain unfilled.

### **History of the Profession**

The profession has undergone a relatively recent evolution from ancillary service to the medical profession, operating in very confined contexts, to the clinical psychologists of today, many of whom act as independent practitioners, contributing to virtually every aspect of healthcare, not only in patient-related activities, but also in environmental, organisational, planning and managerial aspects.

### **Profile of the Profession**

The profile of the movements of the profession reveal trends with serious and worrying implications for the NHS. For example, in 1987 18% of newly qualified clinical psychologists chose not to enter the Health Service (having been trained largely at the expense of the NHS); wastage from junior grades in the same year resulted in 16.5% of all basic grades leaving the Health Service; these and other factors result in a current situation where 20% of all clinical psychologist posts remain vacant.

These factors necessitate an urgent examination of the terms and conditions of service, such to ensure adequate recruitment to the profession and retention of those within it.

The profile suggests that, unlike many other NHS professions, the causal factor of problems is not a shortage of individuals keen to pursue a career in clinical psychology - the competition for training places in 1987 resulted in there being 8.4 eligible applicants for each place. As stated above, the main contributory factor to the shortfall is a grossly inadequate number of training places.

### **The Need for Psychology in Healthcare**

We conclude that the need for psychology in healthcare is enormous, given that the application of psychology to the behavioural and psycho-social dimensions is one of very few potentially fundamental influences on the health and well-being of the population. Our subsequent recommendations are based on the following argument.

The case for the need and potential impact of psychology within healthcare is based on the amount of morbidity and mortality which could either be prevented or effectively managed by psychological intervention.

A significant proportion of illness is determined by behaviour. The estimated number of

people consulting their GP with behaviourally-related problems is thought to represent about 50% of all consultations. One can assume, therefore, that the number of people debilitated, disabled or dying from a physical illness with a behavioural cause is very high. In addition to this, about 15% of the population present to a GP with a psychological problem which is sufficiently distressing to lead the individual to seek professional help.

Healthcare is currently financed on the premise that illness is to be treated rather than prevented. There is little acknowledgment that much illness is attributable to avoidable "risk" behaviour and that a much more effective approach to such illness is to attempt to influence and change the behavioural factors which contribute to its onset.

The World Health Organisation's initiative: Health for All by the Year 2000 is founded on such an acknowledgement. It is based on the underlying assumption of an intimate relationship between people's behaviour, their lifestyle and their level of health. If HFA 2000 is a serious aim, governments everywhere should be looking to introduce a different model of health services, where emphasis is on primary care. Psychologists are a fundamental cornerstone within such a framework.

In particular, HFA 2000, in its recognition of the behavioural aetiology of many conditions, and therefore the potential contribution of psychology to primary care, requires great expansion in psychological skills and knowledge. These are needed, for example, to develop and evaluate preventive and health education programmes, focusing on reducing health-damaging lifestyles and the adoption of health-enhancing behaviour and attitudes.

Clinical psychologists also have an essential role in secondary healthcare. There is evidence to show that brief psychological interventions can reduce the use of other health services, making savings which are greater than the cost of providing psychological services (the "medical off-set phenomenon").

Certain psychological interventions have been shown to improve particular physiological conditions, such as coronary heart disease, hypertension, diabetes and asthma, sufferers of which are all high users of medical services. Studies on the effectiveness of psychological/behavioural intervention with this type of patient have shown that short-term outpatient sessions of this sort are linked to a medical off-set effect, resulting in reduced utilisation of inpatient services and other associated hospital costs. Patients receiving this type of intervention have been shown to require less hospital treatment and, moreover, the effect lasts for between 3 and 5 years after the end of the psychological intervention.

The acknowledgement of this by healthcare managers could have potentially major implications - not only does it imply more cost-effective provision of services, but there would be significant benefits to the patient who would, where appropriate, receive less drastic/invasive treatment and would be taught the skills to enable a greater degree of self-management.

However, the application of psychology in healthcare is not confined to the health problems of people. Psychological theory also has a major contribution to processes such as the methods used to deliver healthcare and the way in which healthcare facilities are organised, managed, evaluated and developed.

All of these factors, if seriously acknowledged and acted upon, have important and potentially radical implications for the role of psychology within healthcare and the healthcare system in its entirety.

## **The Activities of Clinical Psychologists and Other Disciplines**

The activities in which clinical psychologists are engaged are many and varied. They include:

- o clinical work
- o staff support
- o teaching and supervision
- o service planning
- o research and service evaluation
- o ambassadorial activities
- o organisational activities
- o management
- o administration

The utilisation of psychology is not confined to clinical psychologists - it is used extensively by a wide range of healthcare staff. The range of other disciplines' application of psychological techniques is infinitely variable, from no use of psychological method, to being as skilled as a clinical psychologist in particular tasks.

The range of psychological skill possessed across the various disciplines can be located within a skills framework related to three levels of activities:

- Level 1      basic "psychology" - activities such as establishing, maintaining and supporting relationships with patients and relatives, and using some simple, often intuitive techniques, such as counselling and stress management.
  
- Level 2      undertaking circumscribed psychological activities (such as behaviour modification). These activities may be described by protocol. At this level there should be awareness of the criteria for referral to a psychologist.
  
- Level 3      activities which require specialist psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw-on a multiple theoretical base, to devise an individually tailored strategy for a complicated presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level, which comes from a broad, thorough and sophisticated understanding of the various psychological theories.

Clinical psychologists are the only profession which operates at all three levels. It is the skills required for level 3 activities, entailing flexible and generic knowledge and application of psychology, which distinguishes clinical psychologists from other disciplines.

## Issues

This review has identified a number of main issues:

### Scope of Service

Clinical psychology services are patchy and thinly spread, the majority being too small to provide a sufficiently large and varied service to meet the needs.

There are an inadequate number of qualified clinical psychologists available within the NHS.

Consequently, the current pattern of service provision is one where only a minority of the overall need for psychological intervention is met. Only those with the more serious, severe and chronic problems receive a service, and this is often an inadequate one.

Certain specialties in particular are experiencing chronic recruitment problems - notably, services for elderly people, people with learning difficulties and children.

The preventative dimension is grossly inadequate. There is a need for a more primary/prevention-focused service - amongst the "worried well" are tomorrow's more seriously and chronically mentally ill. Prevention is a more cost-effective alternative to waiting for individuals to become dependent on health services and consequently more expensive to treat.

Psychologists currently are clinically specialised, making for an inflexible service where practitioners are pigeon-holed into specialty slots.

There is significant scope for an extended role for the clinical psychologist in the district general hospital setting.

There is a need for psychologists to provide a greater support role with other healthcare staff.

Clinical psychologists have a significant contribution to make to general managers, although this has not been properly recognised. The similarities in approach to problems makes psychologists a potential consultative source on managerial and organisational issues. The embryonic professional link between managers and psychologists should be cultivated, particularly as major organisational change continues in the Health Service.

### Professional Issues

The role of the clinical psychologist is currently ambiguous and low profile, possibly a result of the fact that they do not have a statutory role. This is linked with mounting pressure to institute statutory registration and licensing (thereby bringing the UK in line with certain other countries).

There is a question about the appropriateness and accuracy of the title "clinical" psychologist, in view of the diverse services they now provide.

Clinical psychologists obtain professional independence whilst relatively inexperienced. There is a need for more post-qualification training and supervision, particularly to those on basic grade. Wastage from senior grade (the grade undertaking most supervision) is having

particular consequences for the amount of supervision available.

Quality control of psychological practice is variable.

Whilst research (health services research and evaluation) is expected of psychologist practitioners, many find they have insufficient time to engage in it.

There are issues about clinical psychologists' relationships with other healthcare disciplines. They are uncertain about their responsibilities in supervising/monitoring others who use psychological techniques. Neither do clinical psychologists have formal responsibility for the training of non-psychology disciplines in psychological method. There is, therefore, no framework for planned and regular training to take place. This relates to the need for a more conscious/considered, planned and co-ordinated psychological skill-sharing process.

There is great variation in the relationship between clinical psychologists and their medical colleagues. Whilst some work as completely autonomous professionals, a few continue to work at the behest of consultant psychiatrists.

The basis for promotion is unsatisfactory, biased towards factors such as length of service and managerial/"head-counting" considerations, at the expense of rewarding professional excellence.

The career structure is inflexible and unattractive due to grading criteria and limited numbers of top grade posts.

The profession is experiencing serious recruitment and retention problems. Overall 20% of clinical psychologist posts are unfilled. Currently the shortfall in training places (coupled with increases to establishments) is the main contributory factor to there being insufficient qualified practitioners to fill posts. However, there is also the issue of wastage from the service, as working in the NHS becomes a singularly unattractive career prospect, financially. Remuneration is an issue which must be addressed if the NHS is to attract and retain clinical psychologists.



## Organisation and Management

The management and organisation of psychology services is varied, with ambiguity over the managerial accountability of professional staff. There is, therefore, a perceived need to introduce improved managerial accountability to service managers for the level and quantity of service provided and the fulfilment of targets and priorities.

The role of the district psychologist is unclear, with variations in responsibilities between districts.

## **Possible Models of Service**

Four service deliver options are presented.

### Option 1: Do Nothing (Status Quo)

#### Scope of Service

The majority of clinical psychology departments are too small to provide a full service; therefore, the service is thinly spread. Clinical psychologists' scope of activities is opportunistic, geographically variable, but generally restricted. Their wider role in areas outside the clinical sphere, particularly organisation and management, is not fully understood by managers and others and, as a result, is generally not utilised.

The needs for psychological interventions far exceed the number of clinical psychologists able to provide a service. As a result, clinical psychologists also work indirectly with clients through the provision of training, guidance, advice and supervision to other staff.

#### Relationship With Other Disciplines

As mentioned above, clinical psychologists' relationship with medical staff sits anywhere on a continuum, ranging between complete independence, to the provision of a service which is largely determined by medical staff.

The relationship between clinical psychologists and other healthcare staff is generally ambiguous because it is not formalised. The training, supervision and provision of advice about psychological tasks occurs in an ad hoc, reactive manner, rather than as planned and co-ordinated activities which come from the identification of what psychological skills are required by others in order to improve the patient care process. There are no formal mechanisms to co-ordinate, direct and control the psychological activities of all staff who engage in them.

## Organisation and Management

The organisation of clinical psychology services is variable. The majority are district-based and budgeted. Other services are provided from one or more units. Some districts do not have a clinical psychology department and receive services from a neighbouring district.

There are dual structures for accountability. Professional accountability is generally vested with the district psychologist. Managerial accountability is usually via the district psychologist to a unit general manager.

## Professional Status

The professional status of the clinical psychologist is currently not bound by statute. The British Psychological Society (BPS) has recently introduced a charter in an attempt to control the quality of psychologist practice; however, this is voluntary. The UK contrasts in this respect with countries like North America, Scandinavia and the Netherlands, all of whom have statutory registration and licensing arrangements.

## Quality Assurance

There is no set of systematic measures or system for monitoring practice. Peer review is a tenet of good practice, but it is not formalised. There is no formal and mandatory supervisory structure for newly qualified practitioners and supervision generally is inadequate.

## **Recommendations**

The following recommendations are designed to remedy problems identified in the current service. They are common components across Options 2, 3 and 4, the alternative models. The particular structural features of each alternative option are described later.

## Amount of Resource

The alternative options entail an increase in the quantity of psychological service provided to remedy the current situation where there is a wide-spread failure to meet the more general needs for a service. (See section on manpower.)

## Scope of Service

It is recommended that the majority of psychologists should practise as generalists, with special interests, since it is the general level 3 skills which are the unique attributes of the psychologist, and not their specialised level 2 skills.

It is proposed that the potential contribution of healthcare psychologists is fully and more formally recognised in both clinical and non-clinical spheres and activities.

Therefore, healthcare psychology services would be applied to the following areas of activity

(a minimum of 10 in all) within each district:

**Primary Care -** illness prevention and psychological and behavioural health promotion.

**Secondary Care -** adult mental health (including rehabilitation)  
child and adolescent services  
services for elderly people  
services for people with learning difficulties  
services for people with physical and sensory disabilities  
physical medicine.

**Tertiary Care -** supra district services.

**Organisation, Management and Service Planning.**

**Training and Research.**

In view of the arguments promulgated earlier, we propose a more equitable balance between primary and secondary services, with greater emphasis on primary care than currently. In recognition of where the majority of need lies and where there is potential for greatest impact, the proposition is that psychologists should be providing as much a health-oriented as illness-based psychology service. An emphasis, therefore, is on the concept of health - the maintenance of personal and psychological health and functioning, the prevention of illness and the treatment of need on a primary basis, where possible. It should be noted, however, that this recommendation does not represent any compromise in the essential service needed by chronically ill individuals - those most vulnerable and most in need of support

This minimum framework makes provision for organisation, management and service planning, and training and research as distinct activities within districts, with psychologists specifically allocated to these tasks.

#### Relationship With Other Disciplines

It is proposed that the process for delivering psychological services through other disciplines becomes formalised, with a defined responsibility for the psychologist in teaching and supervising other staff. We believe that healthcare psychologists should have responsibility, based on sapiential authority, to ensure appropriate use of psychological techniques by others. This would allow greater control over quality and the type of psychological intervention practised by others, allowing skills to be conveyed and utilised in a more considered, co-ordinated and planned manner. This, ultimately, would result in a more co-ordinated mental health service.

We believe it to be essential that the employing authorities provide the initiative to ensure that healthcare psychologists assume responsibility concerning other disciplines\* practise of psychology.

#### Quality Assurance

We consider it important that mandatory registration and licensing be introduced to control the quality of individual psychological practice.

We recommend the institution of a mandatory and formalised quality assurance framework, based on regular and defined peer review.

The alternative options also encompass a tighter and more formal supervisory structure for newly qualified healthcare psychologists. For supervision to be undertaken properly, it must be allocated adequate resources. We therefore recommend that it becomes an explicit part of certain experienced psychologists' job descriptions and is timetabled accordingly.

### Title

We suggest the discipline be titled "healthcare psychology", in recognition of the wide role for psychologists in healthcare and in keeping with the emphasis on preventing illness and maintaining health.

### Management

The management of a psychology service would be co-ordinated on a district-wide basis either by an appointed or elected head or chairman of the district psychology service. Each of the 10 minimum district-wide activities will be managed by a head of service.

We define the tasks of management to be undertaken by the head of service, as described under each option, within the categories of providing:

direction (setting policies and objectives)

control (of standards, defining interventions and overall quality assurance)

co-ordination (tasks involved in the daily organisation and delivery of the service).

### Training/Career Progression

We emphasise the need for on-going training throughout the psychologist's career. We consider that it should take about 12 years from registration as a healthcare psychologist to become head of service and that during this period, the psychologist should have acquired a broad experience. We believe that healthcare psychologists should receive generic "training" up to principal grade. Thereafter they may need to concentrate on a specific activity, although generic interests should be retained. Head of service posts should be regarded as general posts with a special interest.

Career progression from registration should be governed by experience, qualification and personal competence. The proposed training/career progression framework for healthcare psychologists is as follows:

- o A recognised primary degree in psychology (3 years).
- o Training in healthcare psychology (equivalent to training in clinical psychology), leading to a recognised higher degree, with standards set by the BPS (2 years).
- o Registration with the BPS.
- o Post-registration training at basic grade; individual performance review (2 years).

- o Award of licence.
- o Post-licence continuing education and training at senior grade; individual performance review (4 years).
- o Higher recognition by the BPS in order to gain entry to principal grade.
- o Continuing education and training; individual performance review (6 years).
- o Head of service grade; individual performance review.

There would be certain flexibility about time served at each grade to expedite the passage of particularly able practitioners through the promotion scales, to reward excellence.

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### Option 2: Shared Care Service

This option is based on the principle that if psychology is to exert a wider impact on health, it requires a profession which exhibits confidence and responsibility. The psychologist in this model is active in the pursuit of the objectives of a healthcare psychology service, and not predominantly reactive, relying on referrals. The emphasis is on the psychologist's independent ability to utilise level 3 skills. Healthcare psychology would become formally recognised as an independent profession. This would only be acceptable in the NHS if the profession was integrated within the Health Service through collaborative practice.

This option is based on the concept of shared care within the framework of a medically-oriented Health Service. It espouses the roles of the healthcare psychologist as a professional able to:

- o support medical practitioners in the assessment, diagnostic and treatment process;
- o complement medical practice by providing services to ensure compliance with medical care and teach coping/training strategies; and
- o offer effective alternatives to certain medical strategies.

To achieve true shared care and to fulfil their potential contribution, this model proposes psychologist practitioners be afforded equal status with medical practitioners, and that each psychology service be led by a consultant psychologist.

The consultant psychologist would have responsibility for the psychological and behavioural well-being of people within their charge. The consultant psychologist would be responsible for all the psychological services within each area of activity described in the framework above - both client-related and services required on the environmental, organisational and managerial levels. This responsibility would encompass not only the services of psychologists, but would extend to co-ordinating the psychological components of multi-disciplinary services, including, for example, occupational therapists, nurses and social workers.

This last recommendation is intended to remedy the current situation in which many different psychological services are provided within the same client group area, in a largely uncoordinated way, with each discipline answering to different professional heads. Often this results in services which are provided in a discrete, isolated framework, with little communication across discipline boundaries to determine un-and under-met need or unnecessary task/skill duplication.

An advisory committee would be established in each district, comprising all psychology consultants, to advise the health authority on matters pertaining to psychology. An elected chairman would represent the profession within the district.

Independent status would require the profession to pursue statutory chartered status.

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### Option 3: Support Service

The emphasis of this option is on psychology as a support and complement to medical care, acting as a resource for other professions to utilise and undertaking interventions on request. Essentially, the profession would be responsive to medical practitioners, taking referrals from them, either nominally or in practice.

Medical practitioners, therefore, would act as gatekeepers to the service. The psychology service would be responsive to the relevant medical custodian of a patient's overall care for the provision of an effective psychological service.

In this model, psychologists would be utilised, in the main, for their level 2 skills (as a result of their relationship with medical practitioners), undertaking particular procedures on request.

The service would be integrated, but not independent

In recognition of psychology as a supporting science, the service would be led by "chiefs of service" for each area of activity. These individuals would be managerially responsible to a district psychologist and for organisational activities, a psychologist would be accountable to the relevant manager.

The result of this model would be that the psychology service would be less active than in Option 2 in exhibiting responsibility for the psychological and behavioural welfare of individuals. The service would be reactive to demands.

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### Option 4: Independent Service

This option emphasises the independence of the psychology profession from the NHS, in accordance with the philosophy expounded in the White Paper on the NHS (1989) and the Green Paper on Community Care (1988). It places psychology services outside the NHS, able to be contracted by the NHS, local authorities and any other agency, as required.

By virtue of its independence, the psychology profession itself would need to establish the criteria for leadership. Similarly, management arrangements would be a matter for individual practices.

In this model, the scope of services would be constrained by client requirements and would be reactive to demands for service.

The profession would be independent, and not integrated. A major complication with this model is that by being outside the NHS, psychologists would be seen to be independent and therefore have little power to influence healthcare generally, or to integrate their activities with those of other professions.

These options are not mutually exclusive. In practice, aspects of each may be attractive and lead to implementation.

The following table summarises the main components of the four options.

### **Appraisal of Options**

To identify a preferred option, the models were judged against benefit criteria.

The result of the appraisal process was that Option 2: the shared care model, emerged robustly as the model of service delivery which best fulfils the criteria of providing an appropriate, effective, high quality service and the option with best prospects of being implemented, in terms of its likely acceptability to managers, service providers and consumers. It also emerged as an acceptably efficient model.

However, much depends on the argument that psychology has a fundamental role in health and healthcare and that healthcare psychologists should be an autonomous profession. If this argument is not supported, the preferred model is likely to be Option 1, with the recommendations from this review incorporated.

Option 3 would be unacceptable to members of the profession and would perpetuate some of the flaws in the current service. Option 4 might find some support from a section of the profession, but the model would do little to ensure that psychology had a major impact on health and healthcare.

### **Manpower**

#### **Redefined Grades**

The newly defined grades of healthcare psychologist in Options 2, 3 and 4 are as follows:

<b>Trainee</b>	A healthcare psychologist in training, who is under the supervision of another psychologist who is a licensed senior, principal, or consultant/chief grade, or an academically-graded, licensed psychologist. A trainee is studying to become registered with the BPS.
<b>Basic</b>	A registered healthcare psychologist in training, who is under the supervision of a licensed psychologist The basic grade psychologist is registered with the BPS and is in training for his/her license.
<b>Senior</b>	A licensed healthcare psychologist in training for

higher recognition by the BPS. The licensed healthcare psychologist may be expected to provide clinical, management, organisational, teaching and research services, and to act as an independent practitioner within the framework established by the consultant/chief of service.

**Principal**

A licensed healthcare psychologist with higher recognition by the BPS, who is expected to begin to focus his/her services on a specific activity, and provide clinical, management, organisational, teaching and research services within the framework established by the consultant/chief of service.

**Consultant/  
Chief of Service**

A licensed healthcare psychologist with higher recognition by the BPS, who is expected to specialise in an activity, and provide clinical, management, organisational, teaching and research services, and to be head of one of the principal activities described. (Where there is more than one consultant/chief for an activity, one would be designated head of department on a rotation basis.)

Manpower Requirements

To achieve the level of manpower required by the proposals, one consultant/chief of service would be needed for each of the 10 main activities defined as the minimum requirement in each district. This would result in a minimum of approximately 20 healthcare psychologists per district (using the current base for service provision, which may change in the light of recent Government proposals). This would total some 4000 healthcare psychologists in England. For the majority of districts, this represents an increase of 1 healthcare psychologist each year for the next 10 years.

Translated to staffing ratios, this equates to 2 healthcare psychologists per 25,000 population, if averaged out nationally. In those districts with small populations, which are likely to experience recruitment difficulties, sharing of psychologists with neighbouring districts may be expected as a covering arrangement in the short-term.

To achieve this target, it would be necessary to have at least 300 annual intake training posts, or just under 200 more than currently exist. This equates to approximately 14 new training posts in each region in England.

Costs

Option 2 represents a cumulative investment of £27,000 per annum for each district, averaged over 10 years.

Conclusions

It is clearly cheaper not to increase the number of healthcare psychologists. However, there is growing evidence that the application of psychology in healthcare, quite apart from its benefits in terms of the effectiveness and quality of care received by the patient, may have



major cost-saving advantages, it has been shown that where it is applied, it can reduce the utilisation of expensive hospital resources.

Consequently, the investment implied could be recovered once healthcare psychology is of sufficient size to be able to exert an impact in the areas of major need.

## SUMMARY - SERVICE DELIVERY MODELS

	OPTION 1 DO NOTHING	OPTION 2 SHARED CARE	OPTION 3 SUPPORT SERVICE	OPTION 4 INDEPENDENT
<b>Objectives:</b>	The application of the principles and procedures of psychology to health care.	To improve, either directly or indirectly, the standard and quality of life of people who are served by and provide health services, and to alleviate disability, through the application of psychological theories.		
<b>Scope of Interventions</b>	Levels 1, 2 and 3, depending on degree of professional independence	Levels 1, 2, and 3, with emphasis on Level 3	Levels 1, 2 and 3, with emphasis on Level 2	Levels 1, 2 and 3, depending on client requirements
<b>Process of Service Delivery</b>	Direct and indirect Providing others with certain psychological skills	Direct and indirect Formalised role in teaching psychological skills to other disciplines	Direct and indirect Formalised role in teaching psychological skills to other disciplines	Direct and indirect
<b>Relationship with Medical Staff</b>	On a continuum from medical gate-keepers to independence	Independent	Support	Independent
<b>Organisation</b>	Based on Whitley Grades, with District Psychologist as head Part of NHS	Consultant-led with Principal, Senior and Basic Grades Part of NHS	As in Option 1 Part of the NHS	A matter for the profession Independent of the NHS
<b>Professional Status</b>	Voluntary charter	Need to move to statutory charter Licence	Voluntary charter Licence	Voluntary charter Licence
<b>Quality Assurance</b>	Embodied in BPS Code of Conduct	Statutory Quality Control	Statutory Quality Control	Statutory Quality Control
<b>Referral Arrangements</b>	Variable according to the independence of the psychologist	From any source, including self-referral	Through medical staff	From any source, including self-referral

**CHAPTER ONE**

**BACKGROUND AND INTRODUCTION**

## 1. Background and Introduction

- 1.1 This review of clinical psychology staffing examines the need for psychology in health care and identifies the numbers of clinical psychologists required to meet the future needs of the National Health Service (NHS).
- 1.2 In 1988 the Management Advisory Service (MAS) was commissioned to undertake the review by the joint DHSS/NHS Manpower Planning Advisory Groups (MPAG), in cooperation with the profession's representative body, the British Psychological Society (BPS), and particularly, the Committee on Training in Clinical Psychology and the division of Clinical Psychology (DCP). These two committees approached MPAG proposing the review because of the current major shortage of clinical psychologists in the NHS, a situation which will worsen with the continuing increase in demand for services.
- 1.3 This study has had a lengthy gestation period. In 1985 the House of Commons Select Committee on Community Care proposed an updating of the Trethowan Report<sup>1</sup>, together with a rigorous review of the profession.
- 1.4 The main problems precipitating the need for a review have been those relating to the supply of qualified clinical psychologists.
- 1.5 In 1986, MPAG began working with Melvyn Blunt<sup>2</sup> on a preliminary report on the state of clinical psychology manpower and consequent problems. This drew on the evidence from the 1985 Scrivens and Chartton Report<sup>3</sup> on the size of the profession and work done by Whitehead and Parry<sup>4</sup> in 1986, demonstrating the existence of problems.

### *Shortfall Training Places*

- in 1.6 To demonstrate the size of the shortfall problems, current estimated regional projections are that 370 training places are required per year until 1994 (the end of the strategic planning period), to fulfil short-term needs. This compares with the 116 places which existed in England<sup>5</sup> in 1987. Moreover, all indications from regional strategic plans suggest that the demands for additions to current establishments will continue.

### *Expanding Establishment*

- 1.7 Current regional strategic plans suggest a continuing increase of some 113 new posts in England each year. Given that the creation of new posts in some regions is significantly in excess of the strategic estimates, the actual increase in demand for clinical psychologists may well be higher.
- 1.8 This review, therefore, has resulted from a number of factors. One has been the inadequate number of training places for clinical psychologists, with the consequent shortfall in numbers of qualified clinical psychologists entering the NHS. This is partly reflected in the vacancy rate, which in England currently stands at 20% of the total establishment - an increase on the 15% vacancy rate of 1985. The manpower problems have been further exacerbated by the steadily expanding private sector which has attracted clinical psychologists away from the NHS. Another

contributory factor has been the creation of many new posts as part of NHS planning, including schemes such as “community care” and other initiatives. This has been associated with the increasing recognition of the contribution clinical psychologists have in every situation where behavioural and psycho-social factors are at play. The creation of these additional posts have not, however, been accompanied by a commensurate increase in training places.

1.9 The combination of these factors has led to a serious deterioration in staffing levels in recent years.

***Terms of Reference***

1.10 The terms of reference for this study are:

1.10.1 to identify the factors that need to be taken into account when making decisions about appropriate models to meet current and future service demands for clinical psychology;

1.10.2 to make recommendations based on the factors identified, on the preferred model(s) of service. These models must be framed in such a way that provides a basis for the further study of supply of skilled personnel to deliver that model.

1.11 To achieve these general terms of reference, the study’s aims are:

1.11.1 to identify “common” and “core” competencies of clinical psychologists, by examination of representative and innovative patterns of service, taking into account both the unique and transmissible “skills” of clinical psychologists for patient care and the current and future requirements of the service, particularly in the main client group areas;

1.11.2 to determine levels of staff and skill mix required, examine the possibility of introducing support staff and the feasibility of delegating or sharing tasks with other groups and the managerial and professional implications of so doing, and to provide guidance on appropriate numbers of staff for defined populations/client groups;

1.11.3 to examine the educational role of clinical psychologists in training other people in the services.

***Approach to the Review***

1.12 This review was undertaken between September 1988 and March 1989. It is the second of a three phase project being managed by MPAG.

1.13 The first phase has been a manpower survey conducted by the Manpower Planning Department at Northern Regional Health Authority. Its remit was to replicate, update and expand on the 1985 Bath University study<sup>6</sup> in establishing the current and future position on shortfalls in service provision, staffing and training. Chapter 3 presents a summary of a profile of the profession based on the data.

1.14 The third phase will review existing training and education and will be concerned to produce recommendations on training methods to achieve the preferred model of service resulting from

this review.

1.15 The overall approach of this phase has been a high level study designed to provide an overview of clinical psychology services and their future.

**Questions to be Answered**

1.16 We have set out to answer the following questions:-

- o What is the need for clinical psychology in health care?
- o What is the purpose of clinical psychology?
- o Who, other than clinical psychologists, use psychological skills and to what extent are these skills used?
- o What are the issues which need addressing concerning clinical psychology services in health care?
- o What possible processes are there for delivering clinical psychology services?
- o How many clinical psychologists should there be working in the Health Service?

**Approach**

1.17 Our approach has been divided into four phases.

1.18 Phase one of this review has been to identify and understand the key issues and factors which may influence the future provision of clinical psychology services.

**Site Visits**

To achieve this, eight district psychology departments in England were chosen to form the basis for observation. At the outset of the study, each district was visited, and extensive discussion occurred with a selection of clinical psychologists from the range of specialties and of varying grade and a selection of other professionals who were either providing some form of “psychological” care, were significant referrers to clinical psychologists, or were responsible for related services. These included GPs, psychiatrists, other hospital medical staff, various service managers, psychiatric nurses, mental handicap nurses, nurse behaviour therapists, occupational therapists, speech therapists, art therapists, physiotherapists, social workers, other social services personnel, and officers from relevant voluntary organisations (such as MIND).

1.19 The discussions with the other disciplines were intended both to obtain an “external” view on clinical psychology from those working closely with the profession and to identify issues regarding role boundaries and respective competencies in related areas.

**Evidence**

1.20 Evidence has been sought widely both within the profession and from other interested parties on current issues and likely/desirable future developments.

1.21 The study also entailed overseas visits to Sweden, Norway, the Netherlands and the USA. The countries were chosen on the basis that they had well developed clinical psychology services and demonstrated interesting features with possible application to the English context.

1.22 These empirical components have formed the basis for the

observations made in this report and for the generation of possible models of service delivery.

### *Analysis of skills*

#### 1.23 Phase two focused on the issue of skills.

The terms of reference for the review required examination of “skills”, including those which are “core” to the profession, the “common” skills demonstrated by others who are not clinical psychologists and the scope for transferring skills to others. In the light of the likely future environment for health services, this aspect of the review gained some prominence. To address it, we administered two questionnaire-based exercises within the eight district sites.

1.24 The first survey focused on the caseload composition of various professionals undertaking “psychological” tasks, that is, the types of clients and “conditions” receiving a psychology-based strategy from various professions and the approach to the presenting psychological condition. Its purpose was to determine whether there are any distinctions between types of “condition” included in caseload, severity of condition, approach to care/treatment, or degree of responsibility assumed for the psychological health of a client between the various professions involved.

1.25 The second exercise was a competence analysis, designed to be a more explicit and detailed examination of the psychology-oriented skills demonstrated by different professionals when approaching the same presentation. The questionnaire was based on a case study approach and the exercise was followed up with a series of interviews with some of the respondents.

1.26 Both exercises were conducted across the range of environments in which a psychological-based approach to care may be applied by a range of staff groups.

### *Service Delivery Models*

1.27 Phase three has been concerned with the construction of service delivery models. In this phase we sought to address those issues which arose from the two previous phases of the study.

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1.28 The service delivery models are appraised for benefits and costs against criteria which have been constructed as part of the review. The result of the appraisal was then subjected to tests of sensitivity to determine whether there would be any difference in outcome as a result of any changes in underlying assumptions.

### *Manpower Requirements*

1.29 Phase four has been to establish the implications of our proposals by modelling manpower requirements and identifying likely consequences for training requirements.

1.30 During the course of the study we have received co-operation throughout the Service, from clinical psychologists and from other professional groups for whom this study may only be of indirect interest. We are grateful to everyone who has participated and particularly those concerned with the organisation of visits and surveys.

1.31 We have been aware of the trauma which the review has caused within the clinical psychology profession as a whole. Such an

exercise will inevitably cause anxiety amongst those being reviewed and this study, being no exception, has provoked a considerable amount of tension amongst individuals and groups.

1.32 It has also led the profession to examine itself. Many have regarded this as an important by-product of the study.

1.33 Throughout the course of the study, observations and emergent ideas have been discussed informally with various professional groups. There have also been more formal mechanisms for soliciting multi-professional comment and observation and consulting on drafts, which have included a Steering Group and a series of workshops held at the Department of Health.

### **Structure of the Report**

1.34 This report goes on to describe the following:

1.34.1 the history of clinical psychology, the profession today and matters which will reflect on the future of clinical psychology;

1.34.2 profile of the profession;

1.34.3 the need for psychology in health care;

1.34.4 the activities of both clinical psychologists and others;

1.34.5 the prevailing issues which need to be addressed;

1.34.6 the criteria for judging clinical psychology services;

1.34.7 possible models of service;

1.34.8 appraisal of these models against the criteria;

1.34.9 implications of the models for training, manpower and resources;

1.34.1 conclusions.

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<sup>1</sup> Trethowan Report "The Role of Psychologists in the Health Service", DHSS, 1977

<sup>2</sup> Blunt M. A Preliminary Report on the State of Clinical Psychology Manpower and its Problems, Manpower Planning Advisory Group. Discussion Paper, 1986.

<sup>3</sup> Scrivens E. and Charlton D. The Nature and Size of Clinical Psychology ..., Bath Social Policy Papers, N0.6, University of Bath, 1985

<sup>4</sup> Whitehead A. and Parry G. "National Training Needs in Clinical Psychology", Clinical Psychology Forum (No. 6), 7-111, 1986.

<sup>5</sup> Data from Northern Regional Manpower Department's survey 1988.

<sup>6</sup> Scrivens E. and Charlton D. op cit.

<sup>7</sup> Throughout this report where the term "skill" is used it should be recognised that it denotes the wider definition of the word, more recently referred to as "competency", and includes not only the activities engaged in conducting a task, but an individual's knowledge, attributes and values which they bring to that task.



**CHAPTER TWO**

**HISTORY OF CLINICAL PSYCHOLOGY,  
THE PROFESSION TODAY AND MATTERS WHICH WILL  
REFLECT ON THE FUTURE OF CLINICAL PSYCHOLOGY**

## 2. History of the Profession

### *Evolution of the Profession*

- 2.1 Clinical psychology is one of the smallest healthcare professions. In 1988 there were some 1500 whole time equivalent clinical psychologists working in the National Health Service in England. The proportional size of the profession in Scotland and Wales correlates to that of England, whilst staffing ratios in Northern Ireland are lower. Whilst it remains comparatively small, it has undergone relatively recent and rapid expansion in terms of the number of practitioners, the spectrum of tasks they undertake and the range of healthcare settings in which the profession now has a presence. This growth, however, has been sporadic, occurring only in certain geographic locations and in the more “popular” specialties.
- 2.2 The short history of the profession has been one of change: from the technical origins of the test-administering psychometricians in the early post-world war years working mainly within a mental “ill-health” setting, to the clinical psychologist of today, working as an applied behavioural and social scientist, demonstrating an effect in virtually every aspect of healthcare, and operating in a range of patient, environmental, organisational, planning and managerial contexts. Their role has expanded from the traditional setting of the mental illness/mental handicap context to that of offering a service within most healthcare settings.
- 2.3 A formal and recognised role for the clinical psychologist first emerged during the last war, when they were initially used to assist in personnel selection, recruitment and training and were later incorporated into the emergency medical service to work with psychological trauma of casualties.
- 2.4 Some of these psychologists continued to work in hospital services at the end of the war, and were integrated into the National Health Service in 1948. However, their role was essentially one of laboratory scientists, working as an ancillary service to the medical profession, primarily in large psychiatric and mental handicap hospitals. At this stage there was little direct therapeutic practice. This early role is reflected in the profession’s location today within Whitley Council arrangements, where they are grouped with biochemists,

physicists and diagnostic scientists.

- 2.5 The first Whitley circulars relating to the qualifications and conditions of service of clinical psychologists were issued in 1952.
- Recent Developments**
- 2.6 It was not until 1966 that the Division of Clinical Psychology (DCP) was formed in the British Psychological Society (BPS).
- 2.7 In recent years there has been a substantial expansion in psychological knowledge, accompanied by developments in new techniques, which have greatly expanded the scope and value of psychology. These developments have included the emergence of psychometric measurement techniques; the application of learning theory to the treatment of behavioural and emotional disturbance, leading to the emergence of behaviour therapy, marking the profession's entrée into therapy; and the increasing popularity of psychoanalytic and other forms of psychotherapy in this country. By the close of the 1960s, the role of psychologists as clinical practitioners as opposed to laboratory scientists had been firmly established.
- 2.8 More recently, the most significant events for the profession have been the Trethowan Report (1977) and the 1974 and 1982 Health Service reorganisations. Similarly, the Griffiths Report on Community Care and the 1989 White Paper on the NHS will have considerable implications for clinical psychology services, should they be implemented.
- Trethowan**
- 2.9 The 1977 Trethowan Committee marked the formal recognition of clinical psychology as an independent profession with a therapeutic contribution. It was set up in the light of the increasing responsibilities of clinical psychologists, to look at their role in the Health Service. It signalled the close of a particularly uncertain and ambiguous period for the profession. Service organisation had, until this time, been extremely patchy and idiosyncratic.
- 2.10 It ratified the independent status of the profession and formalised the organisation of services, proposing larger departments providing a comprehensive range of clinical psychology services on an area base. The Trethowan Report opened up the potential role for clinical

psychologists in the NHS, beyond the traditional “psychiatric” confines. The report was a catalyst in the expansion of the profession’s numbers and activities. Trethowan was implemented by HC(77)14 in England and Wales and by (GEN)34 in 1980 in Scotland.

***General  
Management***

- 2.11 The introduction of general management to the NHS has had a significant impact on psychological services both structurally and in its introduction of more explicit accountability. After 1982, district health authorities, in considering the management arrangements for clinical psychology, opted either for a district or unit-managed service. The 1984 restructuring led districts to re-examine the desirability of a district-wide, district-managed psychology service, headed by a district psychologist. It set up dualist accountability, whereby psychologists became administratively accountable, through the district psychologist, to a general manager, whilst professionally accountable to the district psychologist.

**The Profession Today**

- 2.12 “Clinical psychology is the application of the principles and procedures of psychology to health care”.<sup>1</sup> Psychologists from other disciplines (such as education) also work within the field of health care occasionally (Appendix 1).

- 2.13 Translating this definition into more specific statements of purpose, clinical psychologists describe their *raison d’être* variously:

2.13.1 To facilitate individuals’ independence.

2.13.2 To promote psychological well-being.

2.13.3 To purposefully enhance the quality of individuals’ lives.

2.13.4 To enable people to make choices for themselves, about themselves.

2.13.5 To help alleviate disability and handicap.

2.13.6 To provide people with coping strategies.

- 2.13.7 To understand and interpret individuals' problems.
- 2.13.8 To enhance physical recovery by psychological means.
- 2.13.9 To help people with psychological health problems which are limiting their capacity to cope with life.
- 2.14 A more formal classification of purposes could be:
- o To assess or assist in assessment.
  - o To analyse or assist in analysis.
  - o To diagnose or assist in diagnosis.
  - o To treat or assist in treatment.
  - o To evaluate or assist in evaluation
  - o To undertake teaching.
  - o To undertake psychological and health services research.
- 2.15 Clinical psychologists provide services on their own or in groups, including groups of a multi-disciplinary complexion.
- 2.16 Clinical psychologists either provide services directly to individual clients, to groups of clients, to families, and to partners; or they work indirectly with clients, through the provision of advice to other professional groups.
- 2.17 Clinical psychologists provide services either directly or indirectly to staff of the NHS.
- 2.18 Clinical psychologists provide services to people employed outside the NHS.
- 2.19 Clinical psychologists apply themselves to environmental factors which influence health and well-being.

	2.20	Clinical psychologists are engaged in service planning and development.	
	2.21	Clinical psychologists apply themselves to the organisation and delivery systems of health care.	
	2.22	Clinical psychologists apply themselves to the management of health care and its resources.	
<b><i>Categories of Task</i></b>	2.23	In summary, clinical psychologists are employed in the following categories of task:	
	2.23.1	The Individual	individuals either as consumers or providers of health services.
	2.23.2	The Group	population, communities and groups which display similar characteristics and may share common problems, risks and objectives.
	2.23.3	The Environment	the milieu in which care is provided and in which people work and which either exerts an influence or is influenced by individuals and groups.
	2.23.4	Organisation	the way in which people are organised to achieve specified purposes.
	2.23.5	Management	the direction, coordination and control of organisations and individuals.
<b><i>Clinical Settings</i></b>	2.24	Clinical psychologists function in a number of different clinical settings. The main specialties are:	
		Primary care, psychological health promotion and illness	

prevention  
 Adult mental health  
 Child and adolescent health  
 Services for elderly people  
 Services for people with learning difficulties  
 Services for people with physical and sensory disabilities  
 Rehabilitation  
 Services to the general hospital – general medical/surgical specialties (physical medicine)  
 Neuropsychology  
 Forensic psychology  
 Substance abuse  
 Services for people with HIV/AIDS

***Non-Clinical Settings***

2.25 The role of the clinical psychologist is not confined to patient specialties. They are assuming a growing organisational role, providing advice and serving as catalysts within management and service planning forums.

2.26 Precisely what they do in each setting depends upon the interests and experience of the individual, the perceived needs of the population and service and the priorities/needs of the district. There is, then, no single role, but different roles in different settings.

2.27 The general categories of activity, expanded in a later chapter, are:

Clinical  
 Staff support  
 Teaching and supervision  
 Service planning and development  
 Research and evaluation  
 Ambassadorial  
 Organisational  
 Management  
 Administration.

***Organisation***

2.28 Organisationally, clinical psychologists work within districts, although some work across district boundaries.

2.29 They work within the community as well as within hospitals.

- 2.30 They are sometimes organised in a central department, or dispersed amongst the specialties to which they relate, at the point of service, or a combination of both.
- 2.31 Not every district provides a similar range of services. In fact there is no standard range of services, nor is there a standard way in which services are delivered.
- 2.32 Some clinical psychologists and clinical psychology services are organised as support services to medical practitioners, particularly consultant psychiatrists. Some have an arrangement whereby limited referrals can be made directly to the clinical psychologists from, say, general medical practitioners, whilst the remaining referrals are all processed through consultant psychiatrists. Other clinical psychology services are independent from any medical practitioner and have developed their own referral policies enabling direct referrals to be made. Some clinical psychologists work within general practices, taking referrals primarily from GPs and some from members of the primary health care team.
- 2.33 Most clinical psychologists aim to work closely with medical practitioners whilst maintaining an independence from them and any other professional group. This neutrality is often regarded as one of their main strengths.
- 2.34 However, sometimes it gives rise to critical comment, particularly from groups of staff who are unable to exercise flexibility in how they deliver their own services. Criticism by others is also directed at this flexibility to choose where, when and how they work, where clinical psychologists form part of a multi-disciplinary team. Often other professional groups do not regard multi-disciplinary team working as amenable to the exercise of such flexibility by one of the integral professionals.
- 2.35 Managerially, clinical psychologists are arranged in a hierarchy, with the whole service normally managed by a district psychologist. In some authorities, however, the service may be managed by unit psychologists, with one of the unit psychologists designated as district adviser. Sub-divisions of the service are generally managed by a top grade, principal or senior clinical psychologist, depending on local circumstances. (The grade definitions are described in 83.15.)



## The Future of the Profession – Some Environmental Considerations

- 2.36 The Health Service is a dynamic organisation, having to respond to the external influences of politics and economics by adapting its internal organisation. Recent government proposals are an illustration of this, where the framework for service provision will change with the application of the market economy concept to the delivery of healthcare, thereby, in part, bringing the NHS more in line with other countries.
- 2.37 Past changes to the NHS have seldom had such radical and direct impact on professional groups (other than to alter priorities). The latest proposed changes within the 1989 White Paper on the NHS will mean a fundamental alteration in the processes by which professional groups provide their services. Finance will have a more direct influence on the process of delivering services than at any previous time since 1948.
- 1989 White paper on the NHS* 2.38 The specific aspects of the 1989 White Paper which will have implications for psychology services include the following:
- 2.38.1 There will be a change in role for district health authorities – becoming purchasers rather than providers – able to buy in services from other districts or the private sector. There will be scope for much wider use of competitive tendering – possibly with wholesale buying in of treatments for patients. Introduction of more competition will fulfil the Government’s desire for a mixed economy in healthcare.
- 2.38.2 If, within a self-governing hospital trust, psychology departments will be providing services according to specific targets and to an agreed budget – this might necessitate the costing of individual/package psychological interventions if providing services to other districts. These hospital trusts will be empowered by statute to employ their own staff, to enter into contracts to provide and buy in services and to generate income.

- 2.38.3 Districts will be encouraged to buy the best service available, whether that is from its own hospitals, hospitals in other districts, self-governing hospitals or the private sector.
- 2.38.4 Services which are not regarded as core, that is those to which patients require guaranteed immediate access, and for which patients may be prepared to travel, will be provided within contracts defining the minimum and maximum number of cases.
- 2.38.5 A district psychology department may provide services outside its own boundaries. Where an internal market system is in operation, a district with short waiting times for particular interventions and a cost-effective service may offer its services to other districts. In addition, a district may be providing supra-district, regional and national services.
- 2.38.6 There will be increased emphasis on monitoring – with the possible application of resource management and the clinical audit concept to clinical psychologists.
- 2.38.7 Greater local pay flexibility will allow freedom to relate pay rates to local labour markets and to reward individual performance. There will be greater freedom to settle pay and conditions of staff.

***Labour  
Market***

- 2.39 Another factor with significant implications for the clinical psychology profession is the changing labour market, which will contain significantly fewer school leavers and proportionately more women.
- 2.40 There is an expected decline by one fifth in the number of 16-29 year olds between 1985 and the year 2001. Amongst this age group, the most significant decline will be in the 18 year olds, which are predicted to decrease by 25% from about 739,000 in 1986 to around

550,000 by 1994.

- 2.41 At the same time, there will be an increase in the numbers of those aged between 30 and pensionable age. Consequently, whilst the working population will undergo little change in overall number, it will have a significantly older profile by the end of the century.
- 2.42 The sex profile of the labour market has also undergone change. Whilst the economically active population increased steadily between 1971 and 1985, the increase was largely attributable to the proportion of women entering the labour market. The proportion of women in the workforce currently accounts for around 49% of the working population and is expected to increase to 50% by 199L In contrast, the proportion of economically active males has fallen steeply as a result of early retirement, redundancies, and the general decline in British manufacturing industry.
- 2.43 The implications of these demographic changes are enormous. A labour-intensive organisation such as the NHS will experience intense competition for the more intellectually able members of the labour market. Clinical psychology, together with other NHS professions, will have to work hard to make itself attractive to this section of the labour market. This will mean having to examine existing remuneration levels and working conditions, including hours worked, to attract die dwindling eligible workforce.
- EEC* 2.44 1992 will have implications for the profession. With the dissolution of EEC barriers, some assessment will need to be made of the standards of training and practice in those European countries from where there is likely to be an inflow of clinical psychologists to the UK.
- “De-professionalisation”* 2.45 A trend manifesting itself both in the NHS and in other contexts which needs to be considered in any professional review such as this, is that of “de-professionalisation”. Certain healthcare professions have recently adopted a more task-based approach to their work. This is evidenced in, for example, the introduction of laboratory aides in pathology departments to undertake circumscribed and limited tasks which can be described by protocol, thereby releasing the more routine work from the more highly skilled and qualified medical laboratory scientific officers.

2.46

With regard to clinical psychology, it is widely acknowledged that the demand for some kind of psychological approach to care (in all hospital settings and in a primary care context), is in excess of the clinical psychologists available to provide it. This raises the issue of whether there are certain of the more straight-forward, simple, but effective interventions which can be undertaken by people trained in psychology to a lower level than existing clinical psychologists.

## Summary

2.47

*The main implications for clinical psychology in relation to the future environment of the NHS are, then, as follows:*

- 2.47.1 *The profession will need to become increasingly more competitive in the context of the changing labour market if it is to continue to attract appropriately qualified individuals.*
- 2.47.2 *Not only will this apply to attracting new recruits, but it will mean introducing mechanisms to ensure it retains those already within the Service.*
- 2.47.3 *Given the prevailing economic constraints within the NHS, it is unlikely that any proposal to expand vastly the profession's numbers will be acceptable, however good the argument for so doing. Consequently, some form of skill-sharing will continue to be necessary and possibly in a more planned, formal way, as opposed to the current ad hoc arrangements, which rely on local circumstance.*
- 2.47.4 *The expanding interests and settings in which clinical psychologists work needs to be catered for by a broad training.*
- 2.47.5 *With the dissolution of barriers in Europe, some assessment will need to be made of the standards of training and practice in those European countries from where there is likely to be an inflow of clinical psychologists to the UK*
- 2.47.6 *If the profession is to successfully fare and flourish and attract adequate funding in a market-driven healthcare system, it will need to demonstrate and promote clearly, unambiguously and actively its value to society.*

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<sup>1</sup> "The Work of Clinical Psychologists", MPAG Reference Group Meeting, British Psychological Society, 31st January 1989; Appendix 2 sets out a further description of clinical psychology from the BPS.

**CHAPTER THREE**

**PROFILE OF CLINICAL PSYCHOLOGY**

**SERVICES IN ENGLAND**

### 3. Profile of the Clinical Psychology

#### Services in England

- 3.1 In this chapter we summarise some of the main findings from a recent manpower survey conducted in 1988 by the Northern Regional Health Authority for the Manpower Planning Advisory Group.
- 3.2 At the time of writing, the manpower survey is incomplete. The data, therefore, must be treated with caution, but it does provide some insight into major themes and concerns facing clinical psychology services.
- 3.3 Figures for 1985 are taken from a previous survey conducted by the University of Bath.<sup>1</sup>

#### Establishment and Occupied Posts

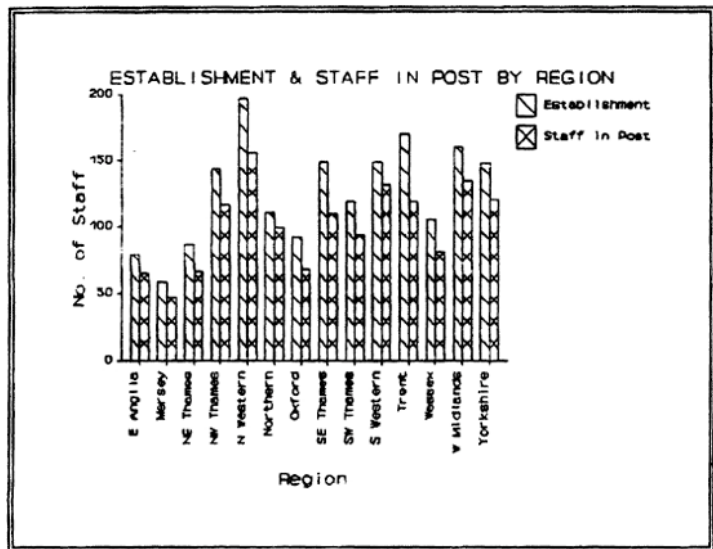
- 3.4 In 1988 there were 1,769 reported whole time equivalent clinical psychologist posts in England, of which 1,407 were occupied. This compares with the situation in 1985, when the reported establishment totalled 1,734 and there were 1,486 clinical psychologists in post.<sup>2</sup>

**Figure 1**

	1985	1988
Establishment	1,734	1,769
Occupied Posts	1,486	1,407

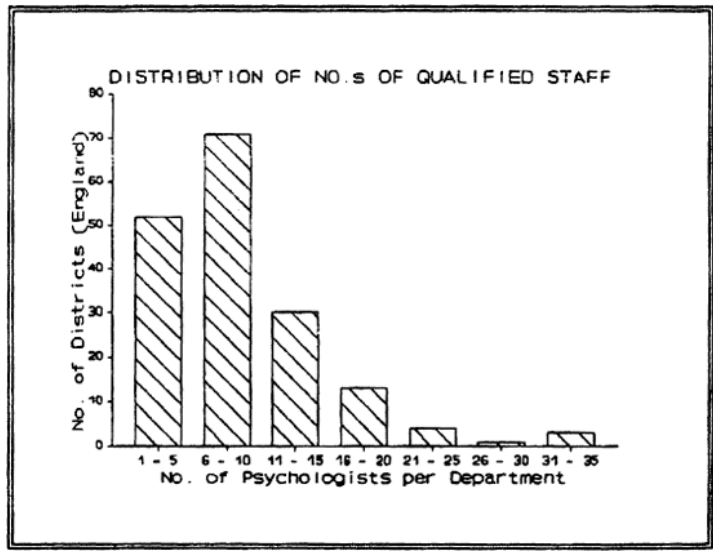
- 3.5 Whilst the establishment has grown since 1985, there are fewer clinical psychologists in post, reflecting the inadequacy of the number of training places in producing sufficient qualified practitioners to fill existing posts, and the increasing retention problems within the profession.
- 3.6 Each region suffers from vacancies in its establishment (Figure 2).

**Figure 2**



3.7 Figure 3 shows the range in size of district clinical psychology departments. It shows the predominance of small departments, with 52 districts having clinical psychology departments comprising between 1 and 5 clinical psychologists and 71 districts with departments containing between 6 and 10 clinical psychologists. 70% of the reported districts, therefore, had psychology departments consisting of 10 or fewer clinical psychologists.

Figure 3



3.8 The distribution reveals a range in the ratio of clinical psychologists to population, as shown in Figure 4 below. This produces an average ratio of 1 : 36,000 people, with the range from 1 : 24,000 to 1 : 56,000.

Figure 4



REGION	POPULATION	STAFFING RATIO TO 1,000 POPULATION
East Anglia	1,992,000	1 : 40,000
Mersey	2,414,000	1 : 51,000
North East Thames	3,761,000	1 : 56,000
North West Thames	3,488,000	1 : 30,000
North Western	3,990,000	1 : 25,000
Northern	3,080,000	1 : 31,000
Oxford	2,476,000	1 : 37,000
South East Thames	3,619,000	1 : 33,000
South West Thames	2,965,000	1 : 31,000
South Western	3,178,000	1 : 24,000
Trent	4,634,000	1 : 39,000
Wessex	2,876,000	1 : 35,000
West Midlands	5,181,000	1 : 38,000
Yorkshire	3,601,000	1 : 30,000
<b>TOTAL</b>	<b>47,255,000</b>	<b>1 : 36,000</b>

### Grades

3.9 Figure 5 shows the distribution between grades of posts nationally.

**Figure 5**

Grade	Number of Posts	% of Total Posts
Basic	200	11
Senior	772	44
Principal	553	31
Top Grade	124	7
Top Grade with Greater Responsibility	120	7
<b>Total</b>	<b>1769</b>	<b>100</b>

3.10 The highest proportion of clinical psychologists are in the senior grade, which is also the grade with the highest proportion of vacancies, as illustrated in Figure 6.

**Figure 6**

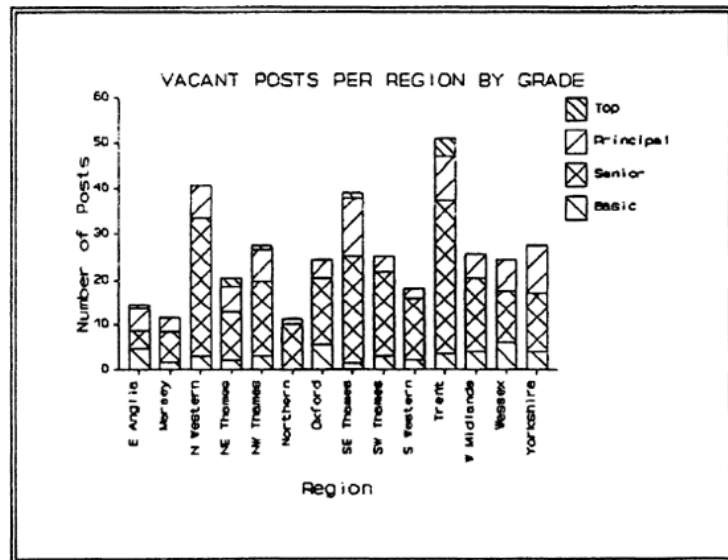
Grade	Number of Vacancies	% of Establishment	% of Vacancies
Basic	43	21.5%	12%
Senior	226	29 %	63%
Principal	82	15 %	23%
Top Grade	9	7 %	3%
Top Grade with Greater Responsibility	0	0 %	-
<b>Total</b>	<b>360</b>	<b>20 %</b>	

3.11 Overall, the vacancy rate is 20% of the establishment. The high vacancy rate at senior grade affects the supervision of trainees, as much of the supervision is undertaken by clinical psychologists in the senior grade.

3.12 All regions suffer problems with vacancy rates, as shown

in Figure 7.

Figure 7



**Specialty**

3.13 The majority of clinical psychologists have adult mental health as their main specialty interest. Whilst some of the headings in Figure 8 may overlap, and the numbers are individuals, not whole time equivalent numbers, the table shows the spread of specialties.

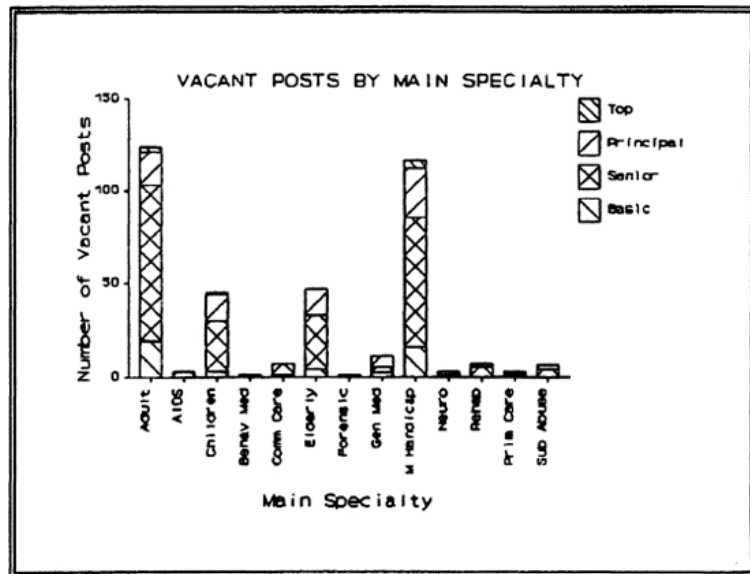
Figure 8

Main Specialty	Total
Adult Mental Health	747
Mental Handicap	399
Children	269
Elderly	161
General Medicine	107
Primary Care	52
Neurosciences	32
Community Care	28
Rehabilitation	25
Substance Abuse	21
Research	15
Teaching	9
Sexual Abuse	8
Forensic	6
Management	6
Physical Disability	3
Physical Health	2
Behavioural Medicine	2
Generic	2
<b>Total</b>	<b>1894*</b>

\* Figures are based on numbers given, not whole time equivalents.

3.14 The high level of vacancies affects the range of specialties, as Figure 9 shows. Predictably, the specialties with the largest vacancies are those with the largest number of clinical psychologists.

Figure 9



### Projected Staffing

3.15 Figure 10 shows the projections for numbers of clinical psychologists in England to the year 1994. This projection is derived from posts proposed in regional strategic plans. Within the establishment it shows predicted number of occupied posts, together with likely losses and gains for each year.

Figure 10

YEAR	1987/88	1988/89	1989/90	1990/91	1991/92	1992/93	1993/94
Staff in Post at Start of Year (WTE)	1,408	1,458	1,544	1,645	1,736	1,837	1,968
Losses (WTE) (a)	341	341	347	354	357	360	362
Gains (New Qualifiers) (WTE) (b)	67	93	104	92	94	117	122
Other Gains (WTE) (c)	324	334	344	354	364	374	376
Staff in Post at End of Year (WTE)	1,458	1,544	1,645	1,737	1,837	1,968	2,104
Establishment (WTE)	1,769	1,951	2,134	2,233	2,306	2,344	2,360
Difference - Vacancy Factor	311	407	489	496	469	376	256

- (a) Losses from the NHS in England.
- (b) Predicted turn out from training courses.
- (c) Re-entrants - clinical psychologists returning to work after a career break.

3.16 Occupancy is affected by two factors: losses from the NHS and gains to the service, which are sub-divided into new qualifiers and re-entrants, that is individuals coming back to work after a career break.

3.17 The numbers of newly qualified clinical psychologists

available to take up posts, based on existing plans for training places, is set to rise by 55% from 67 to 122, between 1987/88 and 1993/94. However, the majority of entrants to the profession come not from the new qualifiers, but from clinical psychologists re-entering posts after a career break. So for example, in 1987/88 re-entrants represented 80% of the total gains. This has significant recruitment implications if the majority of those entering the profession are re-entrants. Any such recruitment strategy has to consider what factors make return to NHS work an attractive proposition.

3.18 Figure 11 shows the projected changes in grade over the strategic period.

Figure 11

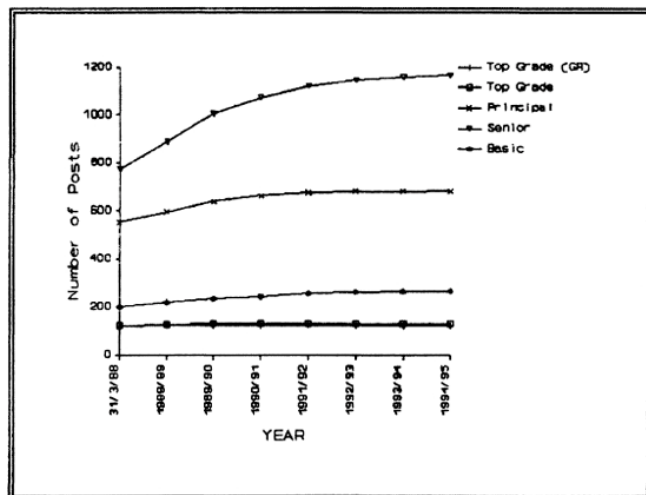
GRADE	Grade Distrib. %	YEAR								Grade Distrib. %
		1987/88	1988/89	1989/90	1990/91	1991/92	1992/93	1993/94	1994/95	
Basic	11%	200	220	238	246	259	265	268	269	11%
Senior	44%	772	886	1,005	1,073	1,121	1,146	1,159	1,166	49%
Principal	31%	553	594	641	663	677	681	681	683	29%
Top Grade	7%	124	128	129	129	129	131	131	131	6%
Top Grade (GR)	7%	120	121	121	121	121	121	121	121	5%
TOTAL	100%	1,769	1,949a	2,134	2,232a	2,307a	2,344	2,360	2,370	100%

(a) Total does not correlate with figure given in Figure 10.)

3.19 Figure 12 plots these projected grade trends.

Figure 12

Projected Figures for Clinical Psychology Posts



Training Places

Intake

3.20 In 1987 there were a total of 116 Clinical Psychology training places in England.

3.21 Figure 13 presents the profile of student intake between 1980 and 1987. It shows the age and sex composition of the intake and the actual intake as a proportion of applicants eligible for places.

Figure 13

### Student Profiles - England

			1980	1981	1982	1983	1984	1985	1986	1987
			Intake	Intake	Intake	Intake	Intake	Intake	Intake	Intake
No. of Eligible Applicants			544	688	1,040	1,113	1,179	825	938	983
A G E	No. under 21 years	Male	0	0	0	0	0	0	0	1
		Female	0	0	0	0	0	0	0	3
/	No. 21-25 years	Male	11	8	7	10	5	9	16	15
		Female	26	39	29	31	36	29	40	51
G E N D E R	No. 26-30 years	Male	7	11	8	12	13	11	12	9
		Female	8	5	13	23	15	22	22	18
O F	No. 31-35 years	Male	2	2	5	5	7	4	4	4
		Female	4	6	6	7	6	4	5	8
I N T A K E	No. 35-40 years	Male	1	2	3	0	1	0	3	1
		Female	3	2	2	4	5	4	4	3
	No. over 40 years	Male	0	0	0	1	0	0	1	1
		Female	0	0	2	1	1	1	2	2
Total Actual Intake			62	75	75	94	89	84	109	116
Ratio of Applicants per Place			8.7	9.1	13.8	11.8	13.2	9.8	8.6	8.4

#### Output

3.22 Figure 14 summarises the data concerning numbers qualifying, losses in training and the number of newly qualified clinical psychologists entering the Health Service.

**Figure 14**

	1983	1984	1985	1986	1987
Number Qualifying	65	76	78	79	83
Losses in Training	4	2	2	4	5
Qualified Going into the NHS	50	60	61	66	68

3.23 The number of new qualifiers taking up NHS posts, even when combined with those re-entering the NHS, comes nowhere near the numbers required to keep pace with vacancies and the creation of new posts. Thus, the more posts being established, the greater the number of vacancies which are likely to occur, unless more training posts are created.

### Summary

- 3.24 *The main factor to emerge from the manpower survey described in this chapter is that whilst the profession is technically expanding in terms of the increases in numbers of posts established, in real terms it is contracting due to its significant supply problems.*
- 3.25 *Unlike many other health care professions, its supply problems do not stem from a shortage of individuals keen to pursue a career in clinical psychology. The competition for training places, reflected in the 1987 ratio of 8.4 applicants to each place, confirms this.*
- 3.26 *With no current shortage of individuals seeking a career in clinical psychology and, at the other end, a growing establishment, the bottleneck in the system and the causal factor of the shortfall in qualified clinical psychologists available to fill the number of posts that exist appears to be the limited number of training places. Several studies have been undertaken by the BPS identifying this as the problem and suggesting appropriate increases to overcome the shortfall.*
- 3.27 *However, the implications for the profession resulting from the survey span wider than the need to increase the number of training places. This will not solve all the problems. Given the imminent demographic “time-bomb”, the profession cannot guarantee the continuation of the generous pool of eligible applicants, especially in view of the significant financial drawbacks of pursuing a career as a clinical psychologist in the NHS. The effects of the financial drawbacks of entering the NHS and the existence of more lucrative options is demonstrated by the proportion of newly qualified clinical psychologists who take up jobs elsewhere following completion of training. In 1987 18% of the newly qualified did not enter the NHS (having been trained largely at the expense of the NHS). Furthermore, wastage from those in junior grades is becoming a significant feature, with 16.5% of all basic grades leaving the NHS in 1987/88.*
- 3.28 *Other considerations are the profile of a profession in which there are proportionately more females than males and clustered in the 25 to 35 year age group, and where gains to the profession are predominantly re-entrants following a career break, rather than the newly qualified. This all points to the need for an urgent examination of the terms and conditions of service - how to ensure adequate recruitment to the profession and retention of those within it. These issues are further described and addressed later in this report.*

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<sup>1</sup> Scrivens E. and Charlton D. The Nature and Size of Clinical Psychology ..., Bath Social Policy Papers, No. 6, University of Bath, 1985.

<sup>2</sup> Unlike the 1985 survey, the 1988 study did not encompass special health authorities. It should be noted, therefore, that when comparing 1985 and 1988 data, the former includes special health authorities, whilst the latter does not. In 1985 the number of psychologists working in SHA's was about 40.

**CHAPTER FOUR**

**THE NEED FOR PSYCHOLOGY IN**

**HEALTH CARE**



4.

### **The Need for Psychology In Healthcare**

4.1 For years behavioural and social scientists, people interested in social medicine and epidemiology, as well as medical practitioners, have been seeking to establish reasons for illness and disease.

4.2 It is not for this review to explore and repeat the various avenues of study, but it is important to contribute to the raising of health service providers' consciousness to the importance of behaviour as a determinant of health, and risk behaviour as a determinant of illness.

#### ***Behaviour as an Influence on Health***

4.3 Making the case that behaviour has a significant impact on the health and welfare of people is, these days, relatively easy. Each year thousands of people die in the UK from infectious diseases, accidents, violence and conditions such as cardiovascular disease, cancers, diabetes, cirrhosis of the liver and respiratory diseases, which are often developed as a result of unhealthy and sometimes dangerous behaviour. The evidence is being identified continuously, and has given rise to such concepts as "avoidable deaths".

4.4 Post-natal influences on illness and disease can now be judged largely (apart from socio-economic factors) to be those which individuals determine by their own behaviour (smoking, eating, exercise) and are as important influences as those which depend on the action of society - for example the provision of food which is fit for consumption, and protection from hazards.

#### ***Prevention and Treatment***

4.5 Translating what is known about the influences on our health into guidelines for societies is notoriously complex. The major investment in healthcare is in hospital medical care, on the assumption that we are ill and need to be made well. A more accurate assessment is that many of us who would otherwise be well, are made ill by our own personal actions. Very little of the nation's investment in healthcare is applied to preventing illness; most is used for treatment.



- 4.6 Changes in our overall approach to health can only be gradual, and considered over a long timescale. Changing a pattern of healthcare which has existed for hundreds of years, in the form of hospitals, requires us to think over a timescale of decades.
- 4.7 Similarly, another major difficulty is the different timescales within which healthcare professionals work and their expectations about what time-frame is necessary for evidence of success. The physician works to a relatively short timescale, and if unsuccessful (for example, in persuading patients to give up smoking), may conclude that it is not possible to alter morbidity-inducing habits. Yet, over a longer time period, as reported by the Royal College of Physicians, smoking habits are changing. Similarly, success in terms of significant reductions in certain diseases, will only become evident in the longer term.
- 4.8 Behavioural influences on health are sensitive matters to discuss. Many people who can quite easily accept the need for public intervention in food policies, for example, and such matters as the protection and control of the environment and the provision of medical care, become deeply suspicious of attempts to modify personal behaviour.<sup>1</sup>
- 4.9 In general there are two forms of objection raised to the suggestion that behaviour should be modified by public action:
- 4.9.1 that this would be an unreasonable intrusion on the rights of the individual;
- 4.9.2 that any such attempt would be certain to fail, and in so doing, would constitute a waste of public money.
- 4.10 There is no general approach to changing behaviour which can be applied on a mass scale. However, the issues should perhaps be considered individually and with imagination, as well as tact.

***“Health for All  
by the Year  
2000”***

4.11 An objective of the World Health Organisation (WHO) is to promote “Health for All by the Year 2000” (HFA 2000). The WHO initiative is based on the underlying assumption of a very intimate relationship between people’s behaviour, their lifestyles, and their level of health.

4.12 Intervention with people’s behaviour and lifestyle is generally approached with caution. The more acceptable approach is to wait until people present themselves to a healthcare worker, most often a general medical practitioner, and then intervene using the presenting problem as the basis for intervention.

***Prevalence and  
Incidence***

4.13 Determining the prevalence of those problems with a behavioural cause is virtually impossible. This is largely due to the difficulties of definition and the need to categorise the problem in terms of an illness, either mental or physical. Measuring the incidence of such problems is equally difficult, as incidence may be influenced by the presence or absence of an appropriate healthcare worker. Thus the overall morbidity of behaviourally-based problems is unknown.

4.14 Despite this, the estimated number of people consulting general medical practitioners with problems with a behavioural base is generally believed to be no less than 50% of consultations; therefore it is a fair assumption that the number of people debilitated, disabled or dying from a physical illness with a behavioural cause is very high. In addition, something of the order of 15% of the population present with a psychological health problem which is sufficiently distressing to cause the individual to seek professional help. We need to think, therefore, of a large proportion of the population with psychological and physical health problems which are behaviourally induced.

***Intervention of  
Psychology***

4.15 The intervention of psychology into these problems is at two main points.

4.15.1 Psychology can intervene at the primary care level to prevent behaviourally-based health problems

from becoming conditions requiring treatment by medical intervention.

- 4.15. Psychology can intervene in a number of ways once a health problem is presented for primary or secondary medical care:
- o to support medical intervention by assisting in assessment, diagnosis and treatment;
  - o as a complement to medical intervention through the use of psychological strategies to enable people to cope with the effects of their condition and the subsequent medical intervention and to enhance compliance with medical regimes; and
  - o as an alternative to medical intervention where the behavioural base to a health problem is more effectively addressed than the health problem itself and the medical treatment of it.

*Primary Level*

4.16 In looking at the first of these levels of intervention, the HFA 2000 initiative reflects a growing acknowledgement of the contribution of psychology to primary care. On primary mental healthcare specifically, the strategy requires great expansion in the psychological skills and knowledge available. In so doing it creates an opportunity for psychologists to consolidate their professional base and to demonstrate the contribution of psychology in the interests of the public.

4.17 If the HFA objectives are to be attained, it would appear that governments everywhere should be looking to introduce a different model for health services, whose emphasis is on primary care (with concomitant allocation of resources). The 1978 Alma Ata declaration describes the features of such a model:

4.17.1 gives priority to those with greatest

- need;
- 4.17.2 addresses the main problems of the community;
- 4.17.3 provides promotion, prevention, treatment and rehabilitation services;
- 4.17.4 integrates other services: education, housing, food industry, etc.;
- 4.17.5 maximum individual and community self-sufficiency;
- 4.17.6 fully utilises local resources;
- 4.17.7 ensures comprehensive coverage;
- 4.17.8 uses appropriate health technology (ie, wherever possible, social and behavioural strategies should be used as alternatives to medical technical strategies);
- 4.17.9 has a supportive referral system;
- 4.17.1 provides healthcare on a multi-professional basis, bringing together medical, psycho-social, behavioural and social skills.

4.18 One of the main conclusions of HFA/2000 is that because of the integral link between the behavioural and psycho-social dimensions and health, it should be incorporated into the planning and provision of healthcare. This has far-reaching implications for the role of clinical psychologists in a much wider planning and policy arena. Some clinical psychologists are already rising to this challenge and are discharging such a role in their health authorities.

4.19 An implication of the recognition of the

behavioural aetiology of many conditions is the need for expansion in the numbers of clinical psychologists working in the primary care setting.

- 4.20 The preventive role for the clinical psychologist would be accentuated in this model. There is much scope for psychologists to develop and evaluate preventive and health education programmes, focusing on reducing health-damaging lifestyles and the adoption of health-enhancing behaviour and attitudes for the general population.
- 4.21 In these activities clinical psychologists would need to dovetail their-tasks with others, in particular with the proposed Directors of Public Health whose purpose is to implement Public Health - “the science and art of preventing disease, prolonging life and promoting health through organised efforts of society”.<sup>2</sup>
- 4.22 Studies have been done to determine which (in the opinion of GPs) disorders encountered in the primary setting, are most effectively dealt with by intervention from a clinical psychologist. These have been described as: phobias, problems of anxiety and stress (including stress-induced/exacerbated illness such as cardiovascular disease, migraine and asthma), habit and obsessional disorders, smoking and drinking problems, psychological adjustment to physical illness and other significant life events, psycho-sexual and inter-personal problems, and educational and occupational difficulties/decisions.<sup>3 4</sup>
- 4.23 One result of expanding the number of clinical psychologists working within the primary care setting is that demand for their services would increase significantly. Consequently, integral to working within a primary setting, together with more indirect working through other professionals, would be the development, evaluation and provision of short-term and simple diagnostic, intervention and preventative methods.
- 4.24 Studies examining the efficacy and cost-effectiveness of psychological treatment have

shown how effective short treatments can be.<sup>5 6</sup>

4.25 Because it would not necessarily be appropriate for clinical psychologists always to work directly with patients, they would have an important role, as they do currently, in training and supervising other primary care professionals in the provision of certain simple, easily applicable psychological techniques. The role of the clinical psychologist, in terms of the proportion of time spent undertaking direct clinical work, and the extent to which they are more appropriately used indirectly, as a source of training, supervision and advice to other primary healthcare professionals, needs to be carefully considered. Apart from the importance of best utilising their expertise, there are significant resource implications involved.

*Secondary Level*

4.26 The argument for an increasing clinical psychologist involvement at the primary level does not detract from acknowledging the essential role for the clinical psychologist with clients with long-term problems. The increasing chronicity of conditions also has implications for the amount of clinical psychologist intervention required in long-term care,

4.27 There is well-documented evidence to show that brief psychological interventions can reduce the use of other health services, making savings which are greater than the cost of providing psychological services. (This is known as the medical off-set phenomenon.)

4.28 Studies have also been done on the use of psychological intervention to improve physiological conditions. Sufferers of chronic diseases such as coronary heart disease, hypertension, diabetes and asthma are high users of medical services. They also often have psychological problems as a result of their condition. Furthermore, emotional distress is known to influence the course of the disease, can influence the speed and extent of recovery and can affect the individuals' management of their own condition.

4.29 Various psychological and behavioural

interventions have been developed for such physical conditions. Studies into the outcome and effectiveness of psychological intervention (and particularly psychotherapy) with this category of patient, have been summarised by Van den Bos and De Leon.<sup>7</sup>

4.30 These studies have shown that outpatient psychological intervention (of between two and six sessions) is linked to a medical off-set effect and the more psychological sessions, the stronger the medical off-set phenomenon, resulting in reduced utilisation of inpatient services and other associated hospital care costs.

4.31 Thus, it would appear that patients with this type of long-term condition who receive psychological intervention over a period of time, require less hospital treatment. Moreover, this effect lasts for between three and five years after the end of psychological intervention.

4.32 At the treatment level of intervention then, the application of psychological theories is having a growing and significant impact.

4.33 The acknowledgement of this by healthcare managers could have potentially major implications - not only does it imply more cost-effective provision of services, but there would be significant benefits to the patient who would, where appropriate, receive less drastic/invasive treatment and would be taught the skills to enable a greater degree of self-management of their condition.

***Efficacy of  
Clinical  
Application of  
Psychology***

4.34 In order to answer the question “does psychology work?”, we commissioned a review of the efficacy of the clinical application of psychology, which appears in an original form in Appendix 3. The review covers the application of the commonly used psychological interventions and focuses on their use for children and young people, adult mental health, elderly people, behavioural medicine, and people with learning difficulties. There is ample evidence in this review of the use of psychology as a support, complement and alternative to medical strategies.

	4.35	These studies show a need to research the appropriate application of psychological theories, to evaluate them, and to research the outcome of their use.
<i>Psychology in Health care Delivery Systems</i>	4.36	However, psychology in healthcare is not confined to the health problems of people. The maintenance of good health and the improvement and maintenance of the quality of life is also influenced by the methods used to deliver healthcare, and the way in which healthcare facilities are organised, managed, evaluated and developed.
	4.37	Social psychology applies psychological theories to the organisational problems of delivering healthcare, and the problems of integrating healthcare services into the communities they serve, and tailoring them accordingly.
<i>Psychology in Management</i>	4.38	Psychology is also used in the management of healthcare, in the planning of services, in their evaluation and the processes for coordinating the components of a healthcare service.
	4.39	The Health Service is a dynamic organisation adapting itself constantly to the economic, social and technological environment in which it operates. Changes in the organisation of the NHS may mean that health services must become more responsive to need in order to survive and prosper. The ability to adapt depends in large part on the change strategies adopted, and psychological theory has a major contribution to these processes.
<i>Psychology in Human Resource Management</i>	4.40	Management is also about communication and about “human resource management”, that is, obtaining the best from people and ensuring their continued interest and commitment to the work they do. Equally, management is concerned with ensuring that appropriate people with appropriate skills are related to the tasks which have to be completed. Psychological theory has a very definite contribution in these areas.
	4.41	Working in healthcare creates its own stresses and



pressures. The Health Service is a stressful environment - those who provide professional healthcare, support services and the managers of the services are all placed in immensely stressful situations, be it coping with seriously ill people, or having to manage major change. The application of psychology to these matters not only lubricates the processes of delivering healthcare, but can prevent problems from becoming sufficiently serious to generate discontentment and to impair the capacity of people to work.

- 4.42 The application of psychology is not only important as a direct intervention used by clinical psychologists; it is used by everyone delivering healthcare.
- 4.43 All healthcare workers who practise their vocational skills with patients require the ability to engage the patient, to place the patient at ease, to communicate with the patient effectively, to counsel the patient, and often to do all these things with the patient's relatives and carers. The effectiveness of these basic interpersonal skills makes a major contribution to the successful outcome of care, and the quality of experience which patients endure at the hands of healthcare workers.
- 4.44 With an increasingly articulate and knowledgeable consumer of health services comes a greater demand for information and understanding of the processes of healthcare. Here too, psychology has a valuable contribution.

### Summary

- 4.45 *The case for the need and potential impact of psychology within healthcare is based on the amount of morbidity and mortality which could either be prevented or effectively managed by psychological intervention.*
- 4.46 *A significant proportion of illness is determined by behaviour. The estimated number of people consulting GPs with behaviourally-related problems is estimated to be about 50% of all consultations. One can assume, therefore, that the number of people debilitated, disabled or dying from a physical illness with a behavioural cause is very high. In addition to this, about 15% of the population present to a GP with a psychological problem which is sufficiently distressing to lead the individual to seek professional help.*
- 4.47 *Healthcare is currently financed on the premise that illness is to be treated rather than prevented. There is little acknowledgement that much illness is attributable to “risk” behaviour and that a much more effective approach to such illness is to attempt to influence and change the behavioural factors which contribute to its onset.*
- 4.48 *The World Health Organisation’s initiative: Health for All by the Year 2000 is founded on such an acknowledgement. It is based on the underlying assumption of a very intimate relationship between people’s behaviour, their lifestyles and their level of health. If HFA 2000 is a serious aim, governments everywhere should be looking to introduce a different model of health services, where emphasis is on primary care.*
- 4.49 *In particular, HFA 2000, in its recognition of the behavioural aetiology of many conditions, and therefore the potential contribution of psychology to primary care, requires great expansion in psychological skills and knowledge. These are needed, for example, to develop and evaluate preventive and health education programmes, focusing on reducing health-damaging lifestyles and the adoption of health-enhancing behaviour and attitudes for the general population.*  
*Clinical psychologists also have an essential role in secondary healthcare. There is evidence to show that brief psychological interventions can reduce the use of other health services, making savings which are greater than the cost of providing psychological services (“the medical offset phenomenon”).*
- 4.51 *Certain psychological interventions have been shown to improve particular physiological conditions, such as coronary heart disease, hypertension, diabetes and asthma, sufferers of which are all high users of medical services. Studies on the effectiveness of psychological/behavioural intervention with this type of patient have shown that short-*

*term outpatient sessions of this sort are linked to a medical off-set effect, resulting in reduced utilisation of inpatient services and other associated hospital costs. Patients receiving this type of intervention have been shown to require less hospital treatment and, moreover, the effect lasts for between 3 and 5 years after the end of the psychological intervention.*

4.52 *The acknowledgement of this by healthcare managers could have potentially major implications - not only does it imply more cost-effective provision of services, but there would be significant benefits to the patient who would, where appropriate, receive less drastic/invasive treatment and would be taught the skills to enable a greater degree of self-management of their condition.*

4.53 *However, the application of psychology in healthcare is not confined to the health problems of people. Psychological theory also has a major contribution to processes such as the methods used to deliver healthcare and the way in which healthcare facilities are organised, managed, evaluated and developed.*

4.54 *All of these factors, if seriously acknowledged and acted upon, have important and potentially radical implications for the role of psychology within healthcare and for the healthcare system in its entirety.*

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- <sup>2</sup> Public Health in England - The Report of the Committee of Inquiry into the Future Development of the Public Health Function. Cm 289. January 1988.
- <sup>3</sup> Kincey J.A.: General Practice and Clinical Psychology - Some Arguments for a Closer Liaison (1974), Journal of the Royal College of General Practitioners, 24, 882-888.
- <sup>4</sup> Marzillier J.S. and Hall J.: What is Clinical Psychology? (1984), Oxford University Press.
- <sup>5</sup> Rosen J. and Weins A: "Changes in Medical Problems and Use of Medical Services Following Psychological Intervention", American Psychologist (1979), 34, 420-431.
- <sup>6</sup> Mumford E., Schlesinger H. and Glass G.: "The Effects of Psychological Intervention on Recovery from Surgery and Heart Attacks: An Analysis of the Literature", American Journal of Public Health (1982),72, 141-151.
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- Cummings N. and Follette W.: "Psychiatric Services and Medical Utilisation in Pre-Paid Health Plan Settings: Part II", Medical Care, (1968), Vol.6, 31-41.
- <sup>7</sup> Van den Bos G.R. and De Leon P.H.: "Use of Psychotherapy to Improve Physical Health", Psychotherapy (1988), Vol. 25, No.3, 335-343.

**CHAPTER FIVE**

**THE ACTIVITIES OF CLINICAL PSYCHOLOGISTS**

**AND OTHERS**

## **The Activities of Clinical Psychologists and Others**

### ***Activities of Clinical Psychologists***

5.1 The activities in which clinical psychologists in the NHS are engaged are many and varied. We list below a range of activities in which they participate.

#### Clinical

5.1.1 undertake assessments of clients' cognitive functioning, personality and their emotional and psychological state;

5.1.2 apply psychological interventions to problems - both on an individual and group basis;

5.1.3 treat patients indirectly through the provision of training, guidance, advice and supervision to other staff involved in psychological intervention;

5.1.4 act as a catalyst to stimulate others;

5.1.5 develop programmes of care for others to discharge;

5.1.6 develop health education and promotion programmes;

5.1.7 co-work with other healthcare personnel in providing assessment and therapy;

5.1.8 assess clients for

resettlement, develop option plans, devise rehabilitation programmes for clients and provide pre-discharge preparation for clients who are to be repatriated;

5.1.9 assist in general medical treatment - either by enhancing compliance with treatment (by tackling poor motivation, depression, low understanding), or providing psychological support to enable patients to come to terms with the consequences of medical intervention and/or their condition;

5.1.10 act as advocates for client groups;

5.1.11 provide support to carers/families of individuals receiving treatment;

5.1.12 advise and support self-help groups;

#### Staff Support

5.1.13 provide professional staff support services - “occupational health” role in providing counselling, stress management and other therapeutic support;

### Teaching and Supervision

- 5.1.14 teach and supervise clinical psychology students;
- 5.1.15 supervise inexperienced clinical psychologists in specialist techniques, and mutual supervision between experienced clinical psychologists;
- 5.1.16 train other healthcare staff in “psychological” skills (for example, interviewing technique, problem definition and behavioural observation);
- 5.1.17 teach and supervise other disciplines in the application of psychological theory;
- 5.1.18 teach others management skills (communication skills, understanding group dynamics);

### Service Planning

- 5.1.19 provide a consultative role on appropriate models and systems of care, identifying problems in clinical/team systems - acting as “trouble-shooter” and providing advice on appropriate systemic change in the care environment;
- 5.1.20 engage in service

planning and development and act as catalysts to service innovation;

### Research and Evaluation

5.1.21 engage in epidemiological research - identifying and analysing population need for psychological health services;

5.1.22 undertake service evaluation - appraising delivery systems and monitoring the appropriateness, effectiveness and quality, and changes in the provision of services;

5.1.23 evaluate changes in health policy,

5.1.24 undertake research - testing the efficacy of interventions and developing and applying new methodologies;

5.1.25 research and develop new psychological methods for use by others in a variety of settings (primary and hospital/residential);

### Ambassadorial

5.1.26 raise the profile of clinical psychology and promote its image as a credible and valuable discipline;

5.1.27 publicise clinical



psychology services and work to improve the knowledge of others about its role and potential contribution;

### Organisational

5.1.28 undertake organisational change activities, applying psychological knowledge and skills to the effective functioning of the organisation and management (assisting in the development of organisation and management skills and, for example, providing a recruitment and selection service for key posts);

5.1.29 act as team facilitators;

### Management

5.1.30 liaise with and co-ordinate other agencies' involvement in assessment and treatment;

5.1.31 manage workload, staff and other resources;

### Administration

5.1.32 make arrangements for patient care (planning appointments);

5.1.33 keep patient notes and records up-to-date;

5.1.34 deal with correspondence;

5.1.35 data collection (to fulfil Körner and other requirements).

5.2 In most of these activities clinical psychologists are applying psychological theories. Many of these activities are not clinical in orientation.

5.3 With respect to the clinical therapeutic activities, there are a number of theoretical and practical applications which are in common use. They are:

Counselling  
Behavioural therapy  
Cognitive behavioural therapy  
Psycho-sexual therapy  
Marital and family therapy  
Psychotherapy  
Transactional analysis  
Gestalt approach  
Construct therapy  
Memory retraining

A fuller list of therapies appears in Appendix 4.

*The  
Activities of  
Others*

5.4 Whilst members of multi-disciplinary teams might, to a large extent, handle similar cases and use many common therapies, each would approach the tasks from a different perspective. It is appropriate here to describe the distinctions and different orientations of the main disciplines working within the mental health arena.

Psychiatrists

5.5 Psychiatrists are concerned with the diagnosis and treatment of psychiatric illness. They focus (although not exclusively) on organic, pathological disturbance and psychosis and this, the connotation of psychiatric illness, differentiates their caseload from others. The law requires them to carry medical responsibility for a patient in contact with health services due to mental illness. They also have other statutory responsibilities under the Mental Health

Act, relating to the admission and discharge of individuals to/from inpatient psychiatric care. Their treatment strategies tend to be physical - pharmacological and electro-convulsive therapy, although many psychiatrists also employ psychotherapeutic interventions and there are a number of specialist psychiatry posts in psychotherapy at consultant and senior registrar level.

5.6 The training of psychiatrists requires them to be medically qualified for not less than three years, and to pass the membership examination of the Royal College of Psychiatrists. Aspects of psychology examined include:

5.6.1 Human psychological development.

5.6.2 Basic psychological processes in the adult.

5.6.3 General principles of social psychology.

5.6.4 Psychotherapy.

### Psychiatric Nurses

5.7 Their professional objectives, which they share with other disciplines in the field - occupational therapists and social workers, for example, are to offer support and maximise the potential and functional ability of an individual. Their distinctive contribution is the clinical nursing duties they undertake, including the administration of injections and drugs to mentally ill individuals.

5.8 Psychiatric nurses provide nursing care to patients in hospital and in the community. As well as tending to physical care needs, in providing emotional support they use a variety of psychological interventions, from the more general type, such as counselling and anxiety management, to more focused psychological strategies, such as behavioural and cognitive therapy, for which they require specialist training (provided either as part of

their own professional, post-qualification courses or by a clinical psychologist). The latter they frequently provide under supervision from a clinical psychologist.

5.9 A characteristic of their caseload is their involvement with the long-term maintenance of people with long-standing psychological health problems. This includes the administering of injections, together with providing general emotional support to an individual and their family. They do, however, also work with individuals suffering from less severe psychological health problems - phobias, anxiety and depression, for example.

5.10 Their training involves the three year Registered Mental Nurse (RMN) course, after which they can do a number of post-basic English National Board (ENB) courses to specialise in a particular orientation, problem or therapeutic intervention. These include:

5.10.1 adult behavioural psychotherapy;

5.10.2 psychodynamic techniques;

5.10.3 principles of psycho-sexual counselling.

### Mental Handicap Nurses

5.11 Nurses work with people with learning difficulties in residential settings and in the community, assisting individuals to develop self-help, work, educational and social skills and providing nursing interventions. They assess developmental attainment, self-care and social competence, including communication skills; write individual care plans; implement developmental and behavioural training; and often provide general group “therapy” in areas like social skills. They also support families in the day-to-day management of an individual.

5.12 Specialist post-basic courses are available in

behaviour modification techniques and this represents the main “boundary” area with clinical psychologists. They are taught a limited range of behaviour modification techniques and to exercise some initiative in developing behavioural programmes in association with others in a multi-disciplinary team. A clinical psychologist will frequently oversee the behaviour modification programmes implemented by nurses.

### Nurse Behaviour Therapists

- 5.13 These are nurses specially trained (via a post-basic course) in behavioural psychotherapy. They are trained to work in a therapeutic team, with more than the usual degree of autonomy and with limited consultation with psychiatrists and clinical psychologists. They help formulate appropriate behavioural analysis of problems and treatments and are not only able to act as main therapist, but can co-ordinate other personnel in comprehensive therapeutic programmes.
- 5.14 The majority of their work is in providing therapy for adults with neurotic and personality disorders (anxiety states, phobias, obsessive-compulsive disorders, sexual dysfunction, sexual deviation and social maladjustment, for example). As well as working with individuals, they also undertake group, marital and family therapy. Techniques used include imaginal or “in vivo” exposure (desensitisation, flooding), response prevention, anxiety management, aversion control, role play, social skills training and devising operant programmes.
- 5.15 The discipline evolved with its very specialist and focused treatment approach specifically because there were insufficient clinical psychologists to work with the numbers of people with the types of disorder that respond well to a behavioural therapeutic strategy. Nurse behaviour therapists receive referrals from the spectrum of healthcare disciplines, including psychiatrists and clinical psychologists.

## Occupational Therapists

- 5.16 The objective for OTs is to maximise an individual's functioning equipping the patient with the necessary practical life skills required to be as independent as possible. Their approach is inevitably broad based and holistic, seeking to address the social and emotional needs of an individual, as well as physical needs. It is their use of activity as the basis for therapy to improve functioning and facilitate rehabilitation which distinguishes the profession. As members of multi disciplinary teams they often undertake explicitly psychological tasks in fulfilling their objectives.
- 5.17 Their main approach is a task-oriented, behavioural one. As with social workers and psychiatric nurses, they are generally less theoretical and not as highly structured in their approach as clinical psychologists. They undertake certain psychological interventions in a more functional/pragmatic way to that of a clinical psychologist. OTs can be found using forms of behaviour, cognitive and cognitive/behavioural therapy (anxiety management for example), counselling, family, marital and other non-directive group therapy (running support groups, for example), and social and coping skills training. As members of multi-disciplinary teams they will assess, plan programmes and treat clients with psychological problems. They are, however, generally supervised by a clinical psychologist in undertaking psychological therapies and often co-work with clinical psychologists.
- 5.18 OTs working with people with learning difficulties will assess and plan therapy programmes using a holistic approach which addresses the learning difficulty and psychological overlay. They will employ a behavioural approach in teaching social skills, communication skills, and self-help skills.
- 5.19 OTs working with elderly people will undertake various assessments relating to orientation, mental capacity and psycho-motor testing, as

well as employing similar therapeutic interventions as those described above.

5.20 The basic diploma in occupational therapy contains psychology components. In addition, there are elective post-qualification, courses in the following areas:

5.20.1 play diagnosis, play therapy and drama therapy;

5.20.2 generic courses in child and adolescent psychology;

5.20.3 courses for OTs working with people with learning difficulties;

5.20.4 assessment techniques, including rating scales and other psychological tests;

5.20.5 anxiety and stress management;

5.20.6 conductive education for neurologically impaired adults.

### Social Workers

5.21 Psychiatric social workers have statutory responsibilities under the Mental Health Act relating to the assessment, rehabilitation and aftercare of individuals compulsorily admitted to inpatient psychiatric care. Further training beyond the basic CQSW is required if an individual is to become an approved social worker under the Mental Health Act. Social workers also have a statutory role in child welfare/protection.

5.22 More generally they share the objectives of the other disciplines described above, but bring a social perspective to an individual's problems. They will become involved with a case with a view to ameliorating the social/environmental stresses associated with psychological problems.

Their primary focus, therefore, is with providing practical assistance and support with housing, welfare benefits, and other practical matters. However, psychological theory and method provides social workers and the other disciplines mentioned here, with both the conceptual framework and technical skills for working with people with psychological problems.

- 5.23 Whilst their casework comprises the provision of practical support for individuals in hospital and the community, because of the inseparable nature of social and emotional problems, psychiatric social workers can be found employing a variety of psychological interventions - some in an unstructured, sub-conscious way, whilst others have undergone specific training in a psychological approach. They will be involved in counselling, relaxation training, behaviour modification (usually under supervision from a clinical psychologist), group work (such as anxiety management), marital therapy and psychotherapy. It is frequently claimed by social workers that psychodynamic theories of human development and groups are the most relevant to their needs. These are, however, given minimal emphasis on basic and post-qualification courses.
- 5.24 Two of the main issues focused on by a study on the teaching of psychology on social work courses, described in Appendix 5, were the tasks for which social workers need psychology and the necessity of teaching psychology for field practice.
- 5.25 Of the tasks of a social worker, Sutton<sup>1</sup> wrote: The legal responsibilities carried by social workers are daunting: they include the investigation of, and intervention in, cases of suspected child abuse, such as violence or incest; the placement of children, often distressed or unmanageable, in such foster homes as can be found, and attempting to support the foster parents; inquiring into the suitability of people interested in adopting children; investigating the appropriateness of supporting an application for the compulsory admission of a patient to a psychiatric hospital;



and the carrying out of supervision orders placed by courts upon, for example, young offenders. In addition, they are required to offer help and support to the mentally handicapped and their families, to the aged, to those discharged from psychiatric hospitals and needing help in the community as well as to members of ethnic minority groups ...” Elsewhere<sup>2</sup> she continued: “social workers ... are expected to be able to forecast whether parents will neglect or injure their children, whether those who have offended in the past will offend again and whether a given type of court order will prove effective.”

### Speech Therapists

- 5.26 The speech therapist is concerned with identifying, assessing and treating communication disorders. Because disorders in communication are frequently accompanied by psychological problems, speech therapists often find themselves providing psychological interventions.
- 5.27 A speech therapist’s caseload will, then, include not only the assessment of communication disorder, but also the emotional and social consequences on an individual and their family. They will assess in both a physical, linguistic sense and a cognitive sense. Assessments are often done jointly with a clinical psychologist, reflecting the common interest in communication and language disorder.
- 5.28 Speech therapists administer a battery of tests to make their assessments: these include assessments of memory and perception, aphasia tests to discriminate between dementia and depression, and tests for functional communication and reading abilities.
- 5.29 Their psychologically-oriented therapeutic activities include counselling and informal behavioural and cognitive therapy - language being a higher cognitive function, and therefore requiring cognitive treatment approaches.

- 5.30 A speech therapist's training can be acquired on an under-graduate and post-graduate basis. The psychological components of the courses include normal development (birth to old age), abnormal developmental processes and behaviour, and psycholinguistics. A research methodology and statistics component is also integral to their training.

### Psychology Technicians

- 5.31 This is another group involved in providing a service, aspects of which are common to clinical psychologists. Psychology technicians are frequently psychology graduates who are acquiring relevant work experience prior to embarking on a clinical psychology training course.
- 5.32 They can be found working in a variety of health specialties (particularly in services for people with learning difficulties). They undertake very circumscribed tasks, and are required to be subject to close supervision by a clinical psychologist. Psychology technicians have little autonomy to exercise discretion. Tasks associated with psychology technicians are the administration of psychological measurement tests and assisting in long-term care projects.

### Managers

- 5.33 Managers use psychology skills in such activities as: communication, inter-personal relationships, handling group dynamics, counselling and stress management.
- Observations on the Psychological Component of Non-Psychologies' Activities*
- 5.34 The exposure to and "training" of managers in psychology is likely to include a substantial grounding in some theoretical aspects (particularly those with a psychology degree, a higher degree in business management or post-graduate management training).
- 5.35 The main reason for the wide usage of

psychological theory and method across professional boundaries is that the discipline of psychology provides a useful frame of reference within which to locate many clients' problems and provides appropriate tools for addressing these. It is frequently perceived as a more appropriate model for locating/explaining certain presentations than the medical model, with its focus on organic cause and effect. It is its holistic perspective, its acknowledgement that individuals represent the dynamic interaction of various dimensions: psychological, emotional and social, as well as physical. which is its attractive feature to other healthcare disciplines.

- 5.36 The range of other disciplines' application of psychological techniques is infinitely variable, from no use of psychological method, to being as skilled as a clinical psychologist in particular tasks. The extent to which other disciplines practice elements of psychology depends on the discipline, the individual and also the setting.
- 5.37 Some undertake psychological tasks in an informal, almost sub-conscious way - most healthcare staff, for example, are likely to use non-directive counselling as an integral part of the patient care process. It is a means of acknowledging every dimension or the patient's needs - emotional, as well as physical - and enables them to provide a more rounded care package. Where there is deliberate transmission of psychological skills, in this context, the purpose is to make other healthcare professionals more skilled at doing their job - not to create "quasi-psychologists".
- 5.38 Whilst it is generally true to say that a large number in these other disciplines practice elements of psychology in a more general, less structured way, at the other end of the spectrum, there are non-psychologists who have been trained to practice particular psychological interventions in a conscious, focused and very skilled way - psychiatrists and behaviour nurse therapists, for example, social workers using psychotherapy, having completed specialised post-qualification courses, or an OT who has specialised in the treatment of eating disorders and does very little "occupational therapy" in the conventional sense of

the term.

*Framework  
of  
Psychologic  
al Skills*

5.39

This variation in the extent to which psychological method is employed, the formality/consciousness with which it is used, and the range and sophistication of the psychological skills possessed suggests to us a continuum of psychological knowledge and skill contained in three *levels*:

5.40

Level 1

Both clinical staff and managers need and use certain “psychological” skills. These may be regarded as rudimentary, but are nevertheless extremely important in enabling them to apply their vocational skills. The basic use of “psychological methods, sometimes intuitively, forms an integral part of the carer/patient relationship and parts of the care package and are used in activities which include:

establishing a relationship with the patient and relatives (establishing rapport, communicating empathy);

maintaining a supportive relationship (advising and supporting);

interviewing technique (ability to listen, draw out and challenge);

recognising, interpreting and using verbal and non-verbal cues relating to problems;

basic “psychological” interventions which are not necessarily consciously acknowledged as such and can be/are carried out without specific training:

- counselling
- stress/anxiety management (not in the formal cognitive/behavioural sense)
- relaxation techniques
- supportive group work
- simple behavioural techniques.

At this level, the application of psychological skill is the lubricant of good professional practice.

5.41 Level 2

Skills required to undertake circumscribed activities entailing psychological interventions for which one is qualified and/or has had specific training (such as behaviour modification, as undertaken by mental handicap nurses or behavioural psychotherapy, as practised by nurse behaviour therapists). Within certain mental health disciplines - such as occupational therapy or social work, some practitioners choose to develop a special interest either in a psychological intervention - specialising in family or marital therapy, for example - or in treating a particular disorder - for example, psycho-sexual or eating disorders. However, at this level it is necessary to recognise the constraints/limits of one's contribution and skill in the psychological dimension and to recognise the signs indicating the need for referral onwards for a more specialist service. At this level there should be an awareness of the criteria for referral to a clinical psychologist.

5.42 Level 3

Activities which require specialist psychological intervention skills in circumstances where there are deep-rooted underlying influences, or which call for the capacity to draw on a multiple theoretical base to devise an individually tailored strategy for a complicated presenting problem. Flexibility is the key to competence at this level, which comes from a broad and sophisticated understanding of the various psychological theories. It necessitates the ability to select and adapt more complex approaches and to combine approaches if appropriate.

*Skills*

5.43 We have sought to establish the skills of clinical psychologists within this framework. Our use of the term "skill" embraces knowledge, attitudes and values, as well as discrete activities in performing tasks.

*Attributes*

- 5.44 We identify first the attributes which clinical psychologists possess. These attributes are a further description of their work. They arise from the application of psychological knowledge - theory, practice and experience.
- 5.45 In describing these attributes we do not imply that clinical psychologists alone possess them.
- 5.46 Clinical psychologists have a strong academic tradition. Because of the narrow entry gate to the profession they need to be intelligent and academic achievers. They bring a theoretical as well as vocational perspective to their work.
- 5.47 Their theoretical knowledge provides them with a substantial body of knowledge about human behaviour and a variety of theoretical models for interpreting and understanding such behaviour.
- 5.48 The knowledge combined with training in applied psychology commonly develops in each individual an ability to form alternative hypotheses to help explain a given set of behaviours. A common attribute of experienced clinical psychologists is that they have built their own "model" - usually an amalgam of other theoretical perspectives - which informs their own work. The clinical psychologist may create his/her own paradigm in order to understand and resolve a presenting problem.
- 5.49 Partly because they have to internalise the conflicting perspectives of a variety of alternative models, clinical psychologists appear to cope well with uncertainty. They do not expect to find the "right"<sup>1</sup> answer to a given problem; instead they seem to be able to say "I don't know", and then to formulate a possible answer and test its relevance.
- 5.50 Clinical psychologists tolerate and indeed encourage an ambiguity of role in many circumstances. For example, they can be full members of a multi-disciplinary team and at the same time can act as external observer and occasionally as "therapist" to the group.
- 5.51 Clinical psychologists can appear inconsistent to

others. Apparently similar cases can elicit quite different responses from different clinical psychologists or indeed from the same clinical psychologist. This can be explained in two ways: firstly the detailed analysis undertaken by a clinical psychologist of a client may identify differences between the cases which were not apparent to the referrer and secondly, the need to constantly test hypotheses may lead the clinical psychologist to test an alternative approach.

5.52 Psychological training, and the theoretical perspectives it offers, underpins the “holistic” approach which practitioners have to their clients. Clinical psychologists explore the needs of the client as an individual, as part of a group and as an inhabitant of a particular environment. Their interventions also occur at an individual, group and environmental level.

5.53 A fundamental characteristic of the profession is found in the clinical psychologists’ approach to clients. They perceive themselves to be partners with the client, offering assistance but unable/unwilling to impose therapies or interventions.

5.54 Clinical psychologists are inquisitive and gain personal enrichment from both the process of “understanding” and then “solving” problems.

5.55 These attributes denote the use of discretion at level 3. The flexibility in applying psychological theory may, to some, be seen as a lack of maturity for the profession. To others, and to us, this flexibility and generic application of psychology is a strength, possibly preventing the profession from becoming narrow and losing its usefulness.

*Ambiguities*

5.56 However, the clinical psychology profession exhibits paradoxes. On one hand they may be singularly described as clinical psychologists, on the other they are individualistic in their interests and exhibit possible ambiguities within their profession.

5.57 It is not for us to make any judgements about the

ambiguities, merely to make observations. Again some will say that the ambiguities are a reflection of an immature profession, not knowing where it is going, nor knowing, with confidence, its own stance on matters. Others see the ambiguities as a strength.

5.58 Among the ambiguities are:

5.58.1 Artistic/scientific.

The use of science as a basis for assessment and treatment of patients, but the use of personal experience and philosophy when engaged in planning, organisational and human resource/ management matters.

5.58.2 This ambiguity may arise from the fact that, at undergraduate level, psychology is to be found in both the faculty of arts and the faculty of science of universities.

5.58.3 Clinical psychologists (and others) combine intuition in their level 1 activities and use of skill and empirical work in their level 2 and level 3 activities.

5.58.4 Clinical psychologists appear to have significant latitude in deciding whether to focus on individual patients/clients, or whether they will concentrate on organisational and management issues, or both.

5.58.5 Clinical psychologists undertake practical work as well as engage in evaluative and developmental research.

5.58.6 They can be caring concerned individuals as well as being dispassionate and impartial.



- 5.58.7 They are occasionally diffident, reluctant even to participate with others, and they can be assertive, although seldom outspoken.
- 5.58.8 They want freedom, and responsibility, but cannot come to terms with the implications or responsibility.
- 5.58.9 Clinical psychologists try to see the world holistically, yet some are closer to the reductionist outlook of the medical profession.
- 5.58.10 They are unsure whether to share their knowledge or keep it to themselves. Equally, they are uncertain about whether to work individually or corporately with other clinical psychologists and other staff.

***Intellectual Skills***

5.59 The core intellectual skills of clinical psychologists are to be found within the main activities of:

- assessment of problem,
- analysis of problem,
- formulation of problem,
- application of theory to problem,
- application of technique to problem,
- planning programme of intervention,
- executing programme of intervention,
- monitoring intervention,
- evaluating intervention,
- training,
- research.

***Implementation Skills***

5.60 The core implementation skills arise from the use of psychological knowledge and include:

- problem-solving skills,
- inter-personal skills,
- listening skills,

communication skills,  
analytical skills,  
hypothesis-forming skills,  
research and evaluation skills,  
interpretative skills,  
consultative skills, and  
skills needed to apply psychological  
therapeutic theories.

***Work context  
Skills***

5.61

In addition, clinical psychologists will possess work context skills in:

organisational change,  
management,  
administration.

***Skill of other  
Healthcare  
Works***

5.62

We were also interested in establishing the skills of certain other healthcare workers, particularly those skills which might overlap with clinical psychologists.

5.63

We, therefore, surveyed the psychological skills which different disciplines applied to the same case studies in services for children, elderly people, adult mental health and those with learning difficulties. We selected these client categories because it is in these groups that the greatest potential overlap of skills will occur.

5.64

The general observations are as follows:

5.64.1

All the healthcare workers interviewed undertake level 1 activities, and use level 1 skills. The individuals and the training schools/practical attachments they have experienced will result in different emphasis being applied to level 1 activities. Some regard level 1 skills as being fundamental to their abilities to carry out their vocational work, whilst others made the assumption that they were naturally talented in carrying out these activities.

5.64.2 Nearly all the healthcare workers interviewed undertook level 2 activities, using level 2 psychological skills to carry out specific techniques. The techniques covered were:

Psychiatrists -	behavioural analysis psychotherapy phobia anxiety management marital therapy advanced counselling
Social Workers	group work anxiety management psychotherapy
Occupational Therapists -	relaxation therapy anxiety management behavioural therapy
Psychiatric Nurses - (Community and Hospital)	behavioural therapy anxiety management reminiscence therapy bereavement counselling psychotherapy negotiation
Speech Therapists	anxiety management

5.64.3 None believed they undertook level 3 activities with level 3 skills. However, some individuals have been trained to a high level within specific fields of psychology, for example, psychotherapy. Those with such training do not necessarily have the broad psychological training which enables them to call upon alternative theories and approaches as circumstances dictate. To us, therefore, they do not possess level 3 skills.

5.65 Often healthcare workers complement each other in multi-disciplinary teams. Within such a context, cases are often allocated on the basis of non-professional criteria: special interests, personality, whether an individual's time/caseload permits, and so on. Whilst the distinctions between professional

contributions become less clear, there do appear to be factors determining a clinical psychologist's intervention with a case - the severity and complexity of the problem, for example.

5.66 As identified above, there is much evidence of other disciplines using comparable therapeutic interventions to those employed by clinical psychologists (especially certain forms of cognitive/behavioural therapy such as anxiety/stress management, counselling, marital and family therapy). It is, however, acknowledged by other disciplines that clinical psychologists are, in the main, more skilled and more sophisticated in certain interventions (psychotherapy, being a notable example).

*Distinctiveness  
of the Clinical  
Psychologist*

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

5.68 As with other professions, their distinctiveness stems from their training, the resultant theoretical underpinning and the orientation that this imbues. "Scientist-Practitioner" is the term frequently used to describe their professional approach. They are applied behavioural and social scientists with a clinical role. Scientific method and systematic scientific enquiry determines the way in which they practice. Hence characteristics of their approach are hypothesis-testing, collection of evidence to confirm or deny a hypothesis and thorough evaluation of their intervention.

5.69 Their scientific, analytical approach to situations lends objectivity. This ability to take a detached overview of a problem stems partly from the fact that, unlike many other disciplines, they are not involved with the minutiae of day-to-day patient contact and do not have their perspective determined by narrower concerns. They have a broad framework in which to situate an individual's problem, whereas other disciplines'

perspectives are more focused.

- 5.70 Their objectivity also results from the fact that they do not provide services from a statutory base and can, therefore, afford a more risk-taking approach, not being bound by a legal framework.
- 5.71 The minimum five year academic and practical training equips the clinical psychologist with a knowledge base, the depth and breadth of which results in a deeper understanding of psychological processes than any other discipline. Whilst others may display competence in certain psychological methods, they possess only parts of the total knowledge base.
- 5.72 Consequently, clinical psychologists have a broader framework and range of expertise. A sophisticated and eclectic grasp of treatment models allows for flexibility in intervention and the capacity to change direction mid-course, should another approach present itself as more appropriate. It also enables them to determine and tailor the most appropriate intervention to an individual's needs and meet a diversity of need.
- 5.73 The capacity to tailor therapy precisely to a given problem or context makes them more than skilled practitioners of a set of techniques/skills. They have the ability to exercise discretion and make autonomous professional judgements about the application of methods, on the basis of a well-rounded knowledge of the treatment options.
- 5.74 Where there are sufficient numbers, a clinical psychology department can offer a high level of specialisation in certain areas.
- 5.75 Their ability to understand, analyse and intervene in a complex situation means that they are able to work on different levels - treating patients, identifying the impact on carers and the impact of the social system.
- 5.76 Amongst the criteria for referring a client to a clinical psychologist are complexity and severity of problem(s). They are viewed as better able to

intervene successfully with the more difficult/intractable, severe and complex cases. (Psychiatrists, for example, will sometimes refer as a “last resort”, when their battery of strategies have been exhausted.)

- 5.77 Related to this is the perception by others of their ability to treat to and at a deeper level, and with a degree of rigour.
- 5.78 Because of the way in which their job descriptions are phrased, clinical psychologists are able to a considerable extent, theoretically, to control their workload. This allows them to work in-depth with clients and is not an opportunity afforded to the same extent to psychiatrists, nurses, and social workers.
- 5.79 They are viewed as research-based practitioners, with a training and more active interest in research than other disciplines. They are one profession which measures the effects of intervention routinely, understands the clinical significance of the results and is able to interpret these statistically. The reciprocal link between theory and practice means that research and theory inform and are influenced by clinical practice.
- 5.80 Because patient-related activities do not form the total of their job, they make time and have an inclination to keep abreast of research findings and are able to translate research into the treatment setting.
- 5.81 Clinical psychologists are particularly valued by others within the healthcare setting for the alternative perspective they bring. Some disciplines are imbued with a perspective and understanding of behavioural problems and emotional distress, derived from the medical model, which sets out to treat symptoms often in isolation from other influential factors. Psychology, on the other hand, represents a bridge between the medical and social work models - the one with its focus on organic pathology and the other with its sociological and social policy perspective. It offers a holistic perspective on the individual and their needs, recognising that any

intervention needs to take account of the individual as a dynamic and interactive state, comprising; the emotional, cognitive, behavioural and social, as well as the physical.

- 5.82 In comparison with psychiatry, where the main focus is on pathology and begins with the disease process, clinical psychologists have a perspective which encompasses normal, as well as disordered psychological functioning. It has its own body of knowledge and perspectives about mental illness. Its treatment strategies seek to effect changes from working on a behavioural and cognitive level. This contrasts with psychiatry's mainly pharmacological/ECT base (acknowledging that some psychiatrists also make extensive, use of psychotherapy).
- 5.83 Clinical psychologists are seen by others as capable of a lateral, fresh, innovative and sometimes radical view of problems (both "clinical" and organisational).
- 5.84 Psychology is like no other discipline in the extent to which it shares skills from its own base with others - a major role for the clinical psychologist is the transmission/teaching of skills to others. This skill-sharing process is not reciprocal. No other profession shares such a large proportion of its knowledge/skill base with other disciplines.
- 5.85 As well as their contribution at the individual level, clinical psychologists have a good perspective of the "framework". This places them in a position to comment on service issues and contribute to strategic review. Their grounding enables them to analyse, comment on and scrutinise diverse topics and issues.
- 5.86 An examination of the criteria others use in determining whether to refer clients to a clinical psychologist further illuminates what is distinctive about their contribution. When health professionals were asked during the site visits, certain local factors determined what types of condition would be referred onto a clinical psychologist. Consequently specific situations/disorders and the requirement for

particular interventions were cited. These have been omitted from the list below, because they do not apply "across the board". The following criteria are confined to those which generally apply.

5.87 Criteria for Referral to a Clinical Psychologist

- 5.87.1 Severity/complexity of case and underlying factors.
- 5.87.2 Seemingly intractable problems that others have tried unsuccessfully to treat.
- 5.87.3 Where diagnosis/causal factors are unclear and there are difficulties in drawing up a treatment programme.
- 5.87.4 Need for broader framework and range of expertise.
- 5.87.5 To prevent an explosion of psychological problems.
- 5.87.6 Requests for a specific assessment of a client - to define the problem, the level and cause, and forecast optimal capacity from the assessment.
- 5.87.7 Referrals under the 1981 Education Act - assessment cases are sometimes deemed to be appropriate for referral to a clinical psychologist.
- 5.87.8 Where a client needs to be seen by the clinical psychologist to devise a care programme, which may be discharged by other professionals.
- 5.87.9 Where longer-term plans are being made for a client and there is a need to know the individual's



capacity to cope in a particular situation and the most appropriate environment for their needs.

- 5.87.10 Requirement for a particular therapeutic intervention - for example, individual psychotherapy. Where others are also providing certain psychological interventions, cases are often referred to a clinical psychologist if a more complex, thorough or combined approach is indicated.
- 5.87.11 Where the client is manifesting particularly challenging behaviour.
- 5.87.12 For some people seeing a clinical psychologist does not carry the same concern/negative stigma as seeing a psychiatrist, and this is sometimes a reason for referral to a clinical psychologist.
- 5.87.13 Where emotional or cognitive problems are regarded as primary to a physical condition.
- 5.87.14 Where some aspect of a patient's psychological state is interfering with compliance with or effectiveness of treatment.
- 5.87.15 Other disciplines will often refer to a clinical psychologist as a source of advice, rather than always directly referring a client on.
- 5.87.16 Individual clinical psychologists' special interests will, of course, also determine what types of cases are referred.

***Philosophy  
of "Skill-  
Sharing"***

5.88

If the objective *of* clinical psychologists in providing psychological care to individuals is to optimise the capacity of individuals to live as

whole, independent people, then they have to reject the notion of their monopoly in achieving this. It requires an acknowledgement of the need for collaborative working. The corollary to this is the consequent sharing of psychological skill. This, however, is not to say that there is not a role which is uniquely the role of the clinical psychologist.

5.89 Recognizing the contribution of psychological theory and method to strengthening the functioning of individuals, skill-sharing is motivated by a belief that the care process will be enhanced if individuals within other disciplines think in a psychological way. Moreover, there is more need for psychological care and support than clinical psychologists alone can meet. Skill-sharing greatly increases the extent of need which can be addressed. It also has benefits for the clinical psychologist in that it provides scope for them to develop new and innovative roles.

5.90 There are, however, distinct drawbacks, even dangers in some instances, to the free accessibility which non-psychologists have to psychological methods. The dangers thereof have been eloquently described thus: others sometimes “treat psychology like a supermarket where theories fill the shelves like cans, they take the can, open it (often without understanding the cooking instructions), devour the contents and all too frequently suffer the indigestible consequences. One of the after-effects of antiperistalsis can be the abandonment of all theory.”<sup>3</sup>

***Training  
Other  
Disciplines  
in  
Psychology***

5.91 Some description is given earlier in this chapter on the extent of psychological training other disciplines receive as part of their basic courses and opportunities for post-qualification specialisation. Should individuals pursue certain post-qualification training, they may well become as accomplished in a specific approach as a clinical psychologist. There appears to be a link between the clinical psychologist resource available and the amount and degree of specialisation of others in psychological techniques.

5.92 Where clinical psychologists undertake in-house training of others in psychological method, it is usually in relation to a particular technique which is expected to yield a pre-determined outcome (and can thus be described by protocol). The relative certainty of outcome is the main indication for passing on psychological skills.

5.93 More widespread use of general protocols for circumscribed psychological tasks (such as certain behaviour modification programmes for people with learning difficulties) is regarded as having potential value. The degree to which they are developed and used, however, would be heavily influenced by the interests of the clinical psychologists. Moreover, their use would need to be monitored to guard against misuse.

5.94 There appears to be limited opportunity for certain other disciplines to refresh psychological skills once acquired. A primary means of maintaining competence in psychological skills is through multi-disciplinary working and opportunistic attendance on courses. The involvement of psychology departments in the maintenance of others' skills appears to be minimal. Whilst psychology departments do respond to requests for specific skills training, this cannot be regarded as synonymous with regular updating, maintenance and appraisal in competence in general psychological skills.

5.95 There are implications of the skills framework in terms of scope for training input by clinical psychologists. They will need to make decisions about what level of skill they will teach. For instance:

5.95.1 the clinical psychology department could undertake to provide training to all healthcare staff and management to establish and maintain level 1 skills;

5.95.2 they could also teach selected personnel from other staff groups certain level 2 skills.

5.96 In both cases, the purpose of the training is to enable the other disciplines to undertake their own job more effectively.

## Summary

### Activities of Clinical Psychologists

5.97 *The activities in which clinical psychologists in the NHS are engaged are many and varied. The categories of activities are:*

- 5.97.1 *Clinical*
- 5.97.2 *Staff support.*
- 5.97.3 *Teaching and supervision.*
- 5.97.4 *Service planning.*
- 5.97.5 *Research and evaluation.*
- 5.97.6 *Ambassadorial activities.*
- 5.97.7 *Organisational activities.*
- 5.97.8 *Management.*
- 5.97.9 *Administration.*

### Activities of Non-Psychologists

5.98 *The range of other disciplines\* application of psychological techniques is infinitely variable, from no use of psychological method, to being as skilled as a clinical psychologist in particular tasks.*

5.99 *The range of psychological skill possessed across the various disciplines can be located within a skills framework comprising three levels:*

5.99.1 *Level 1 - basic “psychology” - such as establishing maintaining and supporting relationships with patients and relatives, and using some simple, often intuitive techniques, such as counselling and stress management.*

5.99.2 *Level 2 - undertaking circumscribed psychological activities, such as behaviour modification. These activities may be described by protocol. At this level there should be awareness of the criteria for referral to a psychologist.*

5.99.3 *Level 3 - a thorough understanding of varied and complex psychological theories and their application.*

5.100 *Almost all healthcare workers use level 1 and 2 skills. In particular, medical, nursing occupational therapy, speech therapy and social work staff use these skills. Some have well developed specialist training in level 2 activities.*

5.101 *Clinical psychologists possess skills and knowledge at all three levels. Their particular contribution is their rounded knowledge of psychological theories and their application.*

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<sup>1</sup> Sutton C. (1981): “Social Workers as Applied Psychologists. A Plea for Sensitive Support.” Bulletin of the British Psychological Society, vol. 34, 465-467.

<sup>2</sup> Sutton C: Psychology for Social Workers and Counsellors: An Introduction, Routledge and Kegan Paul, London. 1979

<sup>3</sup> Breakwell G. and Rowett C: “Collaboration Between Social Workers and Psychologists”, Bulletin of the BPS (1982) 35, 65-66.

**CHAPTER SIX**

**OBSERVATIONS ON PREVAILING ISSUES WHICH  
NEED TO BE ADDRESSED**

## **6. Observations on Prevailing Issues Which Need to be Addressed**

6.1 This chapter describes our observations of the main issues for the profession, as perceived by clinical psychologists and those working with them.

### Role

#### *Ambiguity*

6.2 The profession is ambiguous about its rightful role(s). Some practitioners are of the view that the profession should focus on direct patient care, whilst others are convinced that maximum effect is to be achieved by seeking to influence the environment, organisation and management of health services. This dichotomy to an extent reflects the varying specialties in which clinical psychologists work.

6.3 Others' perceptions are all too often reflected in the classic confusion over what is a clinical psychologist and the distinctions between psychiatrists, psychotherapists and clinical psychologists. Others perceive a need for greater clarity about what the clinical psychologist has to offer.

6.4 It is often left to individual practitioners as to how they choose to develop their role and this, coupled with the general widening of their activities, has resulted in ambiguity. There is a need for a definitive statement of role(s) for clinical psychologists, which needs to be legitimised and clearly stated to users, fellow service providers and managers.

#### *Low Profile*

6.5 The widespread paucity of knowledge about the full contribution of the clinical psychologist, is due partly because services are often not sufficiently promoted or high profile. Clinical psychologists do not generally promote either their role or their image adequately. There is a need for better publicity about what services are available. It is recognised, however, that increased awareness of clinical psychology services may lead to demands for services which cannot be supplied by current resources.

### Scope of Service and Activities

#### *Variable Sized Services*

6.6 There is wide variation in the numbers of clinical psychologists in district departments. Whilst a minority are of sufficient size to provide a good range of services, the large majority are too small to provide a sufficiently large and varied service to meet the needs. Services then, are extremely patchy. Overall however, there are inadequate numbers of qualified clinical psychologists available within the service and this represents one of the main issues underpinning the commissioning of this review. The results are that services are often limited, the needs for a psychological service are not being adequately met and there are problems with providing the speed of response deemed necessary.

6.7 A component of a clinical psychology service should be the availability of sufficient time to provide individual service to

clients. The application of psychological theory often entails sessions lasting several hours over weeks and months. This need for time places a limitation on the availability of service.

***Need for a  
Rounded Service***

6.8 One of the main criteria by which others would judge a clinical psychology service is the extent to which it provides a comprehensive service. In the context of an environment where there is constraint on resources, the primary concern should be with providing a “rounded” service - a fairly generalist one with recourse to a wide range of approaches, targeted at where most need lies, rather than providing highly specialised and sometimes esoteric services.

6.9 Related to this is the current problem of a service which is too thinly spread. Whilst there is an indisputable shortage of clinical psychologists in the service, the situation is exacerbated by the pigeon-holing of clinical psychologists into specialty slots. Greater flexibility of practice and therefore coverage would be possible if more clinical psychologists were to work from a more generic base, which is feasible in view of the fact that a significant number of approaches are applicable across client groups. This does not detract from recognising the need for a certain amount of specialisation in the unique problems of client groups.

***Under-served  
Specialties and  
Unmet Need***

6.10 The current pattern of service provision is one where only a minority of the overall need for psychological intervention is met. It would appear that there is a need to increase the provision of clinical psychologists in most areas of activity in each district.

6.11 Some specialties are experiencing chronic recruitment problems (notably services for elderly people, people with learning difficulties and children). This means that very limited clinical psychologist input is available. The nature of clinical psychologist involvement is frequently limited to assessment, with very little scope for undertaking therapeutic activities other than crisis intervention. Another result is that research and developmental work is stifled.

6.12 Because of constraint on resources, only those with the more serious, severe and chronic problems receive a service, and as indicated above, this is sometimes an inadequate service. Whilst it is essential that these, the most vulnerable client groups, are protected and catered for, there is a huge amount of unmet psychological need in the population. Estimates vary on the proportion of patients consulting their GPs with psychosocial and psychosomatic symptoms, but a conservative figure is about 25% of all consultations<sup>1</sup>. The likely morbidity in the community is, consequently, very high. This represents an issue which must be addressed, rather than hiding behind the reasons (justifiable though they are) why it is not possible to provide a service to the large majority. Amongst the mass of “worried well”, as they are sometimes disparagingly termed, are tomorrow’s more seriously and chronically mentally ill.



- 6.13 There is, therefore, an indisputable need for additional psychologist resource to provide a more primary and preventive focused service, not only for the benefits of the "client", but as a more cost-effective alternative to waiting passively for them to become dependent on health services and therefore more expensive to treat.
- Primary Service**
- 6.14 Our observation, then, is of the preventive dimension being grossly inadequate. We observed a need for a more primary-based service, with clinical psychologist input to the preventive dimension to prevent the mushrooming of psychological disorder. An example is the near non-existent service for individuals with physical and concomitant psychological conditions (for instance, clinical depression in mastectomy patients). This is so even in light of research which shows that minimal clinical psychologist contact makes an enormous difference.<sup>2</sup>
- 6.15 This reflects a need for a closer alliance with public health doctors, GPs, other members of the primary healthcare team and more generally, with the local community.
- Role in the General Hospital Setting**
- 6.16 We observed a limited psychological involvement with physical medicine cases. There is scope for an extended role for the clinical psychologist district general hospital setting. Taken to its full extent, there would be benefits to the patient if psychological input were to be offered routinely (through more psychologically informed care perhaps), rather than only to those exhibiting obvious psychological distress. Currently, many patients in the general acute medical setting, who would benefit, do not receive any psychological help. For example, patients suffering post-surgical psychological trauma - amputees, mastectomy/ hysterectomy patients, and others who would benefit from pain control and counselling directed at coming to terms with radical surgical intervention, the application of coping strategies, and the necessary support to return to normal living.
- Services to HIV/AIDS Patients**
- 6.17 We observed scope for an extended role for clinical psychologists with HIV/AIDS patients and their carers (including staff).
- Epidemiological Role**
- 6.18 Our observation is that until now clinical psychologists generally have had a relatively low profile in the epidemiological study of problem behaviour. Behavioural epidemiology - identifying illness behaviour and how to manage it is a major area for study, being critical in efforts to reduce the numbers of "avoidable deaths" and to increase the quality of life. Whilst it is an area in which some clinical psychologists have engaged in research, it would benefit from the application of wider clinical psychologist interest.
- Service Evaluation**
- 6.19 We observed that clinical psychologists have a valuable and potentially extended contribution to make in developing refined service evaluation models which can be applied to all kinds of services and in helping to establish priorities for the allocation

of resources.

***Support Role to  
Other  
Professionals***

6.20 We perceive a need for a greater preventive and support role for clinical psychologists with other healthcare staff - the teaching of stress-management skills and the running of support groups, coping with the seriously ill patient, for example.

6.21 Hitherto clinical psychologists have had no framework within which they may legitimately support other professional groups in offering psychologically-based services.

***Entrepreneurial  
Initiatives***

6.22 Some clinical psychology departments have adopted an entrepreneurial dimension (such as the marketing of stress-management services to industry). This allows the departments the flexibility to fund psychology service developments in their own districts.

**Professional Issues**

***Absence of  
Statutory Role***

6.23 Many of the problems experienced by the profession with regard to role, are due to the absence of statutory framework for the practise of clinical psychologists. This contrasts with other professions like psychiatry and social work, and with their colleagues in educational psychology. Whilst it is recognised that statutory duties can impede flexibility, the latter's influence and contribution in education are acknowledged and supported by statute.

6.24 The position in this country compares unfavourably with certain other countries. In Norway, for example, the Act of Psychology, which was passed in 1973, clearly set out the professional and ethical requirements for the profession. Consequently, the title of "psychologist" and their activities are protected by law and the Act authorises psychologists to "responsibly care for the sick", one of the consequences of which is that the field of psychology is no longer perceived as "quackery" or a "fringe" profession.

***Registration and  
Licensing***

6.25 Relating to the protection of the role of psychology, is the issue of registration and licensing. The BPS has recently introduced its "charter", but this is voluntary and may not, therefore, cover all practising clinical psychologists. Again Britain contrasts in this respect with the Scandinavian countries, the Netherlands and the USA, all of whom having formal and strict registration and licensing arrangements. These apply both to clinical psychologists who wish to practise in a generalist way and to those who specialise, with a separate, post-qualification license (and training) in psychotherapy, for example.

***Title***

6.26 There is an issue about the appropriateness and accuracy of the title "clinical" psychologist in view of the diverse services they now provide. It may be a very real constraint limiting recognition, and consequently development of the wider roles they are able to fulfil in every aspect of the healthcare environment. The concerns about the title do not, then, stem from a preoccupation with semantics. A profession's title

reflects the acknowledged purpose, function and direction of the profession.

6.27 The current title emphasises an illness orientation to the neglect of the wider concerns with promoting and maintaining psychological and emotional health. Furthermore, it does not adequately describe the range of activities in which NHS clinical psychologists are engaged. It does not, for example, appropriately acknowledge primary psychological services, the growing area of so-called "health psychology", or the increasing input to non-mental-health-related medical specialties, let alone the profession's increasing involvement in organisational, service planning and management-related activities.

### ***Training***

6.28 The orientation of the post-graduate training for clinical psychologists is the main contributory factor to the emphasis on clinical specialisation within the current structure. It produces practitioners who are specialised within certain client group areas, and perpetuates premature client-based specialisation, requiring prospective clinical psychologists to opt for a particular area of practice before they qualify and have had time to practise more generally in the field.

6.29 It is felt by some that the orientation of the training courses which promote concentration on a particular client group(s) is partly responsible for perpetuating the recruitment problems in certain specialties. Newly qualified clinical psychologists enter the service having already concentrated on a particular client group(s). They feel unable to transfer their base easily to another client group. A more generic initial training (with later specialisation if required), would enable a more flexible application of psychological knowledge and skill across client group boundaries.

### ***Supervision***

6.30 Clinical psychologists obtain a so-called professional independence when relatively inexperienced. One of the reasons for this is the general shortage of clinical psychologists to fill posts. This shortage militates against the development of proper post-basic training and supervision. There is a great range of supervisory structures, from the provision of regular supervision to more junior practitioners, to their virtual independence. There is, however, a general need for more post-qualification training and supervision, particularly to those on basic grade, which is widely acknowledged as the grade where continuing in-service training should take place.

### ***Quality Assurance***

6.31 Quality assurance processes generally, not only for newly qualified practitioners, appear equally variable, with much depending on the personal observations and contributions of individual clinical psychologists.

### ***Research***

6.32 Research and the extent to which it is done in district clinical psychology departments, is an issue. Unlike other areas of the NHS, where research and service are separate (largely for funding reasons), it is an explicit aspect of most clinical

psychologists' jobs to undertake research (or health services research/service evaluation), routinely. On the whole, however, clinical psychologists find it difficult to engage in research as part of their routine practice, due to limitations on time. The justification for keeping it in the specification of clinical psychologist posts is that there should be an inseparable and reciprocal relationship between research and practice, with each informing the other. However, in reality, the other tasks a clinical psychologist is expected to perform and particularly the patient-related work, tend to take priority at the expense of research.

***Relationship with  
Other Disciplines***

- 6.33 Some of the larger district psychology departments have sought to tackle the problem by designating posts exclusively for research, In one example, the post combined responsibility for promoting and facilitating the research activities of other clinical psychologists in the department (and other disciplines) - for example, by attracting funding and advising on research methodology - as well as a requirement to undertake a significant amount of research personally.
- 6.34 Clinical psychologists tend to be unsure about their responsibilities in relation to other staff groups who use psychological techniques as part ambiguity relates particularly to whether clinical psychologists should adopt a monitoring/supervisory role with regard to the application of techniques, and if so, what rights of intervention should apply if inappropriate or misuse of techniques/practice is observed This ambiguity is compounded by a reluctance on the part of other disciplines to be overseen. The degree of ambiguity will be dependent on context. In the multi-disciplinary team, there may be less ambiguity over such responsibilities, than in circumstances where a clinical psychologist operates in a less collaborative manner. Overall, however, clinical psychologists have no formal responsibility for other disciplines using psychological techniques.
- 6.35 The current situation exists because of the absence of a framework which designates formal responsibility for the training of non-psychologist disciplines in psychological method. As a result, clinical psychologists provide such training largely on an ad hoc basis, in response to requests from the disciplines themselves. There is no structure which provides for planned and regular training in psychological method on the basis of designated responsibility. In some circumstances this means that clinical psychologists have to push for the opportunity to provide such training, and this is even more difficult where other disciplines are reluctant to interact with clinical psychologists in the skill furnishing exercise, due to a perception of encroachment on their professional territory. This is a sensitive matter for clinical psychologists whose basic intention is to facilitate the acquisition of skill and knowledge by others without being seen to interfere.

- 6.36 Where training of other disciplines does occur on a significant scale, there is sometimes an issue, in that it is not properly recognised and consequently timetabled. Training was not properly depicted as a distinct activity by Trethowan, and this is reflected in practice where it is merged with other routine activities.
- 6.37 There are varying perceptions amongst clinical psychologists as to the purpose of training other staff in clinical psychological skills and techniques. Some see the teaching of psychological skills to other staff as a means of disseminating psychological intervention; whilst others see the process as equipping categories of staff with skills which will improve their capacity to do their job. In view of the variance of practice, there needs to be some common agreement on the purpose of training others in psychological techniques and the extent to which it is done (for example, should clinical psychologists also undertake to maintain the psychological skills of others as well as provide initial training?). This relates to the need for a more considered/conscious, planned and co-ordinated skill-sharing process.
- 6.38 In certain settings there is a need for better utilisation of highly skilled clinical psychologist resource. In some specialties (services for people with learning difficulties, for example) there is scope for further devolving some of the more routine activities to other staff.
- 6.39 In relation to the activities which can successfully be undertaken by other disciplines, are there certain tasks which do not require the exercise of discretion, which can be described by protocol? This would ensure a more standardised approach and level of competence amongst other disciplines and would overcome the problem of “re-inventing the wheel” when training others in techniques.
- 6.40 There is great variation in the relationship between clinical psychologists and their medical colleagues. The contrast is most obvious in mental health, where some clinical psychologists are clearly at the behest of consultant psychiatrists, having the complexion of their caseload determined by referrals from the latter; whilst at the other end of the continuum others are so independent, they have no contact with them.
- 6.41 There are similarities in the thought processes and approaches to problems between clinical psychologists and general managers. However, until recently clinical psychologists have not been active in demonstrating their potential contribution to general managers. Clinical psychologists, by virtue of their background as social scientists, represent a consultative source on managerial and organisational issues - such as establishing objectives and targets, goal planning, and evaluating and monitoring objectives.
- 6.42 Clinical psychologists are seen by managers as being a

profession capable of providing impartial advice on management matters.

### ***Professional Independence***

- 6.43 Many managers have experience of psychology through their training and experience, and recognise the value of professional psychology support.
- 6.44 We perceive a growing professional link between managers and clinical psychologists, particularly as major changes in the Health Service continue to take place.
- 6.45 Clinical psychologists, in general, appear to possess considerable freedom to decide what and how services should be delivered. This raises the question of the professional independence of clinical psychologists.
- 6.46 Custom and practice varies throughout England about the degree of independence clinical psychologists possess in relation to the medical profession. In defining the various types of responsibility, Trethowan stated that clinical psychologists carry clinical responsibility for their patients, whilst doctors assume medical responsibility. However, such theoretical distinctions in some locations bear no resemblance to a reality where medical practitioners act as gatekeepers of the clinical psychology service. This contrasts with other examples where clinical psychologists are totally independent from medical practitioners.
- 6.47 The formal and legal requirements, however, are ambiguous. There has been a progressive erosion of the concept of medical responsibility for everything concerned with patient care. There is, now, a greater focus on individual accountability and responsibility for individual professional and managerial actions. Appendix 7 sets out the British Psychological Society's position on professional responsibility.

### ***Career Structure***

- 6.48 The basis for upgrading clinical psychologist posts is unsatisfactory and appears to be biased, with some exceptions, towards factors such as length of service, and managerial / "head counting" considerations. The emphasis on managerial and administrative responsibilities as the main criteria for advancement is at the expense of rewarding professional expertise/excellence or an individual's special value to the service.
- 6.49 The career structure appears unattractive. An inflexible staffing structure does not provide good career prospects. Currently, once an individual has qualified, there are no further specific educational/ developmental opportunities or requirements for promotion. Therefore, the speed with which a clinical psychologist can reach the top of the career ladder is variable (according to factors such as specialty and geographic area).
- 6.50 The age structure of the profession presents an issue in this respect. The age distribution of the profession means that the number of experienced clinical psychologists will be proportionately greater than the inexperienced for the next 15

to 25 years. The implication of this is that there will be a bottleneck in the more senior grades, thereby limiting the promotion prospects.

***Recruitment and Retention***

- 6.51 The profession is currently experiencing both recruitment and retention problems. The recruitment difficulties are experienced mainly in particular specialties, most notably services for people with learning difficulties and services for elderly people, but geography also exerts an influence, as borne out by the vacancy patterns (see the profile in Appendix 3).
- 6.52 Currently the shortfall in training places is the major contributory factor to there being insufficient qualified clinical psychologists to fill the posts within the service. However, once this problem has been tackled, there is the more serious problem of ensuring the profession remains an attractive proposition to potential prospective candidates. This will necessitate it becoming a reasonably attractive career prospect financially if it is to continue to attract high calibre individuals.

***Remuneration***

- 6.53 Within the profession, there is a growing discontent with the remuneration for clinical psychologists. The recent regrading exercise for the nursing profession has further exacerbated the comparability of pay issue. In common with certain other healthcare disciplines, there is a feeling that the pay scales do not reflect the type of work they do, their knowledge and expertise, or the level of responsibility their work entails. As with the nurses, the solution is not solely a percentage increase, but a review of grades.
- 6.54 There is already a worrying wastage level, particularly from senior clinical psychologist grade, by individuals who are leaving the NHS for the financially more attractive propositions of the private healthcare sector, industry and commerce. This has particular consequences in that it is eating into the supervision resource, since seniors provide most of the supervision to basic grade clinical psychologists.
- 6.55 The profession's arguments for regrading rest on their professional independence. The standard of their training and their clinical competence allows independence of action. The clinical experience required to qualify as a clinical psychologist is comparable to that required of medical students and has in common the degree level pre-clinical qualification. The clinical psychologist's ability to practise as independently as the medically qualified individual is a feature used to support calls for comparability of both status and pay.

**Organisation and Management**

***Organisational Base***

- 6.56 The extent to which collaboration occurs with other staff may be reflected in the degree to which the clinical psychology service is centralised within a single or more departments, or decentralised, with clinical psychologists located with other staff at the point of service.
- 6.57 There are merits with both arrangements or a combination.

Centralisation reduces professional isolation and provides regular opportunities for discussion, supervision and support. Centralisation also ensures more effective use of equipment and facilities. The drawback with centralised organisation is that it provides limited opportunities for close working between clinical psychologists and others, and for the former to influence the use of psychology by the latter.

- 6.58 The argument for decentralised arrangements are based on the desirability of organisational diversification. It is perceived by other staff as desirable for clinical psychologists to be properly integrated within the services to which they have an input - to be part of the service to the client. This co-habitation can influence the way in which psychology is used by others, and the way in which patient services, generally, are delivered. This means being based throughout the district with other disciplines at the point of service, rather than concentrated in a professional department on one site.
- 6.59 Moreover, the issue over the right location for clinical psychologists is becoming more prominent, given the increasing role in health psychology and primary care/prevention. In view of these factors, a hospital base is deemed by some to be inappropriate for a clinical psychology department.
- 6.60 Some districts effectively combine both arrangements, providing a professional base (not unlike a post-graduate medical centre) and having clinical psychologists situated within the relevant patient service facilities.
- 6.61 Some regard it as desirable for there to be a separating out of the clinical practitioner role from other activities, regarding the latter as diluting the essential role. Where psychology departments are small, there can be a tension between the clinical role and the organisational/managerial role, because the patient service is already thinly spread. Some argue that certain of the “non-patient” activities and services do not need to be offered on a district basis. There is a body which favours the notion of creating a supra-district psychology advisory service to provide a service in non-clinical areas where clinical psychologist input is required. Examples might be the provision of staff support services, organisational psychology services selection/recruitment services and other consultative services, such as the design of behavioural components of health education programmes. Some of the training and advisory work with other staff might also be undertaken on a supra-district basis. This would leave the residual district psychology departments as exclusively “clinical” in orientation.
- 6.62 The other side of this argument, however, is that it is the clinical psychologist’s diverse role which renders their value, particularly in the ability to bridge the clinical and management dimensions.

### ***Separation of Roles***



***Managerial  
Accountability***

- 6.63 We observe that regional health authorities may wish to engage psychology services for personnel, organisational and management matters.
- 6.64 District psychologists are often managerially accountable to a unit general manager, whilst providing professional psychological services across several units. The supply of psychology service to units of management is generally discussed with relevant unit general managers.
- 6.65 Clinical psychologists are managerially and professionally accountable to the district psychologist. There arises ambiguity in the management arrangements between unit general managers and the clinical psychologists working in their units, particularly when the district psychologist is accountable to a different unit general manager.
- 6.66 The issue is not exclusive to clinical psychologists. It results from the 1984 re-organisation, which failed to tackle the problems of professional groups operating without accountability to service managers.
- 6.67 There is therefore, a perceived need to introduce improved managerial accountability to service managers (in addition to professional accountability) for the level and quantity of service provided and the fulfilment of targets and priorities. This stems from a contention that service managers should exert more control in issues which have service implications (for instance, ensuring that only research which is applicable in service terms is done in NHS time).

***Role of the District  
Psychologist***

- 6.68 There is no clear, defined and standard role to be found amongst district psychologists.
- 6.69 Their role is highly dependent upon the size of department. For some it is clearly a management position over the professional staff within the department; some district psychologist posts have rotating incumbents, so that the post is shared by several members of a psychology department over a number of years; some provide managerial advice at a unit and district level; some hold budgets, deploy staff, plan and develop services, maintain standards and monitor quality; if the department is of sufficient size, the district psychologist may engage in resource manipulation, entrepreneurial "income-generating" initiatives; whilst others are less managerial, themselves carrying a significant clinical workload (sometimes under the direction of a head of specialty of equal or lower grade) and regard themselves as *primus inter pares*.
- 6.70 There are a number of management tasks which need to be undertaken within the psychology service, particularly in view of the impending changes in the NHS, the changes in the labour market and impending EEC regulations, together with the results of this review.
- 6.71 Whether or not there is a role for an individual to be managerially responsible for all psychology services, or

separate services within a psychology service, within a district, will depend on the model of service adopted. There will always be a need, however, for an individual to be managerially responsible for the service: the only issue being whether for the whole service or whether several people should have responsibility for separate services.

## Summary

6.72 We observe that:

- 6.72.1 *The roles of the clinical psychologist are many and varied and not necessarily adequately represented by the title "clinical"*
- 6.72.2 *The role of the clinical psychologist is concerned with issues of the environment, organisation and management, as well as clinical problems.*
- 6.72.3 *The role is regarded as ambiguous; confused with other disciplines; and confused by the variety of ways in which psychology services are delivered and practised.*
- 6.72.4 *Over-specialisation, particularly at an early stage in a career, may be interesting to the individual, but denies the service of the generic knowledge that appears to us to be the *raison d'être* of the clinical psychologist in healthcare.*
- 6.72.5 *The service has followed traditional lines of assessment and therapy (being founded within a medically-dominated Health Service), leaving largely vacant the important role within primary care, assisting in the prevention of avoidable morbidity and mortality.*
- 6.72.6 *There is a general shortfall of clinical psychologists, one which is set to become even more acute in the light of the inadequate number of training places, the expansion of the profession, and the growing vacancies, partly brought about by poor career prospects, poor comparative remuneration, and the appeal of the private sector.*
- 6.72.7 *There is variation in the control of quality of clinical psychologists' practise, combined with lack of a statutory role, and no requirement for continuing education and training Without strong self-discipline the profession of clinical psychology could rapidly and easily decline.*
- 6.72.8 *There is a huge role for psychology. Close working between clinical psychologists and other disciplines enhances the likelihood of effective use of psychological theories and techniques in specific circumstances. Thus, clinical psychologists have a role in the training and maintenance of psychological skills of other disciplines with the explicit purpose of enhancing the capacity of others to perform their own tasks.*
- 6.72.9 *The management and organisation of the psychological services is varied, with ambiguity over the managerial accountability of professional staff. The role of the district psychologist is unclear, and has variable responsibilities between districts.*

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<sup>1</sup> Goldberg D. and Huxley R. Mental Illness in the Community, London: Tavistock, 1980.

<sup>2</sup> See Appendix 4.

**CHAPTER SEVEN**

**CRITERIA FOR JUDGING THE SERVICE**

7. Criteria for Judging the Service
- 7.1 This chapter sets out the criteria used to judge each of the service delivery models described in Chapter 8.
- 7.2 The criteria described here are known as benefit criteria and attempt to encapsulate the positive and constructive descriptions of an ideal healthcare psychology service.
- Overall Aims of Psychology Services* 7.3 The criteria are presented within the overall aim of a healthcare psychology service, which is:  
 To improve, either directly or indirectly, the standard and quality of life of people who are served by and provide health services, and to alleviate disability, through the application of appropriate psychological theories.
- Benefit Criteria* 7.4 Five groups of benefit criteria have been identified for consideration.
- 7.4.1 The appropriateness of the healthcare psychology service in meeting the needs of the population, the needs of those who refer patients and problems to clinical psychologists and the needs of managers.
- 7.4.2 The effectiveness of the psychological service in identifying need, providing and using, in appropriate circumstances, assessment, therapy, problem-solving, and care methods and approaches which have a demonstrable effect, resulting in a positive outcome for the patient, staff member or other individual who has sought the service.
- 7.4.3 The quality of the psychological service in offering and maintaining high standards in the delivery of services. The processes of quality assurance include, in this context, monitoring judgements concerning the use of effective forms of assessment, treatment and care, as well as monitoring the "softer" aspects of standards - the attitudes inherent in the service, its responsiveness, accessibility and general helpfulness to others, as well as the degree of support offered to the staff providing the service.
- 7.4.4 The efficiency of the healthcare psychology service concerns the aspects of managing psychology resources which ensure a high level of service (in terms of effectiveness and quality) for least cost. This includes the processes which enable efficiency to be achieved and monitored.
- 7.4.5 Finally, the aspects concerned with implementing the service delivery models. Different models will have different chances of being implemented according to the ways in which they are perceived and accepted by providers, managers and

consumers of services.

- 7.5 Each group of criteria contain elements which reflect the more important aspects of the area. They are not intended to be comprehensive and exhaustive.
- 7.6 The following are the criteria for judging healthcare psychology services.
- Appropriateness* 7.7 Appropriateness of healthcare psychology services in relation to need:
- 7.7.1 The extent to which the psychology department provides a comprehensive range of services to a district population as follows:
- Primary Care - including prevention and health promotion activities
  - Secondary and in addition to the clinical activities, including:
  - Tertiary Care - research and evaluation, education and training, organisation and management.
- 7.8 The extent to which the psychology service for a district population provides a range of assessment, therapeutic and problem-solving methods, including:
- Behavioural
  - Cognitive/behavioural
  - Psychodynamic
  - Educational/retraining
  - Systemic
- 7.9 The extent to which the application of psychological services support medical prevention, diagnosis, care and cure, in appropriate circumstances.
- 7.10 The extent to which the application of psychological services complement medical prevention, diagnosis, care and cure, in appropriate circumstances.
- 7.11 The extent to which the application of psychological services is an alternative to medical prevention, diagnosis, care and cure, in appropriate circumstances.
- Effectiveness* 7.12 The effectiveness of healthcare psychology services in establishing need, and applying effective services:
- 7.12.1 The extent to which the psychology service for a district population establishes the needs of the populations it serves, including the needs of other health practitioners and health care managers.
- 7.12.2 The extent to which the psychology service applies demonstrably effective methods of

- assessment, therapy and problem-solving.
- 7.12.3 The extent to which the psychology service researches the application and effectiveness of methods of assessment, therapy and problem-solving.
- Quality** 7.13 Quality in the delivery of psychology services:
- 7.13.1 The extent to which qualitative standards are set for healthcare psychology services, and policies exist concerning the provision of services.
- 7.13.2 The extent to which the psychology service monitors and evaluates the appropriateness of its services in relation to the needs of the populations it serves, the needs of other health practitioners, and healthcare managers.
- 7.13.3 The extent to which the psychology service supervises, supports and monitors individuals within it.
- 7.13.4 The extent to which the psychology service maintains the psychological skills of other healthcare workers.
- 7.13.5 The extent to which the psychology service monitors the application of psychological skills by other healthcare workers.
- 7.13.6 The extent to which other healthcare workers and consumers are encouraged to register their satisfaction with the quality of psychology services.
- Efficiency** 7.14 Efficiency of healthcare psychology services:
- 7.14.1 The extent to which the psychology services are planned, coordinated and controlled within management resources.
- 7.14.2 The extent to which psychological resources within a district service can be deployed flexibly.
- 7.14.3 The extent to which psychological skills can be flexibly allocated to tasks.
- Implementation** 7.15 Implementation of a model of service delivery:
- 7.15.1 The extent to which a service delivery model is acceptable to management.
- 7.15.2 The extent to which a service delivery model is acceptable to providers of service.
- 7.15.3 The extent to which a service delivery model is acceptable to and known to consumers of service.
- 7.16 As each of the categories of criteria vary in the extent of their influence in procuring an optimal healthcare psychology service, proportional weights have been allocated to each category, as follows:

Appropriateness	-	this is considered to be as important as any criterion in the provision of services, on the grounds that an inappropriate service may be harmful to consumers of the service. 30
Effectiveness		this is considered to be of major importance for the survival and prosperity of psychological services. Ineffective services are not only not beneficial, but consume resources which might otherwise be used to the greater benefit of patients. Ensuring the effectiveness of intervention therefore carries an ethical obligation. 25
Quality		this is less important than effectiveness on the grounds that a psychological service, whilst it may be delivered to a very high standard of quality, may be ineffective. Quality does not guarantee effectiveness. Apart from being detrimental to the client, this would damage, if not destroy, the credibility of psychology and clinical psychologists. 15
Efficiency		this is less important than the other criteria on the grounds that a service could be highly efficient in its operation but at the cost of appropriateness, effectiveness and quality. The value of the service is in its effectiveness, appropriately delivered. 5
Implementation		this is considered to be of equal importance as effectiveness. If the most desirable model is not implementable, the other benefits of the model are lost. 25

7.17 Within each category of criteria, each component is perceived to be of equal importance in achieving the overall criterion. Therefore, each component statement is accorded equal weight within the category.



7.18 These criteria (and the proportional importance attached to them) will be used to appraise the service delivery models. This is described in Chapter 9.

## **CHAPTER EIGHT**

### **POSSIBLE MODELS OF SERVICE**

8. Possible Models of Service

8.1 We now present four service delivery options as a means of looking at alternative ways of delivering services in the context of the future environment for health care in England.

8.2 The options are:

Option 1 Do nothing (status quo)

Option 2 Shared care service

Option 3 Supporting service

Option 4 Independent service

8.3 Option 1: Do Nothing (Status Quo)

*Objectives*

- 8.3.1 Clinical psychology is the application of the principles and procedures of psychology to health care. The outcome of a clinical psychologist's involvement will be the following:
- o a description or account of the situation in terms of the most appropriate psychological theories or models;
  - o implementation of a programme of action (investigation, therapy, research project);
  - o evaluation of the quality, efficiency and effectiveness of the intervention;
  - o assessment and planning of future developments to respond to similar problems<sup>1</sup>.

*Scope of Activities*

8.3.2 The scope of activities within the clinical and other areas in which clinical psychologists are able to utilise their expertise remains opportunistic and relatively restricted, being geographically variable and dependent on the quantity of clinical psychologist resource available, the priorities of

the district health authority and the personal interests of those within the establishment.

	8.3.3	Furthermore, where their wider role is not fully understood by managers and others, they are not utilised in areas which would benefit from their contribution. Similarly, the pressure to see as many patients as possible, often militates against psychologists' wider involvement in organisational and managerial health service matters.
	8.3.4	Because the majority of clinical psychology departments are too small <sup>2</sup> to provide a comprehensive service, the general pattern is one of a service which is thinly spread.
<b><i>Scope of Interventions</i></b>	8.3.5	The scope of theoretical models and types of intervention offered remain variable, dependent on the numbers and special interests of the clinical psychologists within a department.
	8.3.6	Clinical psychologists, however, undertake activities requiring level 1, 2 and 3 skills, depending on the degree of professional independence.
<b><i>Process of Service Delivery</i></b>	8.3.7	Clinical psychologists employ both direct and indirect methods of assessment and treatment. Some carry their own clinical caseload and thereby engage directly in one-to-one or group-based intervention. However, a large number of psychological interventions are applied by other disciplines and there is often a deliberate policy of psychological skill-sharing. This represents psychologists' indirect role in clinical diagnosis and

treatment by the provision of training, guidance, advice and supervision to other staff.

8.3.8 The cascade effect of providing others with certain psychological skills enables more extensive coverage and impact and is a very cost-effective means of providing a service. Moreover, clinical psychologists regard it as a more appropriate way for them to deliver a service in certain situations (for example, teaching the mechanics of specific behaviour modification techniques to staff working with people with learning difficulties), since it allows them scope to concentrate on more complex or severe problems which necessitate their level of skill.

***Relationship  
with Medical  
Staff***

8.3.9 The formal relationship between clinical psychologists and medical staff sits anywhere on a continuum, depending on the context. At the one end, medical staff act as gate-keepers, filtering referrals to clinical psychologists and representing the primary channel through which clinical psychologists get to see clients. In this scenario there is a tight control emanating from the medical practitioner over the caseload and span of activities of the clinical psychologist. It is a continuation of the traditional medical hierarchical structure, but the span of control is extended to include non-medical staff. At the other end of the spectrum, clinical psychologists operate as clinically independent, autonomous professionals, receiving referrals from a wide network of sources and determining the complexion of their own caseloads.

***Relationship  
with Other  
Staff***

8.3.10 The mechanics of the working relationship between clinical psychologists and others will vary locally and are sometimes extremely ambiguous. To a greater or lesser extent clinical psychologists will co-work with other disciplines, train others in particular psychological skills and methods, supervise them in the execution of some psychological tasks and provide a source of advice and support on psychological matters for others to tap. These arrangements, however, are not formalised and tend to occur on an arbitrary and an ad hoc basis.

8.3.11 One of the reasons for the ambiguity surrounding the utilisation of psychological skills by others and the reason why some clinical psychologists regard skill-sharing dubiously, is that often there is no developed philosophy relating to the purpose of training others in certain psychological skills. The issue is regarded as potentially threatening to clinical psychologists where, because no purpose has been articulated, it is believed that they are “giving away” skills to individuals who then have the capacity to establish themselves in competition and challenge the value of a duplication of skills amongst several professionals. Understandably, this can be perceived as particularly threatening within a context where some fallaciously perceive psychologists to be an expensive resource and are therefore of the view that certain of their tasks can be discharged more cost-effectively by others<sup>3</sup>.

8.3.12 The absence of a coherent philosophy for skill-sharing is reflected in the way in which clinical psychologists provide training to other disciplines. It is often ad hoc and reactive to requests coming from the other disciplines, rather than planned and co-ordinated and coming from clinical psychologists' identification of what psychological skills are needed by others in order to improve the patient care process.

8.3.13 The multi-disciplinary team concept represents the congregation of various independent professionals, each with inter-professional accountability outside of the team context. Whilst a multi-disciplinary approach is desirable in terms of quality and scope of care it is able to provide, there are often problems resulting from an absence of mechanisms to coordinate, direct and control the activities of the team as a corporate entity.

### ***Organisation***

8.3.14 The organisation of clinical psychology services is variable. It is district-based (and budgeted) in the majority of health authorities. The remainder provide psychology services either from a single unit, or divided between two or more units (and funded from relevant unit budgets). In some districts, there is no formally designated clinical psychology department and a psychology service is subsumed in and provided by the other services of a unit or is provided by a neighbouring district.

8.3.15 Services' organisational structure

is often defined by Whitley Council grade definitions. In theory, the grading structure is designed to provide definitions upon which to differentiate different levels of work and responsibility and to determine appropriate remuneration. The current Whitley grades and definitions for qualified clinical psychologists are as follows:

8.3.15.1 Basic Grade:

A basic grade clinic psychologist shall have successfully completed an approved course of postgraduate training or shall hold the British Psychological Society Diploma in Clinical Psychology. A condition of appointment to basic grade is that they should be based in settings where there is access to support and guidance from a clinic psychologist of at least senior grade.

8.3.15.2 Senior Grade:

Appointment to senior grade requires responsibility at a greater level than basic grade for psychological services in a delegated part of either a specialist section within a department of psychology or a hospital department's service. Senior grade is the lowest grade at which clinic psychologists are considered eligible to supervise trainees or offer support and guidance to basic grade. Eligibility for senior grade is confined to clinic psychologists who have served not less than two years at basic grade.



8.3.15.3 Principal Grade:

A principal psychologist has responsibility and duties greater than those of senior grade, has served not less than four years in senior grade and is head of a hospital department; or head of a specialist section within a department of psychology; or head of a district service employing no more than one senior grade or engaged mainly in research or development in a specialised topic; or is providing a highly specialised clinical service,

8.3.15.4 Top Grade:

Top grade posts are for psychologists who are: in charge of a department of psychology including at least two senior grades and providing services to a district, or the head of a well-developed specialty of similar size within a department of psychology; or head of a department of psychology in a teaching hospital where the post carries teaching and/or research responsibilities in addition to clinical duties. Promotion to top grade may also be justified on the grounds of professional excellence without the managerial responsibilities mentioned above. Such an individual will have made a distinguished contribution to the furtherance of clinical psychology. This type of appointment is subject to the prior approval of the Joint Secretaries.

8.3.15.5 Top Grade With Greater

Responsibility:

Appointments to this grade are made for individuals who are: in charge of a department of psychology including at least one principal and at least two senior grades, providing services to a district, or is the head of a well-developed specialty of a similar size. Promotion to this level may also be justified on the basis of being head of a department of psychology in a teaching hospital where the post carries teaching and/or research responsibilities in addition to clinical duties, if in addition he/she is making a distinguished contribution to the furtherance of clinical psychology. Such an appointment is subject to the prior approval of the Joint Secretaries. In exceptional circumstances a clinical psychologist may justify promotion to this grade without the managerial responsibilities mentioned above. This type of appointment would also be subject to the prior approval of the Joint Secretaries.<sup>4</sup>

***Psychology  
Technicians***

8.3.16

The extent to which psychology technicians are employed as part of the psychology service varies between districts.<sup>5</sup> Some psychology departments have no psychology technicians. Technician posts are commonly funded from unoccupied posts within the qualified establishment. There is also variation in the specialties to which technicians are allocated. Traditionally psychology

technicians have been employed with client groups where they can conduct a psychological measurement role. They tend, therefore, to be found most frequently in specialties like services for people with learning difficulties and services for elderly people. (The current role of the psychology technician is described in paragraph 5.31 and 5.32.)

8.3.17 According to the 1985 Scrivens/Charlton study, over 70% of psychology technicians had a psychology degree. This reflects the fact that the majority of psychology technician posts are occupied on a relatively short-term basis by individuals seeking to qualify for places on clinical psychology training courses.

***Management***

8.3.18 There are dual structures for accountability. Professional accountability exists via the district psychologist, where there is such a post (or to the district medical officer where no district psychologist exists). Managerial accountability is usually via the district psychologist or other professional head, to a unit general manager.

***Professional Status***

8.3.19 The professional status of clinical psychology is not bound by statute. The British Psychological Society has recently introduced the voluntary charter in an attempt to initiate greater control over the professional credentials of individuals practising as clinical psychologists. This has been a reaction to the explosion of interest and demand for psychological counselling, the commercial consequences of which have been that all manner of quasi-

psychologists have set up practice as “therapists”.

8.3.20 Whilst the voluntary charter is a move in a particular direction, the situation in this country contrasts with the Scandinavian countries, the Netherlands and North America, for example, where stricter registration and licensing arrangements exist, backed up by law.

***Training***

8.3.21 The training for clinical psychologists constitutes an initial three year psychology degree course, followed by further academic and practical training in a two to three year Masters degree course in clinical psychology or, less commonly, a three year NHS-based in-service training, leading to the BPS diploma <sup>6</sup>.

8.3.22 Appendix 7 contains an outline syllabus for a typical Master’s course and the requirements for the BPS Diploma.

8.3.23 In reality the actual time it now takes an individual to qualify is longer than five to six years. Due to the intense competition for places on the Master’s degree and other courses<sup>7</sup>, psychology graduates are required to gain relevant practical experience (working as psychology technicians or nursing auxiliaries, for example) between their initial and postgraduate courses. The total pre-qualification period is frequently in the order of seven years. This compares with similar training periods in countries like Norway, where it is six and a half years and the USA, where the minimal Masters requirement takes

six years, but many now complete doctorates as part of the qualifying process, in which case it can take some nine years.

*Quality Assurance*

8.3.24 Funding for training is available through a variety of sources: NHS - regional and district health authorities (fund about 71% of trainees), MRC and other grants (13%) and self-funding (16%)<sup>8</sup>.

8.3.25 Guidance for clinical psychologist practice is currently embodied in the BPS code of conduct (Appendix 8). This, however, is not the same as the existence and use of a set of systematic standards against which to measure and monitor practise. Within the current environment, the majority of health care professions are being encouraged to establish and monitor clinical standards and it is an exercise in which the clinical psychology profession should be corporately engaging on behalf of its individual practitioners.

8.3.26 The main method for assuring the quality and appropriateness of clinical psychologists' work is through peer review. Whilst this is the best means of "quality assurance" and clinical audit, it is not formalised. It is a tenet of good practice, but there is no mechanism to ensure that it happens. Thus, the extent and frequency with which standards are monitored will vary locally and because it is an "optional extra" and not essential, it is dependent on the time available after the requisite tasks (patient care) have been discharged.

8.3.27 The quality assurance of the work

of newly qualified clinical psychologists is a particular issue. There is nothing which approximates to the supervisory structure for doctors who, due to the hierarchy of the profession, are theoretically “supervised” much further into their career, serving what amounts to an apprenticeship until they reach consultant status.

8.3.28 Within the current system, supervision of basic grade clinical psychologists is a discretionary component. Apart from the implications for the client of having an inexperienced practitioner undertaking complex aspects of psychological care, the basic grade psychologists themselves feel they have insufficient and inadequate support and confirmation that they are practising appropriately and effectively.

8.3.29 The problems stemming from the absence of a formal and mandatory supervisory structure are compounded by the depletion in the ranks of senior grade clinical psychologists. Some of the highest wastage rates within the profession are from senior grades, who are expected to provide most of the supervision to basic grades.

#### 8.4 Alternative Service Model Options - General Observations

8.4.1 The following options entail modifications to the base from which clinical psychologists work, which have implications for the organisation of services and training. Whilst structurally each is different, they share the following features:

**Objectives**

8.4.2

The objective of the profession is:

*To improve, either directly or indirectly, the standard and quality of life of people who are served by and provide health services, and to alleviate disability, through the application of appropriate psychological theories.*

**Scope of Activities**

8.4.3

The potential contribution of the healthcare psychologist is fully and more formally recognised and utilised within both “clinical” and “non-clinical” spheres and activities. They have a role at each level of the NHS - with the individual and group - both “consumers” and providers of health services - at primary, secondary and tertiary levels, within the environment, at an organisational level, and with regard to management issues.

We would expect healthcare psychology services to be applied to the following spheres of activity, within each district:

Primary Care illness prevention.  
eg psychological and behavioural health promotion

Secondary Care eg adult mental health (including rehabilitation), child and adolescent services, services for elderly people, services for people with learning difficulties, services for people with physical and sensory disabilities, physical medicine,

Tertiary Care supra-district services.  
eg for example, for people

with AIDS

## Organisation and Management

### Teaching and Research

The balance of distribution between these spheres of activity will be a matter for local discretion, and will depend on the district. In the main we expect an emphasis applied to primary care, but not at the expense of services for longer term patients. Due to the limitations on resources the primary service would require a targetted approach which identifies high-risk groups in the community. In medical teaching centres there may need to be an emphasis applied to tertiary care services.

### *Scope of Interventions*

- 8.4.4 A range of theoretical models and interventions would be offered in each patient specialty demonstrating benefit from the allocation of psychological resource, with the full range available within the district. The five main approaches to therapy which would be represented in a comprehensive service would be:
- 8.4.4.1 behavioural;
  - 8.4.4.2 cognitive/behavioural;
  - 8.4.4.3 psychodynamic;
  - 8.4.4.4 educational/retraining;
  - 8.4.4.5 systemic.
- 8.4.5 However, the approaches are only a means to an identified end, which is the provision of a comprehensive service to all those client groups exhibiting a need. The emphasis, therefore is on the provision of an appropriate and effective service, and not on the tools used in delivering that service.
- 8.4.6 In each option healthcare psychologists would undertake activities requiring the use of levels



1, 2 and 3 skills. However the emphasised level differs between options.

***Process of Service Delivery***

8.4.7

Healthcare psychologists would continue to work both directly and indirectly with clients. However, the process for delivering psychological services through other staff would become formalised, with a more defined role for the psychologist in teaching and supervising other disciplines.

***Relationship with Other Staff***

8.4.8

The alternative models of service described here rely on the clear articulation of the purpose of furnishing other disciplines with psychological skills and training others in certain psychological techniques. The purpose is to equip other healthcare staff to undertake their own job more effectively (and so improve the patient care process), rather than to propagate a myriad of pseudo- or semi-psychologists of varying competence and skill levels.

8.4.9

In view of this philosophy, healthcare psychologists would be formally responsible for providing training to other disciplines. The responsibility would also extend to the maintenance of others' psychological skills (through the provision of "refresher" courses to determine levels of competence and improve skills where necessary). This responsibility would operate at each of the three skill levels identified. Their role would encompass the initial training and subsequent maintenance of psychological skills at level 1 (including within the general management context); training and

maintenance of competence in particular psychological interventions (level 2 skills) – part of this would entail teaching others to recognise when they should refer a problem on to a psychologist; and the training and supervision of less experienced healthcare psychologists in level 3 applications.

- 8.4.10 Benefits to accrue from more formal responsibility in this area would be greater control over quality and the type of psychological intervention practised by others and an opportunity to convey skills in a more considered and planned way. This would ultimately mean that more co-ordinated mental health services could be provided, identifying where the need is for other healthcare professionals to use psychological interventions and avoiding unnecessary, uncontrolled and chaotic duplication.
- 8.4.11 Psychologists could support other disciplines by providing them with standards of practice which would govern the use of psychology by non-psychologists. Similarly, psychologists could prepare suitable protocols for use by non-psychologists in appropriate circumstances.
- 8.4.12 There is also an issue currently about the absence of a quality control mechanism which attempts to ensure that other disciplines' practise of psychology reaches a minimum standard. It is recommended that the proposed authority vested with the psychologist, should extend to their being given supervisory responsibility to control others'

possible malpractice and abuse in psychological tasks.

8.4.13 We believe that it will be essential for employing authorities to provide the initiative to ensure that health care psychologists assume their responsibilities concerning other disciplines' practise of psychology.

8.4.14 Despite the trend in certain other healthcare disciplines to introduce a tier of lesser-skilled assistants, it is believed that this is unnecessary and inappropriate in healthcare psychology. Such a post could only function with level 1 and 2 skills (level 3 skills requiring a thorough grounding in psychology). There is already a wealth of multi-professional resource of varying skill levels which, rather than having its ranks unnecessarily swelled, needs to be utilised in a more considered and co-ordinated manner. The introduction of a psychology assistant would serve no additional function that is not already undertaken or could be undertaken within the existing staffing patterns.

8.4.15 However, psychology graduates without a professional qualification should not be disbarred from gaining experience in healthcare, but in ad hoc positions, such as technician or research assistant, where there is an undoubtedly valuable role which should be maintained. However, such positions would not be a formal part of the healthcare psychology career structure and would generally be financed by "soft money".

*Quality Assurance*

8.4.16 Standard across each of the alternative options is the institution of mandatory and formalised (structured) Quality assurance. This would be based on regular and defined peer review. A pre-requisite to the peer review process will be BPS agreement on and establishment of a body of professional standards - relating to both process and expected outcome of care, which will be used to monitor practice.

8.4.17 The options also entail a tighter and formal supervisory structure for newly qualified healthcare psychologists. It is recommended that an arrangement be introduced, whereby newly-qualified healthcare psychologists are allocated to an experienced practitioner within the same service, who provides close and regular supervision for at least two years following qualification. This could take the form of both formal supervision (approximately 2 hours a week, of discussion between practitioner and supervisor) and continual informal supervision, via open observation of practice. For supervision to be done seriously and properly, it has to be allocated adequate resources, (and this will mean significantly more resource being made available than current practice). It will mean acknowledging and incorporating it into the timetable of those involved.

8.4.18 The options also require psychologists to monitor the use of psychology by non-psychologists. Healthcare psychologists are to be viewed as psychologist practitioners who have a sapiential authority to ensure appropriate use of psychology by others. The

process of monitoring could be based on the standards suggested in paragraph 8.4.11 above.

***Healthcare  
Psychologists***

8.4.19

In keeping with our emphasis on preventing illness, and maintaining health, and in recognition of the wide role for psychologists in health care, we suggest the discipline be titled “healthcare psychology.” Other titles, such as “clinical” and “occupational psychologists” should be used if the title reflects the prime activity of the psychologist concerned.

***Management***

8.4.20

We identify that there are two discrete but complementary management tasks to be undertaken.

- o The first of these is the task of providing direction - setting the policies and objectives for the service; the standards of quality; the control of standards; the definition of assessment and therapeutic interventions; the overall quality control of the service and the supervisory arrangements for the service.
- o The second relates to the daily co-ordination and delivery of the service:
  - Ensuring the service is up-to-date with appropriate knowledge and techniques.  
Preparing protocols for use by non-psychologists in appropriate circumstances.  
Evaluating and developing methodologies and techniques to keep the psychology services

up-to-date.

Under suitable circumstances, undertaking research and development, and disseminating knowledge.

Under appropriate circumstances, undertaking teaching and supervision of non-psychologists.

Ensuring that appropriate and suitable administrative processes are established to maintain records, administer waiting lists, and administer the daily processes of the service.

Undertaking appropriate assessment and therapeutic processes.

Controlling the assessment and therapeutic processes.

Determining the need for further assessments and therapy.

Accounting for the satisfactory conclusion of assessment and therapy.

Reviewing and critically assessing the choice of methodologies for assessment and therapy.

Participating in clinical trials, as appropriate.

Developing and maintaining appropriate information and communication systems.

Optimising the available resources.

***Resource Management***

Recording results, details and preparing relevant statistics.

Maintaining and controlling the supply and disposal of necessary commodities.

Procuring appropriate resources, including ancillary support services.

- Defining and controlling costs.
- Being accountable and responsible for all services, including ancillary support services.

***Human Resource Management***

Maintaining the knowledge of staff and providing supervision.

Monitoring the health and working conditions of staff, and providing appropriate support.

- Allocating staff to tasks.
- Negotiating terms and conditions for staff, and negotiating contracts.
- Maintaining staff records.
- Counselling and advising on career development.
- Hiring, disciplining and dismissal of staff.
- Participating in appropriate meetings.

- o These management tasks may be allocated between individuals within the

service. The responsibility for ensuring that they are discharged falls to the head of the service as described under each option.

8.4.21 We expect appropriate budgeting mechanisms to be established, and for the manager(s) of psychology services to negotiate with general managers for other appropriate persons) the services to be provided for the resources available. This would result in the need for specifications of services to be provided within each location.

*Alternative  
Options*

8.4.22 The options which follow have been constructed with a view to increasing the quantity of psychological service provided. They represent an increase of psychologist resource in an attempt to overcome the current situation which has specialised at the clinical end of the spectrum to such a degree that there is a wide-spread failure to meet the more general needs for a service. District psychology departments are often rigidly structured into clinical specialties, allowing little flexibility, such as cross-covering of client groups.

8.4.23 The options do, however, continue to recognise that there will always be a need for specialist psychologist intervention with the more serious and complex psychological problems. They do not represent any compromise in the essential service needed by the most vulnerable and those most in need of support. However, there needs to be a more equitable balance between primary and secondary services.



- 8.4.24 In view of where the vast majority of need lies and where there is potential to have greatest impact, the proposition is that psychologists should be providing as much a health-oriented as an illness-based psychology service.
- 8.4.25 An emphasis is on the concept of health - the maintenance of personal and psychological health and social functioning, the prevention of illness and the treatment of the majority of need on a primary basis.
- 8.4.26 Thus the majority of psychologists would be practising with the various client groups from and on a primary base. They would, however, have access to a smaller tier of psychologists who would be specialists in secondary problems. However, we perceive all psychologists as being generalists, with special interests, as it is the general level 3 skills which are the unique attributes of the psychologist, and not their specialisation.
- 8.4.27 In recognition of the impact of environmental aspects on health services, healthcare psychologists would have a developed role relating to the environmental issues which affect health, including the organisation of health services, the interpretation of health policy and the planning of services.
- 8.4.28 Within this framework, all healthcare psychologists would work directly or indirectly with patients, would treat individuals and groups, would provide consultative services to other staff and work in multi-disciplinary

teams.

8.4.29 The primary-based generalist psychologists would be supported by secondary-based generalist psychologists with special interests.

***Referral Arrangements***

8.4.30 Each of the options will vary in their referral arrangements. However, there is no intention that the secondary-based psychologists should receive referrals solely from primary-based psychologists, although it would be hoped that general medical practitioners would refer to primary-based and not secondary-based psychologists.

8.5 Option 2 - "Shared Care"

***Emphasis of this Option***

8.5.1 In this option recognition is given to the application of psychological theories as a major influence on the health of the population. Significant studies have been done in the application of psychology to raise the prospect that psychology applied more broadly to issues of health care and management may prove a more effective complementary and sometimes alternative form of prevention, assessment, therapy and care under a variety of circumstances.

8.5.2 For this prospect to be realised in practice requires a psychology profession which exhibits confidence and takes and/or is given responsibility.

8.5.3 A model of service delivery which supports the importance of psychology is one which recognises the fact that the National Health Service is a medically orientated service, and therefore concerned with

the physical aspects of disease.

8.5.4 Thus, this option promotes the concept of shared care. It supports the roles of a healthcare psychologist as someone able to support medical practitioners in the assessment, diagnostic and treatment process; to complement medical practise by providing services to ensure compliance with medical care, coping strategies and training strategies (amongst other services); and to offer effective alternatives to certain medical strategies (currently most clearly observed within mental health, with evidence arising from within physical medicine).

***Consultant  
-Led  
Service***

8.5.5 Anticipating the growth in the healthcare psychologist's contribution at each of these levels, this service delivery model proposes that the psychology service becomes "consultant psychologist-led", that is, by psychology practitioners of equal status with medical practitioners.

8.5.6 The responsibilities of a consultant are onerous. They include the responsibility for the psychological and behavioural wellbeing of people within his/her charge, regardless of who is delegated the day-to-day responsibility

8.5.7 A consultant psychologist would be responsible for all the psychology services required within that area - both client-related and the services required on the environmental, organisational and managerial levels.

8.5.8 The consultant psychologist would be responsible, not only for the services provided by other psychologists working in that area, but also for co-ordinating the

psychological services provided by certain other disciplines to that client group; for example, occupational therapists, nurses, social workers. This would be designed to overcome the current situation in which many different psychological services are provided within the same client area in a largely un-coordinated way, with each discipline answering to different professional heads. Often services are provided in a discrete and blinkered framework, with little communication across discipline boundaries to determine areas of un- and under-met need or unnecessary task/skill duplication.

8.5.9 So, for example, a consultant psychologist in primary health, would co-ordinate and be responsible for a comprehensive psychological service within a particular patch provided by psychologists, occupational therapists, community psychiatric nurses, health visitors, social workers and any other primary health care worker who regularly provided planned psychological services. The consultant psychologist would also provide a consultancy function, advising general practitioners on the appropriate use of level 1 and level 2 skills (particularly those needed to establish whether or not to refer a patient to healthcare psychologists), providing advice on complex cases, evaluating services and training GPs and practice nurses, for example, in certain psychological skills.

8.5.1 At the secondary and tertiary care level, consultant psychologists would have similar responsibilities, only within the conventional secondary and tertiary specialist areas - adult psychiatry, services for children, elderly people, people with learning

difficulties, neuropsychology and so on. Again, where appropriate, they would be responsible for co-ordinating the psychological component of the multi-disciplinary services.

	8.5.1 1	The consultant psychologist's responsibility would be to ensure holistic care and attention is given to people in his/her charge.
	8.5.1 2	The psychologist within this model has to be active in the pursuit of the objectives of a healthcare psychology service, and not predominantly reactive, relying on referrals.
<b><i>Scope of Intervention</i></b>	8.5.1 3	The emphasis in this option is on the independent ability to utilize level 3 skills.
<b><i>Independent Yet Integrated</i></b>	8.5.1 4	The healthcare psychology service would become formally recognised as an independent profession. This would only be acceptable in the NHS if the profession collaborated with and responded to the work of the medical profession, and, as such, was integrated into the health service through collaborative practise.
	8.5.1 5	This would mean working closely with directors of public health, general medical practitioners, other members of the primary health care team, with medical consultants and their junior medical staff, and all the relevant health care workers who complement and support medical practice.
<b><i>Professional Status/Licensing</i></b>	8.5.1 6	Securing independent status requires the psychology profession to pursue statutory chartered status.
	8.5.1	A statutory charter would require the

	7	establishment of an approving body, which is independent of any professional or staff organisation, for those seeking registration.
	8.5.1 8	We also consider it appropriate for some form of mandatory licensing arrangement to be introduced which licenses healthcare psychologists to practise with clients.
<b><i>Scope of Activity</i></b>	8.5.1 9	We would expect consultant psychologists to be responsible for each area of activity, but that there would be more consultant psychologists working in primary care than within the categories of secondary, tertiary care, organisation, teaching and research.
<b><i>Referral process</i></b>	8.5.2 0	In this model, psychologists would encourage referrals from any source, including self-referrals.
<b><i>Career progression</i></b>	8.5.2 1	We would expect that it would take at least twelve years from registration for a healthcare psychologist to have acquired the necessary experience to become a consultant, and that during that period the psychologist will have acquired a broad experience. Only upon reaching the level of consultant would the psychologist be considered to be a specialist, although clearly that individual would have moved towards specialisation some years prior to their appointment as a consultant.
	8.5.2 2	We see the progression of psychologists from registration being governed by experience, qualification, and the assessment of personal capacity to undertake the work expected in more senior posts. There would be three main steps. The post-registration experience would be at the basic grade and lasting

approximately two years leading to the granting of a licence. Progress would then be to a senior grade, lasting approximately four years, leading to a qualification enabling the psychologist to become a principal. After a further period of six years, the psychologist may compete for a consultant post.

8.5.2  
3 The timeframe for progression would be dependent on the standard of the individual concerned.

8.5.2  
4 These proposed timeframes are guidelines which could be modified in the light of individual assessment by professional assessors at the time of selection for appointment into a more senior post.

***Management  
Arrangements***

8.5.2  
5 In this option a consultant in each area of activity would be managerially responsible for the healthcare psychology service.

8.5.2  
6 For matters of planning for a hospital trust or for primary care, consultants would be expected to co-ordinate their plans in the light of the needs for individual services.

8.5.2  
7 For matters of training and research, the consultants for these activities would be expected to be responsible for ensuring appropriate training for psychologists across the dimensions of activity, and to stimulate and support the training of other health care workers by psychologists from all areas, as well as providing direct training themselves. With respect to research, the consultant concerned would be expected to advise psychologists on research matters, as well as conducting research directly, and seeking resources for research.

8.5.2  
8 Each consultant would be expected to receive a management contract from the health authority, specifying accountability lines, duties and remuneration. Such contracts should be short term, and renewable under appropriate circumstances.

8.5.2  
9 All psychology consultants within a district would establish an advisory committee to advise the health authority on matters pertaining to psychology. A chairman should be elected, who would be, in effect, primus inter pares, and represent the profession within the district.

8.6 Option 3 - Support Service

*Emphasis  
of this  
Option*

8.6.1 Emphasis is placed on psychology as a support and complement to medical care. Psychology acts as a resource to other professions, undertaking specialist procedures and techniques on request.

8.6.2 In this option, therefore, the psychology service would be essentially in support of the medical service and would not attain equal status. The service, would however, be led by “chief psychologists.

8.6.3 The psychology service in this option would be integrated but not independent.

*Chief  
Psychologist-  
Led Service*

8.6.4 In recognition of the importance of psychology as a supporting science, the service would be led by chiefs of service who would be managerially responsible to a district psychologist, but responsive to medical practitioners, taking referrals exclusively from them either nominally or in practice.



<i>Scope of Activity</i>	8.6.5	We would expect chief psychologists to be responsible for each area of activity, and that there would be more working in primary care than within other areas.
<i>Scope of Intervention</i>	8.6.6	In this model, psychologists would be expected to function more with level 2 skills, as a result of their relationship to medical practitioners. Where greater degrees of independence are found it would be possible to utilize level 3 skills
<i>Integrated but not Independent</i>	8.6.7	Healthcare psychologists would be expected to work closely with other disciplines and by virtue of their training, to take a lead in multi-disciplinary work. However, they would not be expected to act independently.
	8.6.8	In this option, the psychology service would be responsible to the relevant medical custodian of a patient's overall care for the provision of an effective psychology service; to the relevant manager concerning organisational activities; and to the district psychologist concerning management matters.
<i>Referral Process</i>	8.6.9	Referrals would come from medical practitioners either nominally or in practice. Medical practitioners would, therefore, act as gatekeeper to the service.
	8.6.10	Thus the service would be less active than Option 2 in taking responsibility for the psychological and behavioural welfare of people. The psychology service would be reactive to demands in its general attitude towards service provision.
<i>Career</i>	8.6.11	As in Option 2 we would expect it to

<i>Progression</i>	take 12 years from registration to reach the position of chief of service. We would see the pattern of career progression to be similar to that of Option 2.
<i>Management Arrangements</i>	8.6.12 In this option the management of a psychological service would remain as a district-wide function headed by a district psychologist.
8.7	<u>Option 4 - Independent</u>
<i>Emphasis of this Option</i>	8.7.1 This option emphasises the potential of psychology as a support, complement and alternative to medical care, and emphasises the independence of the profession from the Health Service. The option pays particular attention to the philosophy of the White Paper on the NHS <sup>9</sup> , and the Green Paper on community care <sup>10</sup> , by placing psychology services outside the NHS as such, but able to be contracted into the Service, by the Local Authority and any other agency, as required.
<i>Consultant -Led Service</i>	8.7.2 By virtue of its independence, the psychology profession itself would need to establish the criteria for leadership. However, it would be expected that psychologists would develop specialist practices in response to demand. We would expect that, should health authorities contract psychology services, the service would be led by psychologists with the similar training and experience outlined in Options 2 and 3.
<i>Scope of Intervention</i>	8.7.3 In this model, psychology services would be constrained by client requirements. The less discerning client may only be concerned with contracting psychologists with well

developed and established level 2 skills.

	8.7.4	Others may recognise the importance of psychology and rely on the provision by psychologists of level 3 skills. Under these circumstances, psychologists may be perceived as offering alternative services to certain medical services to certain medical strategies. The problem arises concerning how these will be financed.
<i>Independent but not Integrated</i>	8.7.5	A major complication of this model is that, by being outside the NHS, psychologists would be seen to be independent and would, therefore, have little power to influence health care generally. Psychologists would find it more difficult to integrate their activities with those of other professions, but would be independent to exercise their own discretion over prevailing matters.
<i>Scope of Activity</i>	8.7.6	The scope of activity would be dependent upon client requirements. However, psychologists would be expected to be able to provide services at the primary, secondary, tertiary, environmental, organisational, management and training levels.
	8.7.7	The service would be reactive to demands for service.
<i>Referral Process</i>	8.7.8	We see the referral process for this option as open to anyone, including self-referrals by patients.
<i>Career Progression</i>	8.7.9	We expect the training required to fulfil this option to be the same as that set out in Options 2 and 3.
<i>Management</i>	8.7.10	This would be a matter for

## *Arrangements*

individual practices.

- 8.8 These options represent different service delivery models. Their main differences are summarised in Figure 15.

## Summary

8.9 *The principal differences are that:*

- 8.9.1 *Option 2 emphasises psychologists' level 3 skills, whilst Option 3 emphasises their level 2 skills.*
- 8.9.2 *Options 2 and 3 establish a formal role for healthcare psychologists in teaching non-psychologists psychological skills and a formal role in monitoring the application of those skills.*
- 8.9.3 *Option 2 presents an independent profession, whilst Option 3 presents a profession in support of the medical profession.*
- 8.9.4 *Option 2 entails the appointment of consultant psychologists to be heads of service, whilst the organisational structure in Option 3 is as it is currently and in Option 4 would be a matter for individual practices to decide upon.*
- 8.9.5 *Option 2 proposes the institution of statutory registration whilst the other options retain the voluntary charter. Each of the alternative options introduces licensing.*
- 8.9.6 *A statutory quality assurance system would be a feature of Options 2, 3 and 4.*

8.10 *In summary, we have used the opportunity of developing alternative service delivery options to address the issues raised by the review. We have prepared options which we believe are sufficiently different to be tested, and yet are not unrealistic. Aspects of each of the options can be found in England today. We go on to appraise these options for benefits and costs.*

Figure 15

SUMMARY - SERVICE DELIVERY MODELS

	OPTION 1 DO NOTHING	OPTION 2 SHARED CARE	OPTION 3 SUPPORT SERVICE	OPTION 4 INDEPENDENT
Objectives:	To improve, either directly or indirectly, the standard and quality of life of people who are served by and provide health services, and to alleviate disability, through the application of psychological theories.			
Scope of Interventions	The application of the principles and procedures of psychology to health care.	Levels 1, 2, and 3, with emphasis on Level 3	Levels 1, 2 and 3, with emphasis on Level 2	Levels 1, 2 and 3, depending on client requirements
Process of Service Delivery	Direct and indirect Providing others with certain psychological skills	Direct and indirect Formalised role in teaching psychological skills to other disciplines	Direct and indirect Formalised role in teaching psychological skills to other disciplines	Direct and indirect
Relationship with Medical Staff	On a continuum from medical gate-keepers to independence	Independent	Support	Independent
Organisation	Based on Whitley Grades, with District Psychologist as head Part of NHS	Consultant-led with Principal, Senior and Basic Grades Part of NHS	As in Option 1 Part of the NHS	A matter for the profession Independent of the NHS
Professional Status	Voluntary charter	Need to move to statutory charter Licence	Voluntary charter Licence	Voluntary charter Licence
Quality Assurance	Embedded in BPS Code of Conduct	Statutory Quality Control	Statutory Quality Control	Statutory Quality Control
Referral Arrangements	Variable according to the independence of the psychologist	From any source, including self-referral	Through medical staff	From any source, including self-referral

<sup>1</sup> "The Work of Clinical Psychologists", MPAG Reference Group Meeting, British Psychological Society, 31st January 1989.

<sup>2</sup> The 1988 manpower survey showed that some 70% of districts employ 10 or fewer clinical

psychologists and only 8 districts employed more than 20.

- <sup>3</sup> Taking community psychiatric nurses as a comparator, CPNs following the regrading exercise have been graded on scale G, with a starting salary of £12,025, rising to £13,925 at the top of the scale. Basic grade clinical psychologists, DV comparison, start on £9,158 rising to £11,073. This represents a differential of £2,807 at the lower end of the respective scales. (1988/89).
- <sup>4</sup> DHSS Advance Letter (SP)1/87.
- <sup>5</sup> In 1985 there was a total of 99 psychology technician posts reported and only one vacant post.
- <sup>6</sup> In 1988 the manpower survey recorded 106 places on training courses for that year.
- <sup>7</sup> In 1987 there were
- <sup>8</sup> Figures taken from 1985 Bath University Study, op. cit.
- <sup>9</sup> DHSS, Working for Patients, HMSO, 1989.
- <sup>10</sup> Griffiths Report, "Community Care: Agenda for Action". A Report to the Secretary of State for Social Services by Sir Roy Griffiths, HMSO, 1988.

**CHAPTER NINE**

**APPRAISAL OF MODELS AGAINST CRITERIA**



*Comprehensive  
Service*

**9. Appraisal of Service Delivery Models**

9.1 In this chapter we assess each of the service delivery models against the criteria set out in Chapter 7.

9.2 The process of appraisal requires judgements to be made concerning each option. The judgements concerning Options 2, 3 and 4 are based on the anticipation of events, should the option be implemented.

9.3 As opinion will differ over these judgements, we set out below our arguments in order that they may be tested. We also conduct sensitivity analysis to establish whether changes to the assumptions alter the conclusion. (The results of the sensitivity analysis are described in Appendix 9).

9.4 **Appropriateness**

9.4.1 We have observed that the current clinical psychology service is patchy in the range of services it offers. This is clearly a result of the rapidly expanding demand for services not being met by the investment in posts and, in particular, training posts, thus causing a wide gap between demand for clinical psychologists and their supply.

9.4.2 Taking account of the planned establishments as set out in health authority proposals, a patchy service would remain for some years to come unless there were to be a substantial increase in the numbers of training posts.

9.4.3 Option 2 - the “shared care” model, provides the framework for a comprehensive service within each district, with the aim that such a service would be achieved within the next ten years or so. Option 2 represents a wider range of services than those provided in Option 1, and places a significantly greater emphasis on primary care, with a view to achieving the overall objective for healthcare psychology services, to influence individual behaviour and psychological state and thus prevent some physical and psychological conditions reaching the stage where they require secondary care.

9.4.4 Option 3 runs the danger of being less concerned with advancing services within primary care. As healthcare psychology services will be in support of medical strategies, the recognition of behaviour as being a significant aspect in preventing certain physical and psychological conditions may be diluted by the focus on supporting medical interventions.

***Range of Assessment,  
Therapeutic and  
Problem-Solving  
Methods***

9.4.5 The independent option (Option 4) may produce the least comprehensive service. Under this option it is conceivable that district health authorities and hospital trusts would purchase only limited and specific services from clinical psychologists. This would leave clinical psychologists to find from elsewhere the resources for teaching and research. Equally, as prevention services yield a relatively long term pay-back, the emphasis on primary care may be diluted in favour of the more immediate returns to be found in secondary care.

9.4.6 In Option 1 we observe that the range of methods already exist within most districts. However, there is a tendency towards individual (psychologist) choice concerning the methods pursued and whilst managers of services may have an influence, there appears to be a less than formal requirement to ensure that district services provide a comprehensive range of methods.

9.4.7 In both Options 2 and 3, there is a more formal requirement to provide the suggested range of methods.

9.4.8 In Option 4, the range of methods is likely to be that required in specific situations by clients in contract with healthcare psychologists. Unless a district specifies the range of methods, it is likely that the comprehensive range will not be supplied.

***Support,  
Complement and  
Alternative to  
Medical Strategies***

9.4.9 In Option 1 the current arrangements are variable, with healthcare psychology services being provided on a continuum ranging between complete independence to the provision of a service which is largely determined by medical staff. At the latter end of the continuum, the healthcare psychology service can be seen to be in support of medical strategies and at the former, some alternative strategies to medical interventions will be used.

9.4.10 Option 2 emphasises shared care, but recognises the valid role of psychology in support of medical strategies. There is increased emphasis however, on providing complementary and sometimes alternative interventions to medical strategies, where appropriate.

9.4.11 Option 3 emphasises the role of healthcare psychology as a support to medical strategies.

9.4.12 Option 4 will most likely yield a variable pattern, but may be biased towards support, by virtue of medical staff referring to healthcare psychologists. However, by marketing services directly to the public, this option may also promote alternative strategies to certain medical interventions.

## *Establishing Need*

### 9.5 **Effectiveness**

9.5.1 In Option 1 the current situation is variable in its approach to establishing need. Some districts pay particular attention to the establishment of need, whilst others (those smaller and under heavy work pressure) respond to demand without a prior assessment of the need for services.

9.5.2 Options 2 and 3 specify the requirement to establish need, but as the exercise is complex and inexact, we do not see that all services will be engaged in the process. We therefore anticipate that in these options the situation may be as variable as current practice.

9.5.3 Option 4 will depend on the marketing strategies of the services. There will be a requirement for each service to establish the needs of its market. This is different to the needs of the population, and to this extent is likely to produce a variable assessment of need.

## *Use of Demonstrably Effective Methods*

9.5.4 On the basis that quality assurance processes are variable, it is assumed that processes for ensuring that demonstrably effective methods are used are also variable in Option 1.

9.5.5 In Options 2, 3 and 4 we propose the establishment of formal quality control processes. We expect such processes to include assessment of the efficacy of methods.

## *Research into the Application and Effectiveness of Methods*

9.5.6 The situation in Option 1 is, again, variable, and generally limited to certain centres which are large enough to promote research, and encourage research activity. What is implied here is more than the evaluation activities in which most healthcare psychologists are expected to be engaged. It is concerned with fundamental research, requiring controls.

9.5.7 In Options 2 and 3 this function forms part of the comprehensive district service and we would therefore expect that over a period of time, all districts would become engaged in this activity.

9.5.8 Whether or not an individual service becomes engaged in research will be largely up to that service, in Option 4. As research is unlikely to be funded by clients, it would be anticipated that less research would be conducted.

### 9.6 **Quality**

## *Qualitative Standards*

9.6.1 The BPS code of conduct provides a framework for standards. However, the establishment and publication of qualitative standards is variable in Option 1.

***Monitoring and  
Evaluation of  
Appropriateness***

- 9.6.2 In Options 2 and 3 we propose specifically that standards are established for the service.
- 9.6.3 In Option 4 the establishment of standards would be a matter for individual services. However, we would expect that standards would be established as part of the marketing strategy for the service.
- 9.6.4 In Option 1 monitoring of this kind is variable and not formally required.
- 9.6.5 In Options 2 and 3 the supervision process and the quality assurance processes should combine to ensure that monitoring and evaluation are carried out on a formal basis.
- 9.6.6 As with other criteria, Option 4 will depend on individual practices. Rigorous monitoring and evaluation may be too costly to undertake in circumstances of financially independent services, particularly if the services remain in high demand. Should demand fall, then it is conceivable that appropriateness would be monitored in order to re-establish or maintain market confidence.

***Provision of  
Supervision and  
Support to  
Individuals***

- 9.6.7 In Option 1 there are no formal arrangements, although it is discretionary good practice to supervise basic grade psychologists. For other grades, supervision is variable.
- 9.6.8 In Options 2 and 3 we make proposals concerning the training of healthcare psychologists which makes supervision in pursuit of higher qualifications an essential feature of the training programme.
- 9.6.9 For Option 4 the position will, once again, be up to individual practices, unless the training programme proposed is applied by the profession to independent clinical psychologists.

***Maintaining  
Psychological Skills  
of Others***

- 9.6.10 The current situation is ambiguous. There is uncertainty over the purpose of training other disciplines, and uncertainty concerning the responsibilities of clinical psychologists in training others. In the main, clinical psychologists respond to requests for training, but the process appears to be ad hoc.
- 9.6.11 In Options 2 and 3, we formalise the processes for the training of other staff and for maintaining their psychological skills.
- 9.6.12 In Option 4 clinical psychologists would need to be commissioned to undertake skills training. Given the interests of professional groups, it is anticipated that only a limited amount of such commissions would arise.

***Monitoring the  
Application of Other  
Disciplines’  
Psychological Skills***

9.6.13 The situation in the current service suggests that virtually no monitoring takes place of the application of skills used by other staff.

9.6.14 This reflects the ambiguous relationship which clinical psychologists have with other staff groups, and their uncertainty over the “ownership” of psychology.

9.6.15 In Options 2 and 3 we would expect the psychology service to be active in monitoring - perhaps more active in Option 2 than Option 3 - as a specific responsibility is given to the service for this form of activity.

9.6.16 In Option 4 we believe it unlikely that healthcare psychologists would be engaged in this activity.

9.6.17 We found considerable interest in obtaining consumer opinion in the current service, but very little evidence that such opinion was, in fact, sought.

9.6.18 In Options 2 and 3 we believe that obtaining consumer opinion may form part of the quality control process, and thus an expectation placed on the service.

9.6.19 In Option 4, the psychology service would be expected to be consumer-responsive in order to survive.

***Consumer  
Satisfaction***

9.7 **Efficiency**

***Planned, Co-  
ordinated and  
Controlled Services***

9.7.1 In the current context the management of services is undertaken within the framework of a service managed by district psychologists. We perceive that this arrangement works well for the current service.

9.7.2 In Option 2, with a consultant psychologist-led service, the management process may be placed at greater risk than the current practice because there would be no single designated head, but a cogwheel-type arrangement which brings together all the consultant psychologists in a corporate management forum. However, the responsibilities of management are more clearly set out in this option, and there would be greater scope for co-ordinating the psychological activities of all staff.

9.7.3 In Option 3 we see a similar situation as for Option 1, with district psychologists.

9.7.4 In Option 4, whilst each individual service may be well managed, psychology services overall are unlikely to be well managed, because there would be no co-ordinating function over other disciplines’

psychological activities. Moreover, it is difficult to see how any comprehensive planning process would work.

9.7.5 We perceive a lack of flexibility in the current service, being constrained by budgetary arrangements, as well as Whitley Council processes and structures. There is also little flexibility to create posts with a capacity to cross-cover client boundaries.

9.7.6 The proposals in Options 2 and 3 which promote the generalist psychologist with special interest are aimed at bringing flexibility into the service.

9.7.7 Option 4 may require the services to be flexible to respond to consumer demand. Specialised services may not be able to survive and prosper as well as general services.

## 9.8 **Implementation**

### *Acceptability to Management*

9.8.1 There are some reservations concerning the current service. They lie mainly in the degree of latitude clinical psychologists have and their apparently uncertain accountability.

9.8.2 In Option 2 we expect that a closer relationship between healthcare psychologists and managers would occur, as a specific activity is established to ensure this.

9.8.3 In Option 3 we would expect the result to be very similar to Option 1, since it entails the continuation of district psychologists, combined with our proposals for management tasks.

9.8.4 In Option 4 the implementation process would depend very much on the attitude of the client<sup>1</sup> towards the psychological services. The client would have freedom to purchase on a fee-for-service basis, and would, no doubt, operate this on the basis of a specification of services to be supplied. This will have attractions to managers in that they would have greater clarity about the services being purchased.

### *Acceptability to Providers*

9.8.5 In Option 1 we have observed that the acceptability to providers of the service is in fact variable depending on where the psychology services lie on the continuum between autonomy and support to medical strategies.

9.8.6 In Option 2 we would expect that the recognition underpinning the psychology consultant-led service would be acceptable to the provider, but that the implications of our proposals, notably the greater control on psychological services overall, may not be a feature that would be wholly welcome to all the

other disciplines.

9.8.7 In Option 3, we expect that the concept of a supporting role for healthcare psychologists would not be acceptable.

9.8.8 In Option 4 the results would depend on individuals' attitudes towards the concept of the market economy, and their personal desirability to practise independently from other health care services.

9.8.9 Currently in certain parts of the country the consumer is disadvantaged by virtue of the lack of a comprehensive range of psychological services or the necessity to wait for access to services, due to lack of resources.

9.8.10 In Option 2 we propose the development of comprehensive services on a district wide-basis, thus making services more broadly available. In addition to this, we focus attention on the provision of primary psychological services, the aim of which is to reduce risk behaviour and prevent psychological problems and thereby limit the likelihood of onset of morbidity.

9.8.11 In Option 3 there is a risk that inappropriate services would be provided to the consumer, in that access would be governed by the gatekeeping powers of medical staff. This may also limit access to psychology.

9.9.12 Option 4 is intended to be consumer-responsive but by the very nature of the market economy may be restricted to those who have the capacity to pay, and therefore detrimental to the majority of health service consumers.

***Acceptability to the  
Consumer***

## **CONCLUSIONS**

- o *Our overall conclusion is that Option 2 - shared care - is the model of service delivery which most closely meets the criteria.*
- o *However, much depends on the acceptance of the argument that psychology has a fundamental role in health and healthcare and that healthcare psychologists should be an independent profession. If this argument is not supported, it is likely that Option 1, with improvements proposed in this review, would be preferred. This amounts to an increase in the number of clinical psychologists, with the service delivery model being as variable as at present*
- o *Option 4 will, no doubt, find support from a section of the profession, but will probably do little to ensure psychology has a major impact on health.*
- o *Appendix 10 describes the outcome of the appraisal in terms of scores and weights in relation to the criteria. The appraisal results are subsequently tested for sensitivity, showing that Option 2 remains the preferred option even after basic assumptions are changed.*

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<sup>1</sup> Client in this context refers to those managers with purchasing capacity.



## **CHAPTER TEN**

### **LICENSING, TRAINING, MANPOWER AND COSTS**

## 10. Licensing, Training, Manpower and Costs

### *Change in Role of Health Authorities*

### *Quality*

- 10.1 In this chapter we set out the general implications of our proposals.
- 10.2 These proposals are being made in the context of a changing Health Service. The roles of district health authorities and regional health authorities are due to be modified, should the White Paper on the NHS be implemented.
- 10.3 Regional health authorities will concentrate on the tasks of “setting performance criteria, monitoring the performance of the Health Service, and evaluating its effectiveness”. They will be less involved in the direct management and provision of services, such as legal, information and management services.
- 10.4 District health authorities “will concentrate on ensuring that the health needs of the population for which they are responsible are met; that there are effective services for the prevention and control of diseases and the promotion of health; that their population has access to a comprehensive range of high quality, value for money services, and on setting targets for, and monitoring the performance of, those management units for which they continue to have a responsibility”.<sup>1</sup>
- 10.5 It is too early to ascertain what the implications of these changes may be on the training and supply of healthcare psychologists.
- 10.6 It seems clear, however, that district health authorities will be responsible for the appropriate provision of services, even though the services themselves come under the control of some other management body. District health authorities will be responsible for the commissioning of services, either directly or indirectly, and they will be interested in the cost and quality of services.
- 10.7 As part of our review we have proposed that

*Assurance*

formal quality assurance processes be introduced.

10.8 We also wish to ensure that minimum standards are set for practising healthcare psychologists, and that all healthcare psychologists satisfy the minimum standards before being allowed to practice independently of formal supervision.

10.9 Currently there is the BPS Code of Conduct (Appendix 10) and the opportunity for registering as a chartered psychologist with the BPS. Whitley Council also sets minimum qualifications for employment in the NHS.

10.10 Given the changing arrangements in the organisation of the NHS, the encouragement of competition and the potential independence of the proposed hospital trusts to employ or contract their own staff, we believe that the current arrangements (some of which may not continue in the future) need reinforcement.

*Licensing*

10.11 We propose that a process of licensing be introduced. Healthcare psychologists will be required to demonstrate attainment of minimum standards prior to being granted a licence to practise within the health services. District health authorities (and family practitioner committees) would be required to ensure that only licensed healthcare psychologists practise within the community and hospitals. A similar requirement would be placed on local authorities and any other agency utilising healthcare psychologists.

10.12 Licensing will be a separate process from the registration requirements of the BPS. Whilst the BPS has clearly articulated concerns for protecting the public, it is a professional organisation which must promote the interests of its members to survive. Whilst this may not be seen by some as a conflict of interest, we believe that in the context of the changing NHS, with the possibility of independent, private healthcare psychologists practising freelance, an independent licensing arrangement is required designed to protect the public from the less

competent psychologist. Currently, there is no requirement on anyone to engage or employ a registered or chartered psychologist.

10.13 The current Whitley Council arrangements require that only those with a recognised post-graduate qualification are eligible for employment in the NHS as clinical psychologists. We do not know how long Whitley Council agreements will continue in the face of a changing Health Service. With this uncertainty we feel that licensing will become a robust and consequently enduring method of ensuring minimum standards of individual competence to practise.

10.14 The time at which healthcare psychologists should seek a licence needs to be placed in the context of the training arrangements.

***Training***

10.15 We emphasise the need for on-going training throughout the psychologist's career. There are, however, specific standards to be achieved at specified career points. The establishment of these standards is a matter for the third stage of the MPAG review. Our purpose here is to set out our ideas concerning the general orientation of training to achieve standards.

10.16 Encouragement should be given to all healthcare psychologists to refresh their knowledge, as well as develop in new areas. This can be achieved by in-service, supervised training, as well as by externally arranged courses recognised by the BPS.

10.17 For basic training in healthcare psychology, we would wish to encourage partnership arrangements between academic institutions and the Health Service, with the academic institutions taking a lead in the theoretical education of psychologists and the Health Service focusing on the application of theory to practical training.

10.18 The proposed training framework for healthcare psychologists is as follows:

10.18.1 A recognised primary degree in psycholog

(3 years).

- 10.18.2 Training in healthcare psychology (equivalent to training in clinical psychology), leading to a recognised higher degree, with standards set by the BPS (2 years).
- 10.18.3 Registration with the BPS (currently, after 3 years postgraduate experience).
- 10.18.4 Post-registration training within the Health Service; individual performance reviews (2 years).
- 10.18.5 Award of licence.
- 10.18.6 Post-licence continuing education and training, in the form of, for example, a further higher degree by research, specialist diplomas recognised by the BPS and recognised in-service training; individual performance review (4 years).
- 10.18.7 Higher recognition by the BPS in order to gain entry into the principal grade.
- 10.18.8 Continuing education and training; individual performance review (6 years).
- 10.18.9 Consultant/chief of service grade; individual performance review.

10.19 We recognise that in making these proposals we are running against a trend to make the period of training three years prior to registration with the BPS. This three year period is often divided into two years of theory and one year of practice, although many courses actively integrate theory and practice for most of the three years. This format underpins the scientific-practitioner approach to training.

10.20 We do not wish to erode this approach. However, we are concerned to ensure that high standards are achieved before a healthcare psychologist practises independently (within the framework established by the head of service). We believe a four year period leading to license would be sufficient to achieve these standards. We would hope that the scientific-practitioner approach would be applied throughout the four year training period.

10.21 We recognise that the BPS is unlikely to change

its requirement for 3 years postgraduate experience prior to registration. However, we feel that the BPS should consider a form of registration after two years training on an approved healthcare psychology course. By reducing the period to BPS registration, the cost of training will reduce and the total numbers of healthcare psychologists needed will be reached sooner rather than later.

10.22 The reduction in the period to registration by the BPS is not intended to compromise on quality and experience.

10.23 Our emphasis is on the maintenance of high standards. This, we believe, is achieved through the granting of a license. The minimum period of postgraduate training required to obtain a license is four years, one year longer than the time required currently for registration with the BPS.

10.24 This framework implies that there would no longer be two routes for training. We are concerned to promote the partnership between academic institutions and the Health Service for all training, and that the training be co-ordinated within regions by a designated regional tutor.

10.25 The period of training from BPS registration to consultant/chief of service grade is proposed as twelve years, or ten years from the granting of a license. In practice this would be dependent upon individual ability. However, our rationale for suggesting twelve years is to reflect the importance we ascribe to the consultant grade, and a recognition of the ever-changing and developing applications of psychology in healthcare. We believe that the consultant grade would have extremely heavy responsibilities, should our proposals be implemented, and that this merits a very wide experience gained over a number of years.

10.26 There is much emphasis on in-service training and supervision implied by this framework. Much of the supervision of trainees is currently undertaken by those in the senior grade. It is this grade which has the greatest shortfall of

psychologists currently. Thus our proposals are likely to be stillborn unless recruitment and retention at this level improves dramatically.

- 10.27 We propose that education and training becomes a specific activity within districts. This relates not only to the education and training of non-psychologists, but is concerned with the training of psychologists. We expect the resourcing of this activity to be an early priority, in order to train sufficient psychologists to implement the remainder of our proposals.
- 10.28 Despite proposing a specific activity of education and training, we expect all licensed healthcare psychologists to be engaged, one way or another, in the education and training of non-psychologists, as well as psychologists.
- 10.29 In keeping with our general proposals, we believe that healthcare psychologists should receive generic training up to the principal grade. Thereafter there may be a need to concentrate on a specific activity (as outlined in our proposals), although generic interests should be retained. However, by the time a psychologist wishes to apply for a consultant or chief of service post he/she should have gained three or four years specialist experience.
- 10.30 Consultant/chief of staff posts should be regarded as general posts with a special interest.
- 10.31 Implementing our proposals requires an increase in the number of training posts. We believe that these posts should be established as supernumerary to the establishment, but funded as though they are established posts. We do not wish to encourage bursary schemes, nor private funding, nor special grants. We believe that training is a proper function of the NHS and that training posts should be funded with a view to signalling the interest of the Service in retaining the trained psychologist. We also believe that in the highly competitive labour market for the more intellectually able, training posts will need to provide a level of security which is to be found in properly established posts.

**Re-defined  
Grades**

10.32

The proposed grades of healthcare psychologist in Options 2, 3 and 4 are defined as follows:

**Trainee** A healthcare psychologist in training who is under the supervision of another psychologist who is a licensed senior, principal or consultant/chief grade or an academically-graded, licensed psychologist. A trainee is studying to become registered with the BPS.

**Basic** A registered healthcare psychologist in training, who is under the supervision of a licensed psychologist. The basic grade psychologist is registered with the BPS and is in training for his/her license.

**Senior** A licensed healthcare psychologist in training for higher recognition by the BPS. The licensed healthcare psychologist may be expected to provide clinical, management organisational, teaching and research services, and to act as an independent practitioner within the framework established by the consultant/chief of service.

**Principal** A licensed healthcare psychologist with higher recognition by the BPS who is expected to begin to focus his/her services on a specific activity and provide clinical, management organisational, teaching and research services within the framework established by the consultant/chief of service.

**Consultant/Chief of Service** A licensed healthcare psychologist with higher recognition by the BPS who is expected to specialise in an activity, and provide clinical management, organisational, teaching and research services, and to be head of one of the principal activities described in our review. (Where there is more than one consultant/chief for an activity, one would be designated head of department on a rotational basis.)



***Manpower  
Requirements***

- 10.33 To achieve the level of manpower implied in our proposals, there will be a need for one consultant/chief for each of the ten main activities we have earlier outlined as being the minimum necessary in each district.
- 10.34 For long-term manpower planning purposes (to ensure that there is not an over-supply of top graded individuals, producing a moribund career structure), the ratio of consultant/chief to other staff needs eventually to be 1:1. This produces a minimum number of approximately 20 healthcare psychologists per district, or 4000 in England. For the majority of districts, this represents a significant increase in the number of health care psychologists from the present position. For others, the minority, this will be seen as a reduction. In putting forward these figures we are making no judgements about the numbers of clinical psychologists needed beyond the minimum of 20 per district. Our arguments within the review would imply that the numbers of psychologists required to achieve the tasks we identify could be greater than 20 per district, but in making our manpower calculations we have had to take account of feasibility of implementation. It is for this reason we make recommendations concerning a minimum number, and it is the minimum number we use to calculate training posts, and other manpower matters.
- 10.35 These manpower requirements equate to an average of 2 healthcare psychologists per 25,000 population if spread throughout the country. In those districts with small populations, sharing of psychologists with neighbouring districts may be expected in the short-term.
- 10.36 In order to achieve the minimum number of 20 healthcare psychologists per district, the average growth per district in England would need to be one healthcare psychologist per year for the next ten years.
- 10.37 In order to achieve one consultant/chief in each of five activities described in our review in ten years would require 500 annual entry training

posts. To achieve the same target in twelve years requires 300 annual entry training posts.

10.38 In order to achieve one consultant/chief in each of ten activities described in our review - with 500 annual entry training posts it would take 22 years, and with 300 annual entry training posts it would take 30 years.

10.39 Should 500 training posts be available it would need to be for a relatively short period - 7 years. Thereafter the number would need to reduce to 300 posts in year nine, to ensure that there was not an over-supply at the top graded level.

10.40 These calculations take account of existing patterns of employment, together with the numbers of existing established posts. The assumptions in the modelling have been that wastage rates will remain constant, apart from trainees where we anticipate a 50% reduction in wastage due to better career prospects, and that promotion periods vary for senior grades (from 6 years down to 4 years). Based on these calculations the new training posts required would be either a little short of 200, or 14 per region for each annual entry (or 29 per region if the achievement of our proposals needs to be accelerated).

10.41 Figures 16, 17 and 18 show the different effects of: maintaining the existing number of training posts (Figure 16); of having 300 training posts or a little less than 200 posts over the current number (Figure 17); and of having 500 training posts - or a little less than 400 posts over the current number (Figure 18).

**Costs**

10.42 We have applied medical payscales to Options 2, 3 and 4 and retained existing scales for Option 1.

The equated scales are:

Trainee	-	Pre-Registration House Officer
Basic	-	Senior House Officer
Senior	-	Registrar
Principal	-	Senior Registrar

Top - Consultant (Options 2 and 4) Top  
 Grades as currently (Option 3)

10.43 The illustrative costs below include the salary costs of 500 trainees, but exclude their fees and expenses.

£m	<u>Option 1</u>	<u>Option 2</u>	<u>Option 3</u>	<u>Option 4</u>
Year 10	33.2	86.5	80.6	86.5
Year 20	31.8	109.3	98.4	109.3
Year 30	31.7			

We estimate the non-staff training costs per trainee per year to be £3,000.

10.44 The illustrative costs indicate an average cumulative increase of £27,000 per annum for each health authority, averaged over the next 10 years.

10.45 We have estimated the effect of increasing the number of training places to 300 per annum with immediate effect. This does not alter the number of top grade posts in year 10 (approx 900), but increases to 30 years the achievement of the target of 10 chief/consultant posts per district. The costs associated with this plan are:

£m	<u>Option 2</u>	<u>Option 3</u>	<u>Option 4</u>
Year 10	69.3	64.0	69.3
Year 20	93.8	85.0	93.8
Year 30	109.4	98.1	109.4

Figure 16

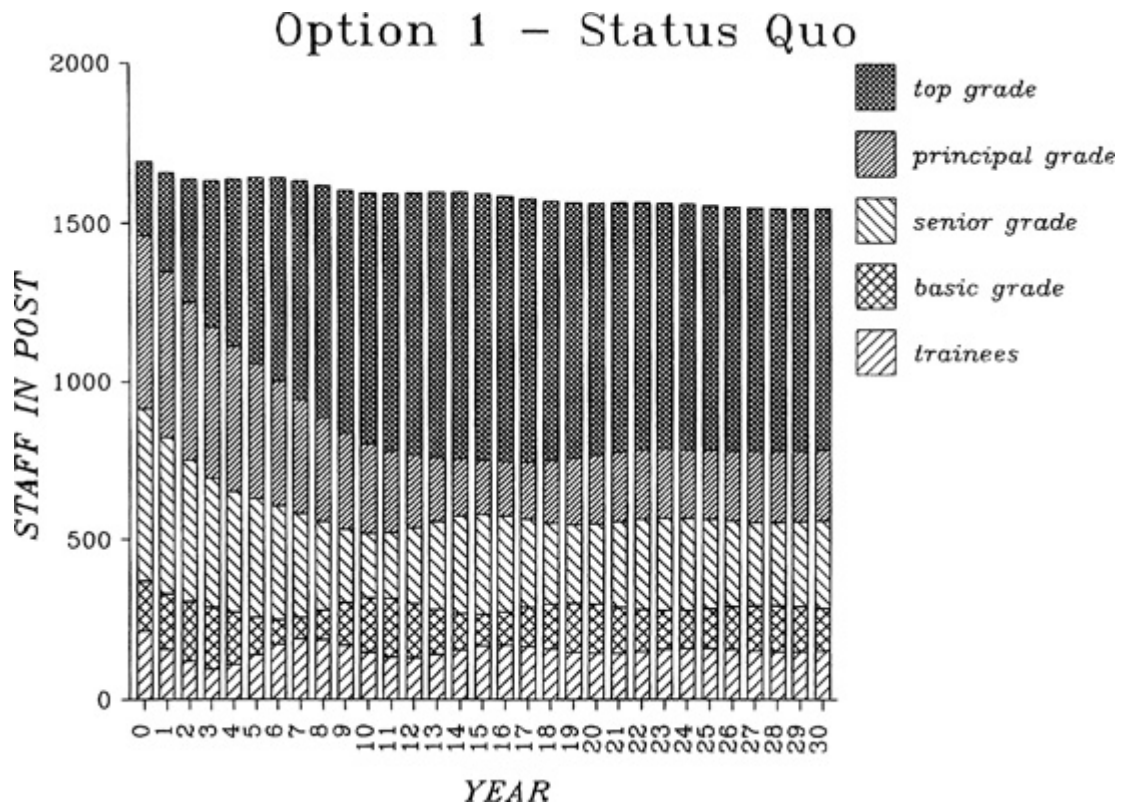


Figure 17

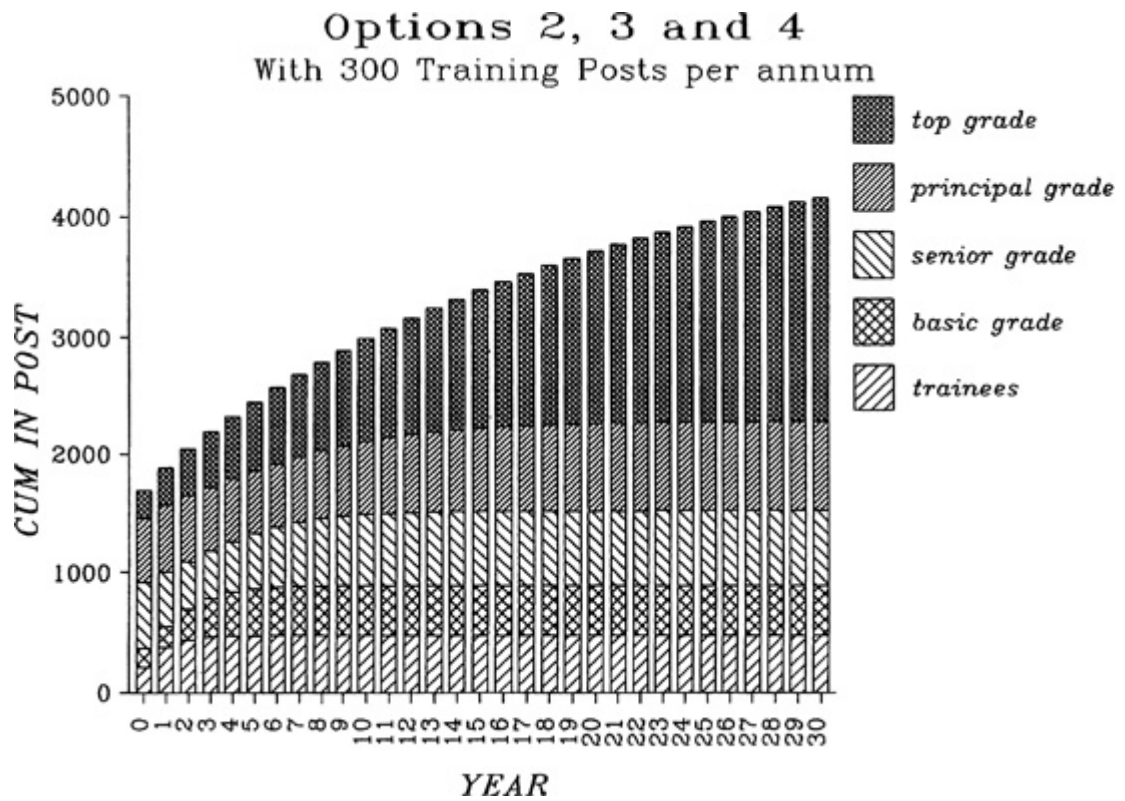
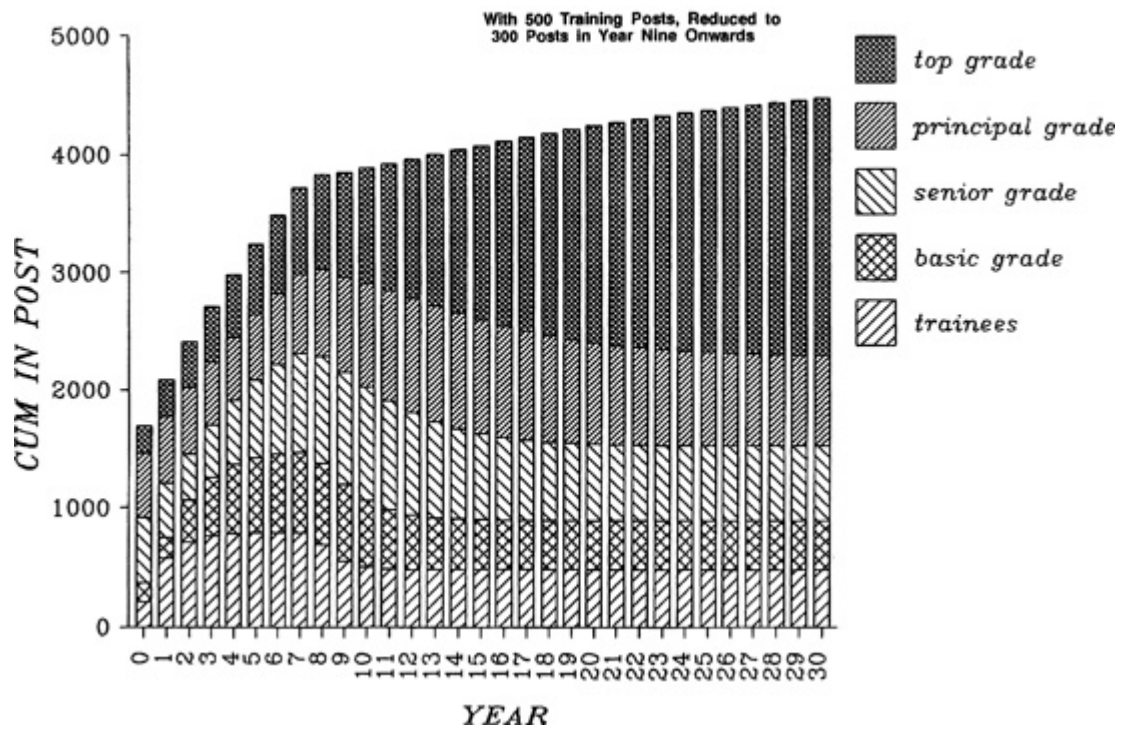


Figure 18

# Options 2, 3 and 4



<sup>1</sup> DHSS, Working for Patients, HMSO, 1989

**CHAPTER ELEVEN**

**CONCLUSIONS**

## 11. Conclusions

11.1 At the outset of this review we set out to answer a number of questions. These are posed in the first chapter.

11.2 In this concluding chapter we summarise our conclusions to each of those questions.

### What is the Need for Psychology in Health Care?

11.3 Psychology has a significant contribution to make to the health and wellbeing of the population. This contribution is made directly to people by assisting them with altering their behaviour to prevent illness and to provide ways of coping with life events and medical conditions. The contribution is also made indirectly, through supporting other health care workers in their own work, by assisting in the assessment and treatment of illnesses and other problems, and by providing advice on the processes and environment in which health care is delivered.

11.4 The application of psychology may also be an alternative to medical strategies in the treatment of certain conditions.

11.5 It is in the activities of preventing people from becoming ill through their own behaviour or psychological state and in the development of effective complementary and alternative therapies to medical strategies that healthcare psychology is likely to make its greatest impact.

11.6 Psychology also possesses a significant role in the maintenance of the quality of life of those who suffer from chronic disabilities. The growing numbers of old people, combined with the numbers of those with learning, significant psychological difficulties and physical disabilities, makes this section of the population a sizeable group who are more dependent on other people for their care than any other group in society. The ability to adapt and cope with living in society makes a major difference to the quality of life of these individuals.

11.7 There is a further significant role for psychology in facilitating the adaptation of health services to their environment and vice versa. Organisational and management issues are becoming increasingly important for two reasons. First, the NHS is changing, with greater discretion being given to those who run and provide services locally. Second, health services are having to adapt to a changing environment, particularly changes in manpower availability. There is, therefore, a major focus on human resource management. The application of psychological theories to these areas has long been recognised in commercial organisations, and will need to gain recognition as a vital discipline in support of organisational change and management within the NHS.

11.8 We have concluded that the need for psychology is potentially infinite.

### What is the Purpose of Clinical Psychology?

11.9 We have concluded that the term “clinical” is inadequate in

describing the purpose of psychology in the healthcare context. We regard as more appropriate a title which reflects a concern for health.

- 11.10 We have defined the objective of healthcare psychology as:  
*“To improve, either directly or indirectly, the standard and quality of life of people who are served by and provide health services, and to alleviate disability through the application of appropriate psychological theories”*
- 11.11 We have concluded that a formal classification of purposes is:
- o To assess or assist in assessment.
  - o To analyse or assist in analysis.
  - o To diagnose or assist in diagnosis.
  - o To treat or assist in treatment.
  - o To evaluate or assist in evaluation.
  - o To undertake teaching.
  - o To undertake research.
- 11.12 The focus for healthcare psychologists is the individual, the group, the environment, the organisation and management.
- 11.13 We conclude that their activities embrace:
- o Clinical work
  - o Staff support
  - o Teaching and supervision
  - o Service planning
  - o Research and evaluation
  - o Ambassadorial activities
  - o Organisational activities
  - o Management
  - o Administrative activities.



### **Who, Other Than Psychologists, Use Psychological Skill, and to What Extent are These Skills Used?**

- 11.14 We have concluded that there are three levels of psychological skill and knowledge used in health care.
- 11.14.1 Level 1 - basic “psychology”, such as establishing relationships with patients and relatives, maintaining and supporting a relationship, interviewing and using some simple, often intuitive techniques, such as counselling and stress management.
  - 11.14.2 Level 2 - undertaking circumscribed psychological activities, such as behaviour modification. These activities may be described by protocol. At this level there should be awareness of the criteria for referral to a psychologist.
  - 11.14.3 Level 3 - A thorough understanding of varied and complex psychological theories and their application.
- 11.15 Almost all healthcare workers use level 1 and 2 skills. In particular, medical, nursing, occupational therapy, speech therapy and social work staff use these skills. Some have well developed specialist training in level 2 activities.
- 11.16 Healthcare psychologists possess skills and knowledge at all three levels. Their particular contribution is in their rounded knowledge of psychological theories and their application.

### **What are the Issues Which Need Addressing Concerning Psychology Services in Healthcare?**

- 11.17 There are issues relating to the ambiguous role(s) of psychologists. We conclude that there is a need for a definite statement of roles for healthcare psychologists.
- 11.18 There is variation in the distribution of psychologists in the Health Service, and we conclude that there is a need for a comprehensive service in each district.
- 11.19 There is a large unmet need for psychologists and we conclude that there is a need for growth in primary care and physical medicine, but not at the expense of services to those with chronic conditions.
- 11.20 There is a need for mandatory quality control processes, as none exist. We conclude that improved quality can be achieved by more formal supervision, by introducing an independent licensing process, continuing education and training and a process for recognising greater experience and qualification.
- 11.21 We conclude that there is confusion over the psychologist’s role with other disciplines and propose a more formal arrangement for support and training of other disciplines.
- 11.22 We observe difficulties in recruitment and retention and conclude that these have come about through the limitation on

training posts, comparatively poor remuneration and limited career structure.

- 11.23 We conclude that the management and organisation of psychological services is unclear, and that the role of the district psychologist is variable.

### **What Possible Processes are There for Delivering Psychology Services?**

- 11.24 We have described four representative models for delivering services. These are:

- Option 1 - Do nothing (status quo)
- Option 2 - Shared care model
- Option 3 - Support service model
- Option 4 - Independent model.

- 11.25 Option 1 is a reflection of the current services and how they are organised.

- 11.26 Option 2 proposes a psychology consultant-led service, aiming to influence peoples' behaviour and psychological state in an attempt to prevent the need for primary and secondary medical care. This option also promotes psychological services as being supportive, complementary and alternative to medical strategies. It advocates an independent yet integrated healthcare psychology service.

- 11.27 Option 3 embodies a psychology service whose role is essentially to support medicine. In this option the psychological service would use level 2 skills, in the main, to provide supportive and complementary services to medical strategies. This model proposes an integrated, not independent, service.

- 11.28 Option 4 proposes the establishment of an independent psychology service outside the NHS. By virtue of this independence, it would not be integrated with other NHS services. The service provided would be supportive, complementary and possibly alternative to medical strategies.

- 11.29 The appraisal leads us to propose Option 2 as the preferred option.

### **How Many Psychologists Should There be Working in the Health Service?**

- 11.30 We conclude that there are ten main spheres of activity which should take place within each district health authority.

- 11.31 We propose that each of these activities should be headed by the most senior graded psychologist.

- 11.32 In order to realise the desirable staffing patterns, it will be necessary to aim ultimately for a 1:1 ratio of psychology consultant to other psychology staff. This means that the service should aim to have a minimum of 4000 healthcare psychologists, of whom 2000 should be on the most senior grade.

- 11.33 This figure means that for each district in England there should be a minimum of 20 healthcare psychologists. For the majority of districts, this represents an increase of one healthcare psychologist each year for the next ten years.
- 11.34 To achieve this target it would be necessary to establish at least 300 training posts, or just under 200 more than currently exist. This equates to approximately 14 new training posts in each region in England.

### **Costs**

- 11.35 It is clearly cheaper not to increase the numbers of healthcare psychologists.
- 11.36 However, there is growing evidence that the use of psychology in healthcare may have major cost-saving advantages, since it has been shown that where it is applied, it can reduce the utilisation of expensive hospital resources.
- 11.37 Option 2 represents a cumulative investment of £27,000 per annum for each district, averaged over 10 years. This option, together with Option 4, represents the most expensive option.
- 11.38 We would, however, conclude that this investment would be recovered once healthcare psychology is of sufficient size to be able to exert an impact in the areas of major need.