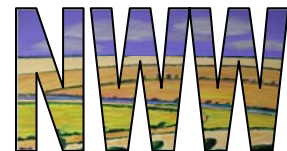


# NEW WAYS OF WORKING FOR PSYCHOLOGICAL THERAPISTS

## OVERARCHING REPORT

This report was commissioned by the National Institute for Mental Health in England (NIMHE) National Workforce Programme in 2008  
[www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk)



The New Savoy Partnership (NSP) is acknowledged for the role they played in bringing together the professional bodies to contribute to this report.  
[www.newsavoypartnership.org](http://www.newsavoypartnership.org)

New Savoy Partnership



Supported by the IAPT programme and published in February 2010

## Preface

*Mike Shooter was President of the Royal College of Psychiatrists when the New Ways of Working Programme commenced in 2003. He co-chaired the work to produce what proved to be the first in a series of New Ways of Working reports. Here he reflects on the work of the programme over the past seven years.*

Early in 2003, when I was still President of the Royal College of Psychiatrists, I went to the Department of Health to discuss a crisis in recruitment that had stretched everyone in mental health services – professionals and patients alike – to breaking point. It was clear that this was not going to be resolved by tinkering around with workforce numbers; the problem went much deeper than that.

Nobody seemed satisfied with their lot. Consultants in every discipline felt overwhelmed by demands on their time and unable to get to grips with the most serious cases. Many team members felt suffocated by a hierarchical, medically dominated structure that failed to make proper use of their talents. Trainees had less and less access to psychotherapeutic models as services turned increasingly to drug treatments for a quick answer to management targets. And patients themselves languished on long waiting-lists for a brief glimpse of a therapist who would probably have moved on by the time of their next appointment. No wonder it was getting difficult to recruit!

What was needed were new ways of working and this latest report shows just how far we have come in changing some of this dissatisfaction in general and in pushing the talking therapies to the forefront of services in particular. The road has not been a smooth one. Some consultants who complained loudest about numbers seemed the most loath to give anything up. Senior trainees who had been so critical of traditional methods were angry that we were selling the family silver just as they were about to get their hands on it. In some teams the skills were just not there to mix. And patients, especially children and adolescents, will still say that their voice is not properly heard or acted upon if it is.

This report makes no secret of what remains to be done, but we now have a growing evidence base for change – not just the randomised controlled trial type of evidence, but narrative evidence from patients, of what it feels like to be on the receiving end of services and what would work best for them. We still dish out too many prescriptions in lieu of face-to-face relationships, talking therapies still need to focus on a wider range of therapies and there is still too much friction between disciplines fighting over territory when the demand is greater than they can cope with put together. But attitudes have changed. There are good examples of new practice. And there seems a genuine political will behind them. Good luck with the next seven years!

### **Mike Shooter**

Past-President, Royal College of Psychiatrists,  
Chair, Mental Health Foundation, YoungMinds, Children-in-Wales,  
Vice-President, BACP.

## Forewords

This document is the final contribution in a series of reports on New Ways of Working for the workforce associated with people with mental health problems. The workstreams that have contributed to this report were commissioned under the National Institute for Mental Health in England's (NIMHE) National Workforce Programme. Since this work was commissioned, NIMHE has been replaced by the National Mental Health Development Unit. It is excellent that we are able to publish this report and set out the views of those who were commissioned to undertake this work.

This report has drawn together a varied group of professional bodies and practitioners, who deliver psychological therapies, and it has enabled them to reach agreement on a number of contentious issues.

The task ahead is to identify how the findings in the report can be used to underpin the Improving Access to Psychological Therapies programme, alongside many organisations and individuals considering where further work will contribute to developing an inclusive and effective workforce.

The first steps in this process are outlined in the latest IAPT implementation guidance, Realising the Benefits, which was published in February 2010.

### **Dr Ian McPherson**

Director

National Mental Health Development Unit (NMHDU)

As the mental health workforce develops, through new ways of working at all levels, it will provide psychological therapies to an ever increasing population with emotional difficulties. This valuable and well researched document aims to address important governance issues for service users, providers and commissioners.

The needs of young people and families are addressed as well as adult IAPT services. The evidence base and need for more research into psychological therapies is highlighted and the fact that talking treatments remain a priority on the "service user agenda" indicates that commissioners and providers need to continue to address this with high priority.

I genuinely hope that this document helps teams develop and deliver effective quality services in a timely fashion to meet the needs of those with mild to moderate common mental health problems.

### **Fenella Lemonsky**

Expert by Experience

Barnet, Enfield and Haringey Mental Health NHS Trust

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## 1.0 Executive Summary

This report on New Ways of Working (NWW) for Psychological Therapists considers the place of the counselling and psychotherapy workforce in mental health services and in the wider healthcare setting. This report is clear that the needs of the psychological therapy workforce must be more central in future workforce planning than hitherto has been the case. It follows NWW reports focused on other professional groups, including psychiatrists, which addressed a core set of questions; How can we organise services to ensure mental health professionals can work effectively to meet the needs of patients, but also in ways that allow for fulfilling jobs, with opportunities for career development and for satisfying, sustainable working lives for the practitioners delivering services?

Five key areas have been addressed:

- The evidence base for psychological therapies: implications for policy and practice
- Identifying the numbers and trainings of counsellors and psychotherapists in England
- Describing a proposed career framework for practitioners delivering psychological therapies
- Clarifying how care pathways and team approaches could inform the integration of IAPT into primary care focussed psychological therapy services
- The workforce interface in providing services to children and young people

Working groups produced reports on these five topics and contributed to the Improving Access to Psychological Therapy (IAPT) programme's parallel consultation, led by the New Savoy Partnership, on the Statement of Intent (announced by the Secretary of State for Health in November 2008). Choice and access, personalised and integrated pathways in primary care, and teams that can deliver these, are prioritised in the Statement of Intent and are central to IAPT's direction of travel.

A further, linked programme to develop competences for psychological therapies, led by Skills for Health, has also begun to define a Career Framework. In March 2010, a Digest of Psychological Therapies National Occupational Standards will be published in partnership with this report and should be read in conjunction with it.

Taken together, this work has helped generate consensus amongst key stakeholders on the issues the IAPT programme may need to consider going forward, and it has begun a wider dialogue about the continued development of an evidence-based profession for psychological therapies.

## 1.1 Key Issues and Areas for Development

The key issues and areas for development identified in this report are listed below. They are intended to support the IAPT programme as services are established and to inspire further discussion. Throughout this report, the importance of understanding the contribution of all practitioners in improving local psychological services is stressed. The goodwill and generosity of all those who have contributed to this report should also serve as a model for how change, collaboration and development in professional practice can occur.

## 1.2 Clinical guidelines and commissioning for choice and effectiveness

The development of current good practice surrounding clinical guidelines is reviewed and it is clear guidelines should focus on:

- Improved access through the development of effective service delivery systems
- Allocating resources towards treatments shown to be effective and away from less effective treatments
- Moving away from ineffective or harmful therapies

## 1.3 Range of Therapies, Choice and Integrating IAPT in local service pathways

### **Range**

From the outset, the national IAPT programme has been committed to promoting the implementation all of the NICE approved evidence based psychological interventions for people experiencing depression and anxiety disorders. Although the first priority was CBT, it was always intended that others would follow. The evidence based interventions as identified in the updated NICE Guideline for the Treatment of Depression (October 2009), are identified in the following table:

Intervention	Indication in the treatment of depression
Cognitive Behaviour Therapy	Recommended by NICE for all severities of depression
Interpersonal Therapy	Recommended by NICE for all severities of depression
Couples Therapy based on behavioural principles	Mild to moderate depression in people who have a regular relationship and where the relationship may contribute to the development or the maintenance of the problem, or where involving the partner is considered to be of potential therapeutic benefit.
Brief Dynamic Therapy	Mild to moderate depression when an individual declines medication CBT, interpersonal therapy, BA or couples therapy or prefers an alternative, or hasn't responded to other interventions.
Counselling	Mild to moderate depression when an individual declines medication CBT, interpersonal therapy, BA or couples therapy or prefers an alternative, or hasn't responded to other interventions.

*NB: The above relate to depression only; CBT is the indicated treatment for anxiety disorders.*

## **Choice**

Offering a choice of therapies remains a challenge for services and commissioners. Effective choice requires that a range of evidence-based therapies are locally available, that users are fully informed about the nature of individual therapies and their effectiveness, and that the provision of choice takes into consideration aspects of cultural acceptability, gender, location, hours of access, ways of delivering therapies and the need to be outcome and recovery-focused. Proposed areas for development include:

- A commissioning guide on the range of psychological therapies to offer choice and enhance the capacity of local services. The views and expertise of service users and voluntary organisations will be particularly important in implementing the choice agenda.
- More research that focuses on how users can make informed choices of evidence-based therapies, whether choice affects outcomes and when choice might not be appropriate.

## **Integration**

Integrated local models, incorporating all or some evidence based interventions and innovative ways of linking psychological therapies with stepped care, both before ( steps 0 and 1) and beyond common mental health problems (steps 4 and 5), could be identified or developed, based on NHS quality and productivity principles.

### **1.4 Building the Workforce**

Counsellors and psychotherapists work in the NHS, the voluntary and independent sectors. Their numbers are significant as there are approximately 30,000 counsellors, 7,000 psychotherapists, 10,000 clinical and counselling psychologists nationally. There are, however, only around 80 IPT therapists. These figures reflect the practitioners registered with a professional body. It is important therefore, not only to increase the size of the workforce through training and recruitment, but also to make better use of those that are available. One of the key challenges facing this workforce is that they are not, by and large, recognised and integrated into mainstream workforce planning and career progression. The following areas of development are proposed:

- Reliable and more meaningful methods of workforce data collection need to be developed.
- Career frameworks and training pathways for psychotherapy and counselling should be developed. It is important that career opportunities exist for local practitioners and for those who may not be graduates nor have a prior professional training.

## 1.5 Strengthening the Relationship between NICE and the Evidence Base within Psychological Therapies

This report outlines the strengths and limitations of randomised controlled trials, together with the contributions that evidence-based practice (EBP) and practice-based evidence (PBE) can make to the IAPT programme. It suggests that:

- Routine patient-reported outcome data should always be collected and that methods should be used to characterise the type of intervention employed.
- The routine collection of outcomes through the IAPT programme offers a unique opportunity to examine the translation of EBP into PBE. This should also enhance the competence and effectiveness of individual clinicians through appropriate feedback and supervision.
- Ways of encouraging greater dialogue between NICE and psychotherapy researchers are considered. Including, how the full range of high quality evidence can be used in order to ensure that effective interventions are identified and are efficiently and competently implemented as part of future guideline development. This will be particularly pertinent to the clinical outcomes data collected through IAPT services and how it might influence the further development of NICE guidelines.
- Commissioning of more research so as to include greater emphasis on couples, groups and families, and also new emergent therapies, and those based on integrative principles. This could include the role that IAPT sites might have to contribute to evaluating innovative approaches.
- The benefits of establishing a national body for research into psychological therapies are considered.

## 1.6 Interfacing with Children's and Young People Services

This report suggests areas for further consideration, in partnership with Child and Adolescent Mental Health Services, Safeguarding Children and other child specialists, including:

- Ensure that all practitioners delivering IAPT interventions to adults in a family setting are equipped with the appropriate skills and competencies required when coming into secondary contact with children and young people. Including for use when:
  - meeting the basic needs of children and young people present during the treatment of adults;
  - fulfilling the statutory duty to cooperate on child safeguarding;
  - providing information or signposting to CAMHS and/or other services.



- Consider whether extending the scope of IAPT to 16-17 year olds under certain circumstances could present a feasible opportunity to alleviate some of the challenges faced surrounding transition from child to adult mental health services.
- Share successes and lessons learned from the IAPT programme with CAMHS colleagues as they explore approaches best suited to increasing access to NICE recommended evidence-based treatments for children and young people.

## 2.0 Introduction

- 2.1 New Ways of Working (NWW) has been a major force for workforce reform in mental health services in England. It began in February 2003 and was a joint initiative between the National Institute of Mental Health in England (NIMHE) and the Royal College of Psychiatrists. Although starting with psychiatrists, it subsequently was embraced by all professional bodies representing applied psychologists, nurses, social workers, pharmacists, allied health professionals, and primary care. It is not possible to make a change to one staff group without considering the impact on the rest of the mental health workforce. (All NWW reports can be downloaded from [www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk)).
- 2.2 The overall aim of NWW has been to;
- Make best use of scarce clinical resources: to enable those staff with the most experience and skills to work with those with the most complex needs; and to supervise and develop other staff to extend their roles and competence to undertake work previously undertaken by people working at consultant level;
  - Bring new people into the workforce, usually at assistant and practitioner levels
  - Together, to work as a team, working within a distributed responsibility model of care.
- 2.3 This work has been closely integrated with the Improving Access to Psychological Therapies (IAPT) programme from its outset. The workforce delivering IAPT exemplifies the principles of NWW. It draws on the expertise of senior clinicians, educators and academics to develop services, to deliver expert therapeutic interventions and to train and supervise others. It has provided an opportunity for a range of current (largely) core professions to extend their role to become High Intensity (HI) CBT therapists. IAPT has also brought a new group of people into the workforce as Psychological Wellbeing Practitioners (PWP), who are graduates and/or living in local communities. A key outcome of this initiative is to train and develop 3,600 extra therapeutic staff between 2008 and 2011.
- 2.4 The NWW programme initially concentrated on the traditional core professions; it deliberately did not engage with practitioners delivering psychological therapies as they were seen as a very diverse group. However, in early 2008, a number of representatives from professional bodies, which covered psychological therapists, requested involvement with the programme. These bodies were the British Association of Counsellors and Psychotherapists (BACP), the United Kingdom Council of Psychotherapists (UKCP), the British Psychoanalytic Council (BPC) and the British Association of Behavioural and Cognitive Psychotherapists (BABCP). They felt that they needed to explore what NWW meant for them generally and what this meant for their involvement with IAPT specifically.
- 2.5 Whilst the overall IAPT initiative had been warmly welcomed by the public and by the professions, the initial focus on CBT had caused some concern amongst

non-CBT therapists. They were seeking ways to highlight other evidence of effective interventions to be factored into IAPT.

- 2.6 Counsellors and psychotherapists were keen to be recognised as an important source of workforce for IAPT services and for other related care pathways, offering other evidence based interventions. They also wished to be part of an exploration of how IAPT and other psychological therapies fitted within existing or redesigned services. Those training as counsellors and psychotherapists also found themselves in a career structure that did not recognise their contribution or understand their training.
- 2.7 Developing new roles as part of NWW has been important, but has proved to be difficult to sustain over time in services. The graduate mental health worker role in primary care, for instance, demonstrated how an innovative role using new graduates, finally ended up being only a stepping stone for most into clinical psychology training. This is an important lesson for IAPT.
- 2.8 A key strategic component of workforce redesign has been the development and use of competences. This has ostensibly been to help build a workforce defined by what it can do in terms of measurable quality standards rather than by what one might assume from professional qualifications, which are surprisingly variable. The competences developed which underpin Agenda for Change are of key importance to NHS staff: Skills for Health National Occupational Standards (NOS) have relevance across health and social care and therefore have currency in IAPT. Nevertheless, the two are different and need to be implemented with care. In the IAPT context, CBT competences were commissioned from Roth and Pilling (2007) and their process of drawing on training manuals and agreeing competences through expert reference groups (ERG) has been adopted by Skills for Health in their commissioning of NOS for therapeutic modalities of not only CBT but also psychodynamic/psychoanalytic, family and systemic, humanistic therapies and supervision. The outcome of this work is integrated within this report.
- 2.9 As a result of these issues and initiatives, the New Ways of Working for Psychological Therapists (NWW4PT) programme was set up to consider the workforce issues as part of an integrated NWW and IAPT programme. It was agreed that it would follow the model adopted by the NWW for Applied Psychologists project, where key work streams would be agreed and then taken forward jointly by the national programme and by representatives of the relevant professional bodies.

2.10 Five work streams emerged:

- The evidence base for psychological therapies: implications for policy and practice
- Identifying the numbers and trainings of counsellors and psychotherapists in England
- Describing a career framework for practitioners delivering access to psychological therapies
- Clarifying how care pathways and team approaches could inform the integration of IAPT into primary care focussed psychological therapy services
- The workforce interface in providing services to children and young people

2.11 In November 2008, the Secretary of State announced a Statement of Intent (Sol) to support IAPT, which highlighted the importance of tackling stigma, providing choice, promoting personalisation and integrating IAPT fully with primary care. This agenda complemented and reflected the purpose and journey of the NWW for Psychological Therapists programme of work.

2.12 In November 2009, the SoS confirmed his commitment and announced that other NICE recommended interventions for depression would become integral to IAPT services as they reach maturity.

## 3.0 Report Purpose

- 3.1 This is to address how counsellors, psychotherapists and other psychological therapists are understood, how their contribution to the implementation of NICE guidance can be facilitated, what career progression might be for them and practically, how teams can integrate new IAPT services with existing or redesigned approaches, all based on the challenging principles of NWW.
- 3.2 This report summarises the output of the work streams and seeks to inform how the broader psychological therapies workforce can contribute to improving access to psychological therapies that are effective and offer choice at a local level, in line with the Statement of Intent and Realising the Benefits: IAPT at Full Roll Out.

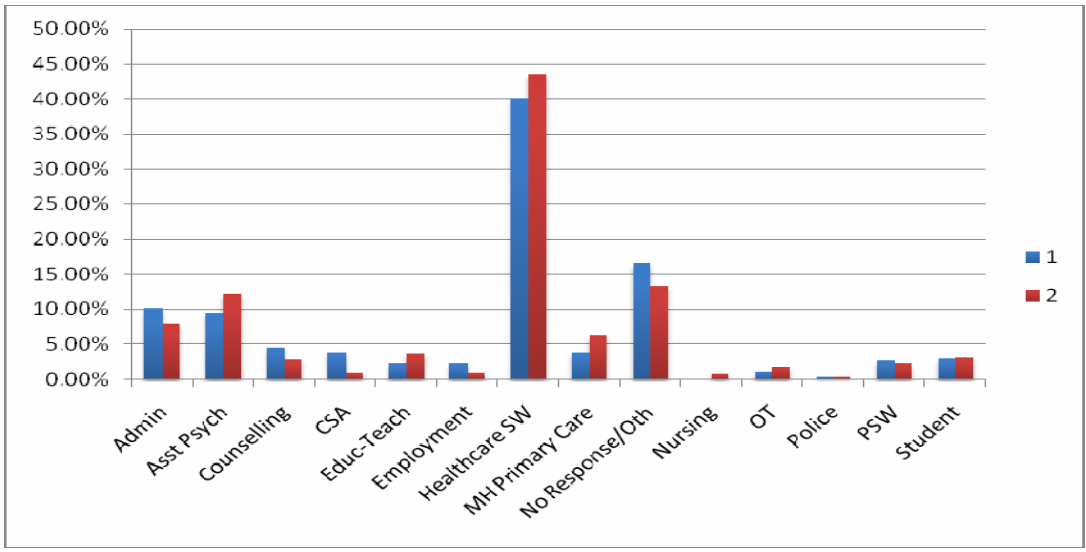
## 4.0 Who is this report aimed at?

- 4.1 This report is aimed at policy makers and PCT mental health commissioners and SHA training commissioners, who should consider the relevant areas for development. By providing the rationale, evidence and context, commissioners can better understand the value and range of services that can be delivered by staff from a variety of professional backgrounds.
- 4.2 IAPT service providers in the NHS, voluntary and independent sectors may benefit from opportunities outlined in this report.
- 4.3 Professional bodies, and their members, will also be engaged in further work to develop a career framework and workforce development and training.
- 4.4 Academics, psychological therapy researchers and university departments will be interested in those sections related to evidence and the call for further research studies and a framework for organising future research.
- 4.5 Service users, carers and policy makers will be interested to learn more about the sometimes ambiguous and confusing professional worlds of counselling and psychotherapy, as this report focuses on professions that are not well understood.

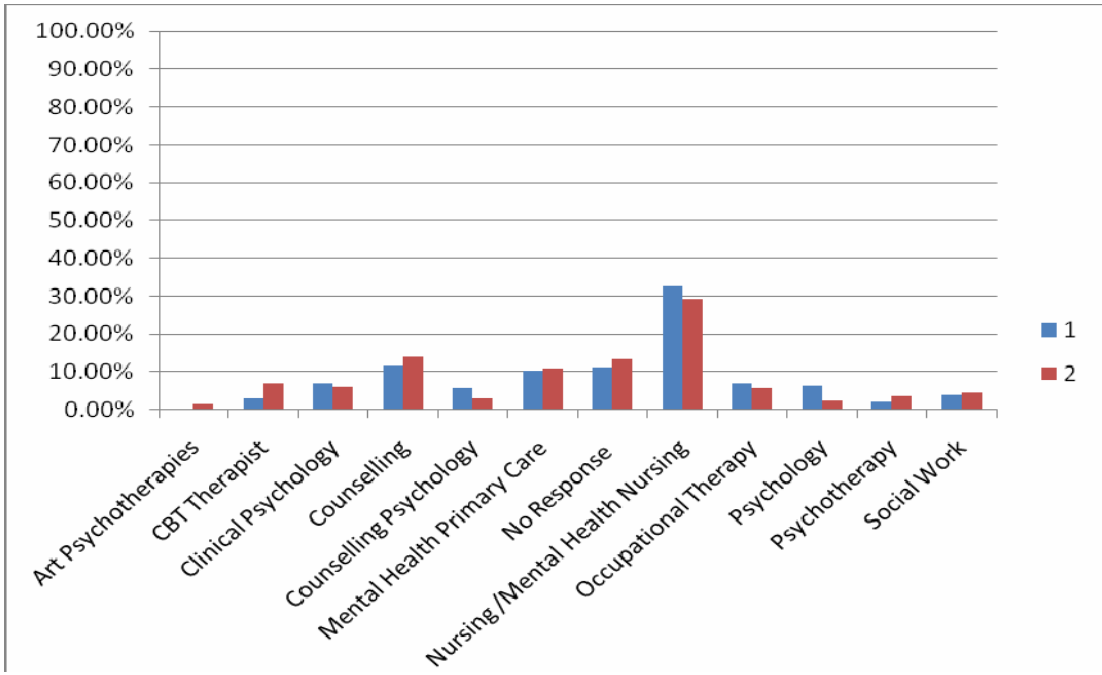
### The context of IAPT

- 4.6 The overall purpose of IAPT is to implement NICE guidance as it relates to anxiety disorders and depression. It has recurrent funding rising to £173 million from 2008 to 2011 in order to treat 900,000 extra people. In order to achieve this, there needs to be an increase of 3,600 extra therapy staff to begin to meet unmet need for treatment and support people in or to return to employment.
- 4.7 The evidence in NICE guidance pointed to prioritising Cognitive Behaviour Therapy (CBT) as this is the therapy with the widest application across depression and anxiety disorders. Practitioners with CBT skills to the appropriate levels of competence were also found to be in the most acute shortage amongst the existing services therefore training courses were commissioned to develop this new workforce.
- 4.8 The model of care for the delivery of CBT interventions is 'stepped care'. This means assisted self help and sign posting being the focus at step 2 and face to face therapy at step 3. The roles to deliver stepped care were differentiated so that Psychological Wellbeing Practitioners (PWP) were developed to work at step 2: they enter training at agenda for change band 4 and qualify at band 5 : High Intensity (HI) Therapists deliver therapy at step 3 and enter training at band 6 (and on band 7 for some) and qualify at band 7.

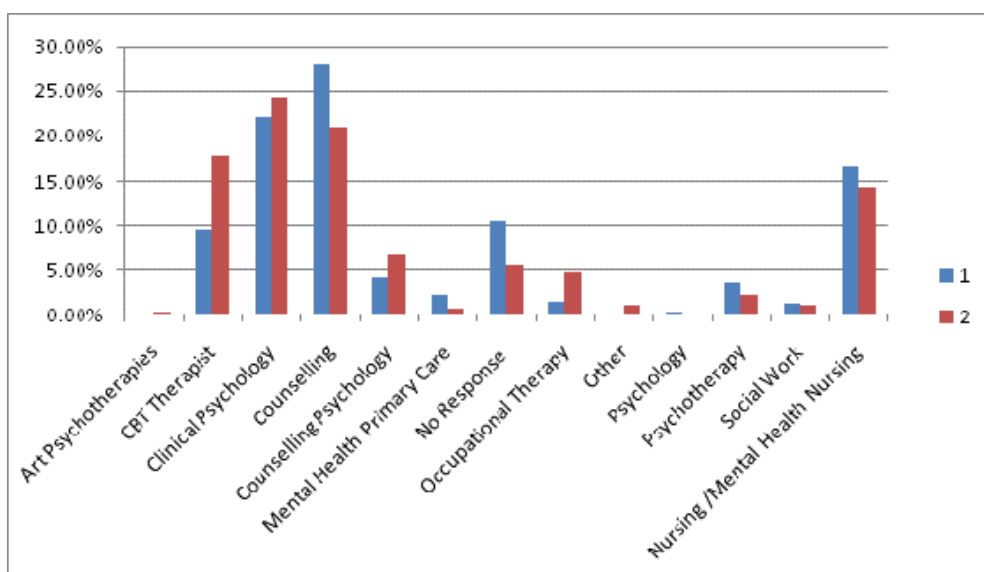
4.9 In Years One and Two of IAPT roll out, those entering the workforce as PWP trainees have been varied in their background:



In years one and two, those entering as High Intensity Trainees have been equally varied:



4.10 In year one, the staff appointed as qualified therapists, who were also expected to supervise trainees were as follows:



4.11 CBT competences were developed (Roth and Pilling 2007) to underpin the High Intensity (HI) curriculum and inform the Psychological Wellbeing Practitioner (PWP) curriculum. They have further been used as the basis of course and individual audit to inform accreditation.

4.12 Accreditation of HI courses is carried out jointly between IAPT (National Advisors) and the British Association of Behavioural and Cognitive Psychological Psychotherapies (BABCP). Individuals are currently accredited through the BABCP, but all professional bodies have agreed, in principle, to utilise the same standards where they have CBT training and practitioners. The aim is to provide career progression for all types of practitioners in IAPT, including those delivering other evidence based interventions. The concept of the Advanced Practitioner is being explored to address leadership, clinical and service development needs in IAPT services.

4.13 Accreditation of PWP/Low Intensity Training began in October 2009, and will follow a similar format to that for HI courses. A bigger challenge is how to sustain and retain this workforce, which is not professionally affiliated and at present not sufficiently understood nor appreciated; this is a challenge to service and education commissioners as well as to professional bodies. It is important that career and role development options are clarified and extended to enable this to happen successfully. The career framework described below also aims to facilitate this.

4.14 Consultation on the statutory regulation of counselling and psychotherapy was undertaken in 2009. The view is that HI therapists should have the protected title of 'psychotherapist'. Although PWPs are out of scope of the current proposals, they are nevertheless an important section of the workforce with



considerable responsibilities and direct contact with vulnerable members of the public.

- 4.15 As part of the implementation process, IAPT service commissioners have had to demonstrate investment in qualified therapists and supervisors, within the context of existing primary care psychological therapy focussed services. There has been an expectation that there should be a ratio of one suitably qualified therapist to two trainees so that supervision in services as well as in universities, is high quality. In practice, due to local circumstances and reflecting the change in emphasis as services mature and become less reliant on trainees, IAPT teams and services vary significantly in size and shape and the redesign of teams remains one of the most challenging areas of implementation.

## 5.0 Method of working in NWWPT

- 5.1 The NWW4PT programme consisted of a Steering Group and five Work Streams (as detailed in section 2.10).
- 5.2 The process was intended to achieve as representative, inclusive and diverse a range of input as was feasible, given inevitable limitations of time, resources and availability. It should be noted that people contribute their expertise voluntarily, and a great deal of hard work has been undertaken.
- 5.3 An equally important intention was to work towards reaching consensus, through respecting different viewpoints, and by resolving issues collaboratively. The outcomes are therefore based on considerable breadth of agreement.

## 6.0 Work Stream Outputs

A summary of each work stream is included below. Full reports are available separately and can be found at [www.iapt.nhs.uk](http://www.iapt.nhs.uk) and at [www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk)

### 6.1 Workstream 1

#### **The Evidence base for Psychological Therapies: Implications for Policy and Practice**

##### **Introduction**

- 6.1.1 The original purpose of this workstream was to identify and prioritise, according to the then available evidence and published guidelines, a range of psychological therapies for possible inclusion into the Improving Access to Psychological Therapies (IAPT) Programme. This work helped to influence but predated the selection of NICE recommended therapies as outlined in the Statement of Intent (Appendix D).
- 6.1.2 Although focused on the implications for IAPT, the brief of the workstream was wider and considered, in general terms, the implementation of psychological therapies from primary to tertiary care and across both physical and mental health conditions. However, there was a focus on psychological therapies for common mental disorders in adults, particularly affective disorders, with workstream 5 focusing on child and adolescence services.
- 6.1.3 A detailed list of recommendations of evidence-based psychological interventions cited in NICE guidance is available in the full workstream report, in order that service users and commissioners can make informed choices.
- 6.1.4 Learning from this workstream should be recognised widely by service users, and especially those from communities where psychological interventions are unfamiliar.

##### **Background and methods**

- 6.1.5 The workstream arose from investment in widening access to psychological therapies via the IAPT Programme. Despite the planned improved access to therapy via new services, the scale of the development challenged some existing practices within the psychological therapies community and led to vigorous debate. This report is informed by some of this dialogue through discussions with representatives from the major counselling and psychotherapy professional bodies, the voluntary sector and user groups, researchers and members of the academic community.

## **Major issues identified, together with specific issues for discussion:**

### **User and carer choice in psychological therapies**

6.1.6 Choice of therapies was identified as a real challenge for services and commissioners. Effective choice requires that a range of evidence-based therapies are locally available, that users are fully informed about the nature of individual therapies and their effectiveness, and that the provision of choice takes into consideration aspects of cultural acceptability, gender, location, ways of delivering therapies and the need to be outcome and recovery-focused. It is therefore suggested that:

- Commissioners work with users and carers to agree the range of choice, from the current NICE evidence-based therapies that local services should be providing. The voluntary sector, grounded in community work, may have additional expertise to offer in helping people make such decisions.
- The workstream concluded that it would be helpful if more guidance and research is considered around how users can make informed choices of evidence-based therapies, whether choice affects outcomes and when choice might not be appropriate.

### **Clinical guidelines and commissioning for choice and effectiveness**

6.1.7 The development of guidelines, based on current good practice surrounding clinical guidelines was reviewed. Guidelines should focus on:

- Allocating resources towards treatments shown to be effective by research and/or in practice and away from less effective treatments.
- The avoidance of harmful or ineffective therapies.
- Improved access through the development of effective service delivery systems.

## NICE and the range of possible recommended interventions within IAPT

6.1.8 The implementation of NICE guidelines with respect to mental health is summarised. With respect to anxiety disorders and depression, the report recommends in order of priority the following psychological therapies for funding and support within the IAPT programme:

Intervention	Indication in the treatment of depression
Cognitive Behaviour Therapy	Recommended by NICE for all severities of depression
Interpersonal Therapy	Recommended by NICE for all severities of depression
Couples Therapy based on behavioural principles	Mild to moderate depression in people who have a regular relationship and where the relationship may contribute to the development or the maintenance of the problem, or where involving the partner is considered to be of potential therapeutic benefit.
Brief Dynamic Therapy	Mild to moderate depression when an individual declines medication CBT, interpersonal therapy, BA or couples therapy or prefers an alternative, or hasn't responded to other interventions.
Counselling	Mild to moderate depression when an individual declines medication CBT, interpersonal therapy, BA or couples therapy or prefers an alternative, or hasn't responded to other interventions.

*NB: The above relate to depression only; CBT is the indicated treatment for anxiety disorders.*

## The relationship between NICE and the evidence base within psychological therapies

6.1.9 The workstream report outlines the strengths and limitations of randomised controlled trials, together with the contributions that evidence-based practice (EBP) and practice-based evidence (PBE) can make to the IAPT programme. It suggests that:

- Routine patient-reported outcome data should always be collected and that methods should be used to characterise the type of intervention employed and the competence/fidelity with which it was delivered.
- The routine collection of outcomes through the IAPT programme offers a unique opportunity to examine the translation of EBP into PBE.
- The routine collection of outcome data might enhance the competence and effectiveness of individual clinicians through appropriate feedback and supervision.
- An expert panel should be established through NICE to consider how the full range of high quality evidence could be used in order to ensure within the NICE guideline development process that effective interventions are identified and efficiently and competently implemented.

## The context of therapies: the role of group, family and integrative approaches.

6.1.10 The workstream highlighted report comments that much of the existing focus from IAPT has been on individual psychological therapies based around a single well-validated model. This section discusses the need to consider other

ways of engaging with clients through the couple relationship or within families. It also recognises that psychological therapies and therapists often adopt approaches which integrate elements from different therapies and which currently have a relatively under-developed evidence base. It suggests that:

- Modalities such as couple, group and family therapy are considered and evaluated in comparison to individual therapies in depression and anxiety as well as other disorders.
- The workstream recommended that further research is commissioned to assess the efficacy of currently under-researched areas of psychological therapy, to newly emergent therapies and especially those based around integration of approaches (e.g. Cognitive Analytical Therapy).

### **Importance of the evidence base for the training of psychological therapists**

6.1.11 The report emphasises the importance of training psychological therapists to be aware and critical of the evidence-base within psychological therapies and to have a critical knowledge of research methods.

- All psychological therapy training should include teaching on evidence-based practice and more general research methods within the field.

### **Developing a national infrastructure for research**

6.1.12 The report emphasises the lack of unified support or co-ordination of funding for psychological therapies research. Researchers are often located across different University departments, returned historically across various Research Assessment Exercise (RAE/REF) panels and are funded from a myriad of sources, but can identify with no one single funding body. The risks and benefits associated with such a development would need to be carefully assessed, however, the group considered that to improve the current position; consideration is given to establishing unifying body to oversee the development and promotion of research strategy and funding within this area (for example a National Psychological Therapies Institute). It might focus on supporting individuals to develop research projects on therapies not currently supported by NICE and, through Fellowships, to develop expertise in psychological treatment research, to conduct pilot studies, and to conduct small scale RCTs.

### **Conclusions**

6.1.13 The efficacy of psychological therapies has been robustly demonstrated, both through recent research and the conclusions from systematic reviews that have constituted the evidence-base for many different clinical guidelines constructed across countries throughout the world. The efficacy of many psychological interventions, as demonstrated by the number needed to treat convention from evidence-based medicine, far exceeds the efficacy of many common medical procedures or pharmacological agents (Wampold, 2007). Moreover, psychological interventions, in general, tend to preserve clinical outcomes at

follow-up and may offer a more enduring form of clinical change process or adjustment to the patient or client than acute pharmacological interventions or maintenance regimes (Roth & Fonagy, 2005; Posternak & Zimmerman, 2007)

- 6.1.14 Access to psychological therapies should be freely available and patients should have equivalent access to treatments as to any other treatment endorsed by NICE for delivery within the NHS. Furthermore, they wish to see the widening of access to all evidence-based psychological therapies, extended beyond the treatment of common mental health problems/disorders, to all other physical and mental health conditions that would benefit from such an approach.
- 6.1.15 It is recognised that not all psychological interventions or therapies may be beneficial to clients and patients. Some may be ineffective whereas others may actually do harm. There are also major variations in the range, depth and extent of evidence to support different psychological therapies. This limits the authority of clinical guidelines to recommend a broad range of therapies that are widely practised. The effectiveness of individual practitioners and their routine clinical outcomes vary significantly within any service, irrespective of the severity or type of clinical problem treated (and type of treatment offered). The group wished to draw attention to the fact that without effective supervision and clinical governance procedures, there remains the potential for a minority of therapists to practise ineffectively or to harm or abuse their patients and clients irrespective of their modality of treatment.
- 6.1.16 Ongoing controlled trials research and the regular monitoring of routine clinical outcomes are the solutions to the variability within efficacy (evidence-based practice) and effectiveness (practice-based evidence). Each approach to data collection (from experimental contexts and from routine practice) has its unique strengths and merits, and we strongly urge that through the IAPT programme those two approaches which are often seen by clinicians as irreconcilable, are enabled to contribute to the development of future therapists, services and clinical guidelines. To that end, the group would encourage a greater dialogue with NICE to review the extent to which the psychological therapies evidence base can support guideline development and consider including a broader range of evidence and methodologies, and embrace a more psychologically-orientated approach to mental and physical health conditions than its current medical and diagnostically-based approach. Training programmes should ensure that therapists are familiar with both of these approaches to collecting evidence.

6.1.17 Further research is necessary for those therapies that have a relatively weak evidence-base and those emerging therapies that are currently in development. A level playing field in research investment within mental health, and increased resources directed to investigation and development of psychological therapies is desired. Making the investment comparable to that in developing new pharmacological agents which are equivalent in terms of effectiveness. The group considered that to improve the current position; consideration is given to establishing a unifying body to oversee the development and promotion of research strategy and funding within this area (for example a National Psychological Therapies Institute).



## 6.2 Workstream 2

### The size and nature of the Psychological Therapy workforce

#### Introduction

6.2.1 The purpose of this work stream was to describe the size and nature of the workforce and associated training programmes required to deliver psychological therapies. It focused on Improving Access to Psychological Therapy (IAPT) services for those with mild to moderate depression and anxiety disorders. Inevitably these services are linked to the broader therapeutic environment and other services providing psychological therapy interventions both within and outside the NHS. This wider agenda was taken into account in the work.

#### Background

6.2.2 Staff enter psychological therapies from a range of occupations, some from specific therapeutic training within the NHS e.g. clinical psychology; some are trained in core NHS professions e.g. nursing, and later develop specific psychological competences; others train directly in counselling and psychotherapy. Training courses vary in title, qualification, theoretical approach, funding base and geographical distribution. More recently, through the IAPT programme, there has been specific funding to train and employ both Psychological Wellbeing Practitioners and High Intensity Therapists. This overall picture results in a workforce with multi-factorial range of skills, competences and experience; making it difficult to categorise, compare and contrast the similarities and differences .

6.2.3 The scope of this work stream was therefore to :

- To describe the size and nature of the Psychological Therapy workforce market, particularly in relation to IAPT.
- To suggest mechanisms, which will provide the ongoing provision of accurate workforce data.
- To investigate what is currently known about the psychological therapy workforce
- To investigate the availability and suitability of current training programmes
- Consider the findings from work stream 1 to ensure recommendations for developing the workforce for the future is in line with the current and developing evidence base

## Emerging Issues

### Understanding the Current Workforce

- 6.2.4 Psychological therapy staff work both within and outside the NHS. Within the NHS, workforce planning takes place which attempts to understand the needs of future services and the staff required to deliver services. To do this, numbers of staff are counted, however, this has been traditionally by professional group. Currently there is no single system within the NHS which collates workforce data and no agreed categories by which psychological therapy staff are designated. Although professional bodies hold numbers of staff belonging to their organisation, at present, there is no obligation to belong to one of the professional bodies. Many of those registered with a professional body may practise within the NHS; counting both NHS and those from professional bodies could lead to double counting. This makes the accurate estimates of this workforce difficult.
- 6.2.5 Counsellors and psychotherapists work in the NHS, the voluntary and independent sectors. Their numbers are significant as there are approximately 30,000 counsellors, 7,000 psychotherapists and 10,000 clinical and counselling psychologists nationally; there are however only around 80 IPT therapists. These figures are based on practitioners who are registered with a professional body.

### Availability and access to Training Programmes

- 6.2.6 Within the UK, there are 476 traditional training programmes for psychological therapies. The data, on what is currently available, has been collected by BACP (2005) and demonstrates the geographical spread and academic levels of courses. In addition, this exercise has demonstrated how the content varies across therapeutic modalities.
- 6.2.7 Prior to the IAPT programme, there were relatively few courses teaching CBT at the level required to deliver NICE recommended evidence based interventions. The IAPT programme has led to the commissioning of Psychological Wellbeing Practitioner courses at postgraduate certificate level and High Intensity Courses at postgraduate diploma level in each of the 10 SHAs. To meet NICE recommendations for the treatment of anxiety and depression, specific curricula for courses were developed thus ensuring trainees met the standards of delivery implemented in clinical trials. IAPT and SHA workforce commissioners will need to address how other therapeutic interventions will be developed in a similar way.
- 6.2.8 The BACP data collection exercise showed the clustering of courses in main urban conurbations (this has been replicated by IAPT training programmes) which may be a problem for access to training in rural areas. Some psychological therapy training courses have already addressed this challenge by providing weekend teaching, blended learning and innovative IT solutions: this should be taken into account in future developments.

- 6.2.9 Many psychological therapy training programmes are delivered on a part time basis; this is in contrast to the initial cohort of IAPT trainees who were expected to be available full time to undertake the training and work in an IAPT service. This is now being addressed in some areas, at the request of SHAs, as this is an important consideration for the future if a new and diverse workforce is to enter IAPT services. Accreditation will be important for these courses too, to ensure they deliver the same high quality training as full time courses.
- 6.2.10 At the commencement of the IAPT programme there was variable interpretation of who might be eligible to train as a PWP or as a HI therapist. Different approaches were adopted in SHAs, however this is being resolved by the use of undergraduate entry options for PWP and the use of the Knowledge, Skills and Attitudes (KSA) portfolio assessment process, as developed by BABCP in the case of HI.

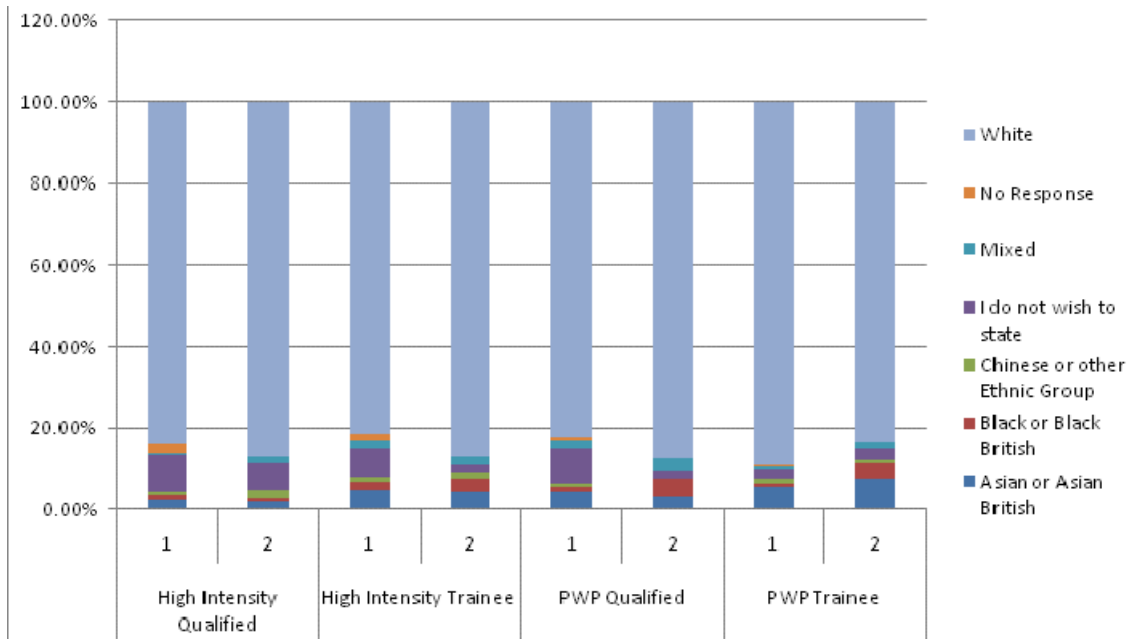
### **Availability of Staff to meet need**

- 6.2.11 In years 1 and 2, the emphasis within an IAPT service has been to deliver CBT. The updated NICE guidelines recommend additional therapies and the interventions will now offered by IAPT services in the coming years. It is also important that IAPT services become embedded in the range of primary care focused services. This will be enabled by local leadership and by developing links with others delivering other psychological interventions e.g. for those with long term conditions. This leads to a complicated picture. People referred into psychological therapy services may have a number of needs, relating to specific diagnostic problems and difficulties which cannot be easily categorised. At the time of referral it may not be obvious which approach is likely to be most effective. In addition staff may be required (especially in primary care) to respond to people with both short and long term difficulties. One of the challenges is to ensure that there are staff who can respond to this diversity, both within IAPT services and on a broader perspective. The question of who should be employed to meet this need must be addressed locally.
- 6.2.12 The IAPT programme focussed on training staff for CBT interventions. We are now planning to increase the range of therapeutic approaches. The debate is still ongoing as to whether staff should only be trained for a specific therapeutic modality or if there should be more of a pluralist approach so that, for example, counsellors previously trained in couples therapy could increase their range of interventions and also be trained to deliver CBT. An adoption of a more diverse approach potentially increases the workforce solutions to meet the needs of a given population. There are sceptics to this approach, as it is perceived as a dilution of what the current evidence base suggests; it is likely that this will be decided locally.

### **Equality and Diversity**

- 6.2.13 The ethnic background of staff employed in services should mirror the local cultural makeup of the population. Information from years 1 and 2 sites suggests that this may be difficult to achieve. The figure below gives a national picture of the ethnic group of trainee; there are, however, variations between

regions. The data is not robust enough to capture specific areas of high ethnic populations within SHA regions. This a matter PCTs need to address for their own communities.



Other areas of diversity should also be addressed including gender, disability and part time working arrangements for staff

## Areas for Development

- 6.2.14 A more robust way of collecting workforce data needs to be adopted. This work has commenced by agreeing new occupational codes, for use within the NHS, for those trained as PWPs and High Intensity therapists. Discussions should take place with DH and employer partners on the potential for the Electronic Staff Record (ESR) to address classification of the psychological workforce more effectively.
- 6.2.15 SHAS are best placed to monitor where new courses delivering psychological interventions develop to help ensure geographical access across England. Courses should also consider innovative ways of making access easier for trainees, to include part time options, week-end or block delivery and the creative use of IT. The BABCP KSA process should be used for those entering High Intensity courses without a prior professional qualification, and PWP training courses should ensure entry routes for those with out first degrees so that there can be a wider of diversity of people entering this workforce. This will, increase the probability of the workforce being sustained in the future.
- 6.2.16 Consideration of how the workforce should be configured within Primary Care services in the future should be discussed as early as possible in the context of widening access to evidence based psychological therapies.

## 6.3 Workstream 3

### Developing a Career Framework for psychological therapists

#### Background

- 6.3.1 The development of a career framework for people delivering psychological therapies illustrates the options available to staff, from different professional and other backgrounds, to progress and change their careers, based on competences rather than on professional delineation. This was highlighted in the Statement of Intent, announced in November 2008 and reinforced in the Secretary of State's speech in November 2009,, where the importance of choice of evidence based therapy was promised.
- 6.3.2 Since 2002 Skills for Health have developed the Career Framework for Health with its focus on skills and National Occupational Standards. It shifts the emphasis from an approach based on the needs of specific professions to one based on the needs of the patients and service users.
- 6.3.3 The NWW Career Framework Working Group discussed and piloted the Skills for Health approach to developing a competence based Career Framework for Psychological Therapists. This work drew together work describing IAPT workforce roles, modality competences and National Occupational Standards. It sought to illustrate the existing shape of career pathways in the various psychological therapy disciplines, and suggest a common framework for providing career progression.
- 6.3.4 The PWP role is important to sustain in the long term; this will require recruitment from a broader section of the community, undergraduate training options, accreditation and the development of senior PWP posts to offer career progression.
- 6.3.5 Other evidence based therapies require IAPT quality standards focussing on therapists operating at AfC Band 7. The idea of an Advanced Practitioner role to enhance leadership in IAPT services, which could be nationally transferable to deliver psychological therapies should be explored to develop leadership and team effectiveness at bands 8.

#### Outputs

- 6.3.6 The key disciplines/settings, which provide training and access routes towards practising as a psychological therapist were identified as follows :
- Psychotherapy
  - Psychology
  - Counselling
  - IAPT
  - Psychiatry
  - Nursing
  - Arts Therapists
  - CAMHS

6.3.7 From this list, several representatives from the identified disciplines agreed to develop a description of the types of role that exist at each level of the Career Framework (levels 1 to 9) and provided a description of the role by describing the job content and tasks that are undertaken in each role. A summary of this work can be found in the main report.

	Psychologists	Psychotherapists	Counsellors	IAPT
9	Head of service	Senior Consultant	Director Head of Service	Head of Service
8	Consultant Clinical Psychologist	Senior Psychotherapist	Consultant Counsellor Clinical lead	Consultant Therapist
7	Clinical Psychologist	Newly Qualified and Accredited	Specialist Counsellor	Qualified HI Therapist
6	Trainee Clinical	Advanced Trainee	Counsellor	Trainee HI Therapist/Senior PWP
5	Assistant Psychologist		Newly qualified Counsellor	Qualified Psychological Wellbeing Practitioner
4	Specialist Support Worker			Psychological Wellbeing Practitioner Trainee
3	Senior Support Worker			Health trainer/STR worker and other staff
2	Listening Skills Worker			STR worker and other staff
1	Basic Skills			

## Lessons learnt

6.3.8 Some of the main lessons include:

- There is a wide range of job titles and roles in use within services, reflected by the diverse range of Job Descriptions submitted to SfH, which are essentially similar.
- Job Descriptions tend to reflect local need and the diversity which arises from this, but ultimately there is similarity in the main generic categories of role being submitted.
- There is widespread uncertainty about the links between Agenda for Change banding, Career Framework processes and job evaluation which adds to the complexity in developing this work.
- Concern exists about the number of different change initiatives that are underway in the field of Psychological Therapies; these include regulation and the development of SfH NOS. Whilst constant change is

a fact of life, the impact of this has on the professions has been significant

- More detail on the utility of National Occupational Standards as a workforce development tool relating to the KSF and Agenda for Change bandings is required

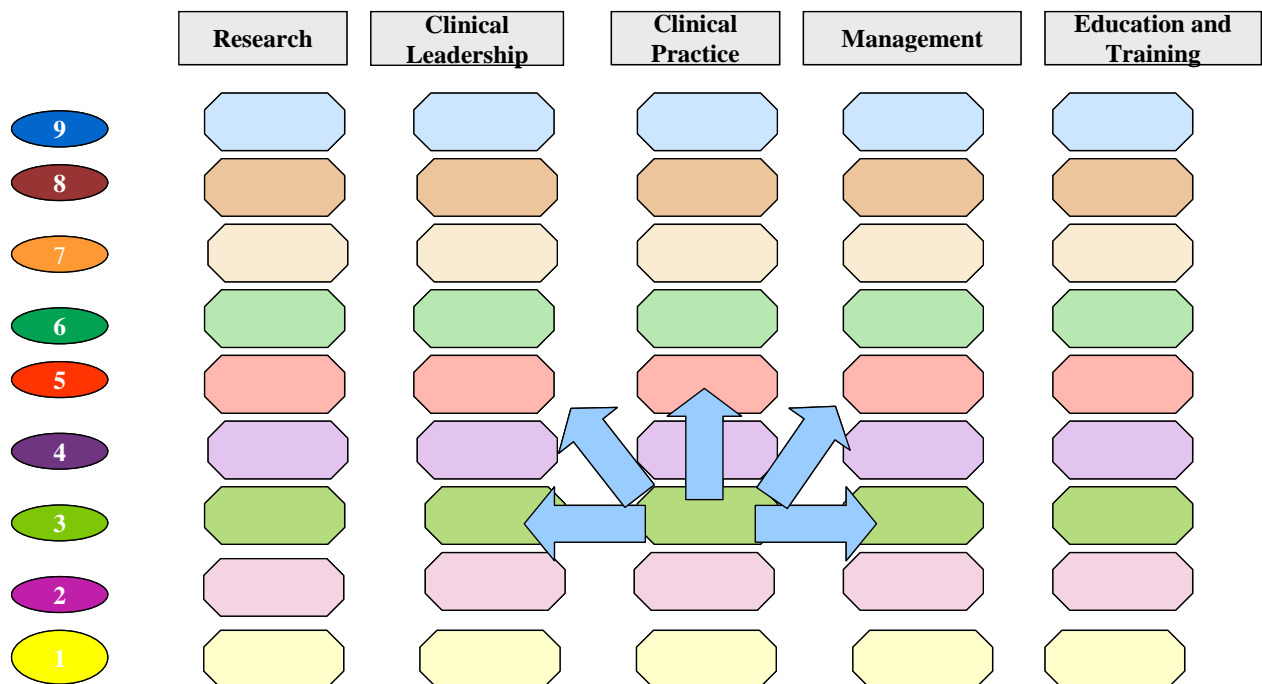
### Areas for Development

6.3.9 The need for a Career Framework model is one that has resonance with the majority of people who engaged with this work, because of the need to articulate and capture how individuals can progress throughout their career

6.3.10 One way forward is to have a model, which is based on the principle of there being core functions for all roles within the Psychological Therapies field, including:-

- Clinical Practice
- Supervision of practice
- Management - a corporate focused set of responsibilities/functions
- Clinical Leadership
- Research – to include Audit and evaluation
- Education and training

6.3.11 These core functions could be used as the horizontal axis for any future work when defining a career framework model. It would be based on these functions that job descriptions/roles are organised. The vertical axis for the Career Framework model would be the nine levels which are used by Skills for Health in previous CF models:



6.3.12 The final construct which has been discussed for a future career framework model is how to represent the level of intensity and time spent by a particular role on each of the core functions identified. It is envisaged that each role within the framework will, once highlighted, show visually the proportion of time spent on the core functions.

6.3.13 An IAPT specific tool could be developed which aims to:

- Provide a facility for staff to self-assess to see how they can enter into the IAPT pathway or indeed move through it
- Articulate the various roles and related educational pathways that exist within the IAPT workforce programme and how practitioners from the range of disciplines can access these.



## 6.4 Workstream 4

### How Psychological Therapists can work collaboratively in multi-disciplinary teams

#### Purpose

6.4.1 Putting the user and carer experience at the heart of the workstream's objectives, the aim was to describe best practice models of multidisciplinary working for psychological therapists and models of effective care pathways using a stepped care approach. This focussed on IAPT services and their interface with other services at both primary and secondary level.

#### Context

6.4.2 The work was positioned in line with the New Horizons vision for mental health and the broader challenge for local teams to work collaboratively to meet the needs of people accessing services, thus presenting a whole system approach to mental health and wellbeing.

#### Methodology

6.4.3 The main focus was to look at the introduction and development of IAPT through the practical experience of three IAPT services, one from each of:

- Ealing PCT
- Haringey PCT
- Knowlsley PCT

6.4.5 These services were chosen to reflect different settings, location, ease of access for gathering information and had the added benefit that group members were familiar with the PCT services.

6.4.6 The workstream conducted in-depth interviews with representatives from all three teams, and subsequently, different members attended meetings of the teams. Having reviewed the gathered information of their experience, the group synthesised the various factors that appeared to contribute to the success or otherwise of the service. In particular, they looked at the areas of:

- leadership
- administrative systems
- communication
- culture / behaviour
- training

Finally, the workstream identified further work that was needed.

#### 6.4.7 Core features that seemed to contribute to successful IAPT team working:

- Working in a collaborative and flexible way around the client and between teams in the local context
- A single point of access for the service
- Integrated training and supervision supported the team during a period of transition and aided working together.
- Staff had respectful, hopeful and positive ‘can do’ approaches, and not “its not my job/role” attitudes
- Staff articulated values and ethics of public service that built transparent, diverse and inclusive workplaces
- Strong leadership from the team manager along with freedom to act for the individual.
- A range of professional, multidisciplinary skills and competences available.
- Clarity about what the IAPT service was.
- The leaders’ personal style influences the team culture, which in turn is crucial to how the work gets done. It appears to be supra- professional in that no one professional group could claim to be the lead profession.
- Clear pathways were based on the stepped care model and an understanding of the use of screening, triage, access, and seeing the right person first, including referral criteria
- The nature of multidisciplinary working depended on where the team was located and how they met together
- New IAPT teams needed initially to focus on service design, operational management and the context in which they would work
- Teams needed to have access to information systems and how to best use systems, such as PC-MIS
- The importance of synergy and an understanding across the team so that:
  - Clinical and other workers were aware of each others roles,
  - High Intensity & Psychological Wellbeing Practitioners/trainees shared information and worked together.
- Teams worked and learned in a multi-agency context.
- Teams working in a flattened operational management structure appeared to be enabled to share decision making.
- Good links were important so IAPT was appropriately meshed with other services, so that it was perceived as an added value service (not as a competitor), had developed real working relationships with other services (with regular meetings), and had clear protocols with them (especially around care pathways/referral)

- Improving client choice, access and information was an issue for further work for all teams.
- Time spent enabling staff to conceptualise the service they were developing, and sharing enthusiasm for its development, enabled discussion amongst the team to help sort out issues.
- There appeared to be a lack of a proper shared understanding of a 'stepped care' model. Within various NICE guidelines, there are different 'steps' for different conditions, which need exploring. (see table below, developed for discussion in Knowlsey PCT)
- IAPT services are configured very differently - both in terms of their positioning within the matrix of other mental health services (primary and secondary) as well as in terms of their internal organisation. It seemed that no particular service model was the right one or the best one.

#### 6.4.8 Areas for development

Pilot sites could be undertaken:

1. To develop thinking on MDT working, to test out the wider IAPT team including other evidenced based psychological therapies, as well as seeing how this relates to non IAPT work,. This could be addressed through the use of CCTA and Lean thinking and two teams are already engaged in the North West.
2. To ensure there is excellent induction into the IAPT Stepped model of care from the outset with new practitioners and new services..
3. To encourage recruitment from local communities, through the PWP role and its potential for development, in the first instance.

	Step 2	Step 3	Step 4	Step 5
<b>Intervention</b>	<b>Graduate mental health and low intensity workers offering:</b> assessment, sign posting, case management, cCBT (fear fighter), book prescription, medication management, manualised therapy and sleep hygiene	<b>Psychological therapists and high intensity workers offering:</b> assessment, sign posting, case management, psychological therapies: brief CBT (by CBT therapists), Ectetic psychotherapies, employment support (links to Jobcentre Plus, condition management, retain, regain across all steps)	<b>Specialist therapists and CBT therapists offering:</b> assessment, case management, CBT and Interpersonal therapy. EMDR, substance misuse specialist nurse therapist offering recovery and progression.	<b>Specialist mental health assessments and treatments EDT Team offering:</b> psychological therapies including CBT, integrative, EMDR
<b>Psychometric Scores</b>	PHQ9 5 > 9 CORE 10 < 14 GAD-7 0 > 10 EPDS 10 > 12 & Q10 = 0	PHQ9 10 > 19 CORE 15 < 19 GAD-7 11 > 15 EPDS 10 > 19 & Q10 = 0-2	PHQ9 19+ CORE 20 < 24 GAD-7 15+ EPDS 19+ & Q10 = 2-3	As previous but with risk items scored.
<b>Common Mental Health Condition</b>	Mild to moderate anxiety inc panic, social anxiety phobias. Mild depression, sleep problems	Moderate / moderate severe anxiety and depression, post traumatic reaction, complex grief, interpersonal issues, work related stress	Severe anxiety based conditions, Panic, agoraphobia, PTSD, GAD, somatoform phobias, OCD, severe depression.	SMI, complex / treatment resistive disorders, PD
<b>Functioning Ability</b>	Minimal impact upon functioning, e.g. work social, personal, sleep diet, minimal avoidance/inactivity.	Moderate impact upon functioning, e.g. work social, personal, sleep diet, minimal avoidance/inactivity.	Moderate / severe impact upon functioning with more complex needs.	Significant impact upon functioning / complex needs.
<b>History</b>	Little past occurrence of symptoms with minor severity.	Previous episodes with moderate severity.	Longer history of condition or recent complex onset.	Enduring condition or complex onset.
<b>Risk Using TAG</b>	Minimal suicidal ideation, no intent. TAG = 0 > 4	Low/moderate suicidal ideation/intent. TAG = >5 "No severe"	Low/moderate suicidal ideation/intent. TAG = >5 "No severe"	High suicide risk

## 6.5 Workstream 5

### Children, Young People and Families

6.5.1 An expert reference group was established within the New Ways of Working for Psychological Therapists programme to consider the interface of IAPT services with children, young people and families. It influenced the other workstreams to ensure the needs and perspectives of this group were considered and embedded in the outcomes of IAPT. Its further purpose was to identify key issues and potential areas for development of IAPT services, including in the context of service users as parents and carers..

#### **The Case of Need**

6.5.2 Difficulties with mental health and psychological well-being in childhood and adolescence are common. Problems can have serious consequences for children's emotional, behavioural and educational development in addition to the resulting distress for the child or young person and their families. Unresolved childhood problems can persist into adult life and have a significant negative impact on life chances. There can be a wide range of adverse outcomes in adult life following child and adolescent problems, particularly those relating to conduct disorder. There is a significantly higher risk of chronic economic inactivity, court convictions and family disruption.

#### **Interfacing with children and young people services**

6.5.3 Mental health services for children, young people and their families are distinct from adult services in a number of significant ways. These differences include: the need for consideration of specific national legislation and policy frameworks relating to children, young people and families; the essentially multi-agency nature of service delivery involving complex networks of care; and the fact that a model of primarily using psychological therapies to treat children and young people is already long established in CAMHS.

6.5.4 Developmental issues are also more significant in any work with children and young people. Mental health problems within a family can impact on a child's emotional, intellectual and social development. With these and other differences in mind, any future development of IAPT to accommodate the needs of children, young people and their families would need to take place within the context of existing child and family services and be designed to complement, rather than replace them.

6.5.5 There are both distinct and subtle differences in the ways that adults, children and young people prefer to receive treatment and access services. In light of this, the existing body of evidence on what works

best for children, young people and families would require consultation as well as consideration of its need for development.

### **Knowledge, evidence and outcomes**

6.5.6 Any move to consider broadening the scope of core IAPT services in certain circumstances would need to be based on the available evidence of what works in mental health, emotional and psychological well-being. Investment in psychological therapies should support improved outcomes and effective practice. There is considerable, and increasing, knowledge of the effectiveness of psychological therapies. However, there are recognised gaps in the knowledge base and often evidence needs careful interpretation by skilled clinicians in its application to the real populations seen in CAMHS.

6.5.7 Effective practice needs to consider both the academic evidence base and practice-based evidence within the service delivery context. There is still a significant lack of good quality research in many key areas of mental health and emotional wellbeing – this is particularly true for more complex and vulnerable groups of young people with mental health and learning difficulties. Further investment is needed for research into psychological therapies that seek to address the needs of children and young people with complex, severe and enduring problems.

### **Key Issues and Areas for development**

6.5.8 The report identifies some areas for further consideration in partnership with Child and Adolescent Mental Health Services, safeguarding and other child specialists:

- Ensure that all practitioners delivering IAPT interventions to adults in a family setting are equipped with the appropriate skills and competencies required when coming into secondary contact with children and young people. Including for use when:
  - meeting the basic needs of children and young people present during the treatment of adults;
  - fulfilling the statutory duty to cooperate on child safeguarding;
  - providing information or signposting to CAMHS and/or other services.
- Consider whether extending the scope of IAPT to 16-17 year olds under certain circumstances could present a feasible opportunity to alleviate some of the challenges faced surrounding transition from child to adult mental health services.
- Share successes and lessons learned from the IAPT programme with CAMHS colleagues as they explore approaches best suited to increasing access to NICE recommended evidence-based treatments for children and young people.

## 7.0 Equalities Impact Assessment

- 7.1 IAPT, as a national programme, has an agreed Equalities Impact Assessment (EQIA), which is being used as the basis of local EQIA processes. The NWW programme of work falls within the context of IAPT, the IAPT EQIA can be accessed at [www.iapt.nhs.uk](http://www.iapt.nhs.uk)
- 7.2 Nevertheless, as our remit extended beyond the first phase of IAPT, the EQIA for NWW was explored in its own right through work streams and through a specially convened workshop of relevant stakeholders, with input from the Department of Health Equalities unit. Many of our suggested areas for development echo and expand upon IAPT's EQIA.
- 7.3 Diversity of the workforce
- The *gender* gap in the workforce suggests a need to improve the numbers in the male workforce, as it is predominantly female currently. Many experienced male staff themselves move into psychological therapy services, as do female staff, out of a personal interest and wish for both personal and professional development. Recruitment campaigns could profile men and highlight positive examples of people with personal experiences of services also contributing on a professional level.
  - The IAPT workforce needs to prioritise recruiting people from local communities; this can be facilitated by ensuring there are opportunities for PWP potential trainees, especially, to access training through undergraduate routes and have more targeted recruitment in order to attract people with disabilities, including mental health problems, to apply for all IAPT training opportunities.
  - We do not currently have much evidence of the *sexuality* profile of the workforce, apart from the information received via the IAPT worker registration form, which has not to date been completed by the majority of people. As we know this represents a risk of potential discrimination it is important we develop a more open culture within IAPT services. It may be an incentive for sexuality to be identified if particular support groups were set up, including perhaps a national lesbian/gay network for IAPT staff.
  - If employers pay attention to the wellbeing of psychological therapists not only will a more diverse, open and supportive culture begin to flourish, but also delivery of services will improve (see below).
- 7.4 Improving access for all people
- The voluntary sector in psychological therapy services has a strong track record in meeting needs across different sections of the community, including those where statutory services may not provide equity of access and benefit. Joint working and easy access routes from and to the voluntary sector are essential, therefore, for IAPT services.



- Staff should embed outreach into the community and be more flexible delivering interventions within communities as a routine part of their working practice.
- Staff should ensure that they know what is available locally for people with diverse needs.
- Working with referrers is important for them to be sensitive in encouraging people to take up referrals, and in monitoring and providing feedback where inequity of access occurs. Although self referral routes, backed by engagement and targeted information is helpful in improving take up of services across ethnic groups, in other areas the people who self refer appear to have the highest DNA rates. These kinds of inadvertent inequalities can be significantly addressed if routine outcomes data are used and deployed.
- Working with families, perhaps following discharge from IAPT services, is working well in some areas where the family group is the key way of intervening; women, in particular, need ongoing support to develop their life skills and assertiveness e.g. South Asian Counselling Project in Manchester.
- It may be that more innovative and oblique approaches need to be developed to improve access - essentially community development. For example, raising awareness of needs and possible benefits of access to psychological therapies amongst older age groups through workshops in day centres could be explored as one strategy.
- In terms of service provision, IAPT has no upper age limit, however the minimum age of 18 may need to be considered.
- There is a need to explore different ways of engaging groups to overcome stigma e.g. outreach work in boxing clubs for young black men; using football arenas for events to engage young men; with religious groups through attending local meetings and establishing links with pastoral counselling services; via the club scene in conjunction with sexual health promotion amongst young people, for lesbian, gay, bisexual and transgender communities.
- *Disability* – we need to have more partnerships working with specialist organisations where there are gaps in the workforce around disability work. We should try to address those gaps by sharing resources.
- We need to provide access training to remind employers to make appropriate adaptations to environments.

## 7.5 Tailoring training and resources

- Educational attainments of different social groups, gender, ethnicity, deprivation, lack of opportunity and social exclusion all need to be acknowledge and addressed in training and adapting training resources. Some self help materials may need to be modified, to ensure accessibility and not assume that either equal interest levels of knowledge exist amongst all audiences.
- Some ways of working are not usable for some groups e.g. telephone work with deaf people, self-help reading materials for people with visual impairment so alternatives need to be made available.



- For example, sign users have a small counselling service nationally. This can be utilised and built on to provide training to improve services for deaf people referred to IAPT services. To do this a specific IAPT PWP course to train people in British Sign Language is needed. SHAS and PCTS are being engaged collaboratively to explore this and to find ways to take different ability needs into consideration.

## 7.6 Choice

- Choice should be offered to patients if they wish to see a practitioner with the same ethnic beliefs as themselves, for example, and this principle needs to extend across the spectrum of equalities.
- Training of staff needs to reflect this aspect of provision and an expected level of cultural competence needs to be achieved and maintained by all staff.

## 8.0 Conclusions

- 8.1 The Counselling and Psychotherapy workforce is important in delivering a range of mental health services, including IAPT and consequently they should have a higher priority in future workforce planning, as IAPT services roll out.
- 8.2 There has been enormous goodwill in bringing together the professional bodies and practitioners and other key stakeholders, who deliver psychological therapies across modalities. This is significant because historically, there are different traditions, identities and interpretations of the evidence, as well as different perspectives on what constitutes an appropriate evidence base.
- 8.3 IAPT has given a welcome impetus to scaling up psychological therapy services, and has raised the profile of psychological therapies for many commissioners. Whilst, to date, there has been a focus on CBT which is welcome and acknowledged as vital, services need to be supported in moving to a more comprehensive service set out in the Statement of Intent and more recently in 'Realising the Benefits'. The areas for development in this report are intended to be helpful in showing the extent of consensus and support for evidence-based ways of delivering these.
- 8.4 An opportunity now exists to move to the next stage and to broaden the base of involvement and ownership of evidence based practice in psychological therapies. The career and practice frameworks emphasising competences, and the commitment to New Ways of Working that are described within and published in conjunction with this report, represent a major step forward for the profession and significant potential benefits for improving quality of services.

# Appendices

- A: Membership of NWW4PT Steering Group
- B: NWW4PT Programme Terms of Reference
- C: Workstream outlines

For the full reports on each of these workstreams please visit [www.iapt.nhs.uk](http://www.iapt.nhs.uk) or e-mail [iapt@dh.gsi.gov.uk](mailto:iapt@dh.gsi.gov.uk)

1. Evidence Based Interventions and treatments available
2. The size and nature of the Psychological Therapy workforce
3. Developing a Career Framework for psychological therapists
4. How Psychological Therapists can work collaboratively in multi-disciplinary teams
5. Children, Young People and Families

- D: Statement of Intent
- E: Abbreviations

## Appendix A: Membership of NWW4PT Steering Group

<b>Name</b>	<b>Representing</b>
Fenella Flemonskey	Service User and Carer
Ann York	CAMHS
Anne Garland	BABCP
Barry Foley	NIMHE NWP & IAPT North West
Barry Nixon	CAMHS
Judi Dumnont Barter	Mental Health Providers Forum (third sector)
Brendan Blair	Social Work
Cathy Harrison	DWP
Diane Waller	HPC
Geraldine Bienkowski	NES
Graham Turpin	IAPT Programme
James Antrician	UKCP
James Mosse	Psychoanalytic Psychotherapist
Jane Rosoman	Ealing PCT & Primary care Counselling
Jeremy Clarke (Chair)	NSP
John Allcock	NIMHE NWP
John Monk-Steel	UKCP
Karen Cromarty	CAMHS
Kath Postill	Service User and Carer
Laura Donington	UKCP
Lydia Hartland-Rowe	ACP
Malcolm Allen	BPC
Marc Lyall	Skills for Health
Marcus Evans	Nursing
Margaret Carruthers	Carer
Margie Callanan	Psychology
Nancy Rowland	BACP
Nick Waggett	NSCAP
Rod Holland	BABCP
Roslyn Hope (Chair)	IAPT Programme
Ruth Duffy	IAPT Programme
Sally Aldridge	BACP
Sarah Davidson	Tavistock and Portman NHS Foundation Trust
Steve Humphries	Psychiatry; NIMHE NWP
Steve Isaacs	Young Minds
Tim Morris	CAMHS
Trudy Klauber	Tavistock and Portman NHS Foundation Trust
Val Huet	Arts Therapy
Vicky Franks	Tavistock and Portman NHS Foundation Trust
Wendy Broom	AHP consultant, Berkshire

## Appendix B: NWW4PT Programme Terms of Reference

### Purpose of group

To address how Psychological Therapists<sup>1</sup> can contribute as a competency-based workforce to improve access to psychological therapies via New Ways of Working (NWW), in the context of regulated standards of proficiency and training.

### Specific Workstreams

1. To participate in the production of a career framework for Psychological Therapists,<sup>2</sup> based on an integrated national competency, job responsibility and pay framework, across all professional groups.
2. To consider how a broader range of evidence based interventions and their underpinning competences can be addressed through the skill mix of Psychological Therapy services.<sup>3</sup>
3. To address how Psychological Therapists can work collaboratively in multidisciplinary teams providing high quality, cost effective services.<sup>4</sup>
4. To describe the size and nature of the Psychological Therapy workforce market and associated trainings, public and private, and put in place mechanisms for ongoing provision of accurate workforce data to inform policy development and commissioning.<sup>5</sup>

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<sup>1</sup> Including Counsellors, Psychotherapists, Psychologists, CBT Therapists, Psychiatrists, Arts Therapists, Nurse Therapists, [as Clinicians, Trainers, Supervisors, Managers, Researchers, Assistants] and others.

<sup>2</sup> Through a working group comprising representatives from Skills for Health, NWW IAPT, Health Professions Council, NHS Confederation, New Savoy Partnership, and Department for Work and Pensions; and for Children, Schools and Families.

<sup>3</sup> As nice guidelines and national priorities require, further and more detailed workforce guidance over time will need to address the following.

- 1) Treatment modalities – individual; couples; group; family.
- 2) Treatment settings – primary care and poly clinics; hospitals and specialist units; third sector; employer provided, schools; prisons and young offender centres; day centres and care homes; universities.
- 3) Treatment models – CBT; dynamic; person centred; family and systemic; IPT.
- 4) Treatment life stage – children; adolescent and young adults; adults; older adults.
- 5) Treatment life context – BME; sexuality; disability; refugee and homeless.

<sup>4</sup> This will be explored through the use of selected teams using CCTA (Creating Capable Teams Approach), and other IAPT- sponsored service redesign methods.

<sup>5</sup> Through linked work undertaken with IAPT R&D and infomatics sub-groups.

## Products

1. (Spring 2009): An initial NWW for Psychological Therapists' report, with illustrative examples from working lives, for use by local service and education commissioners and providers including:
  - a. Outline career framework for practitioners delivering psychological therapies
  - b. Roles of practitioners delivering evidence based psychological therapies in IAPT and more broadly
  - c. Models and case studies of new team configurations, where NWW, new roles and new evidence-based specialties emerge
  - d. Training, numbers and flows in the psychological therapy workforce

## Linked work

1. The IAPT national programme, including all sub groups
2. Regulation with Department of Health and the Health Professions Council and other regulatory bodies
3. Development of National Occupational Standards (NOS) for Psychological Therapies with Skills for Health
4. The NIMHE NWW programme
5. The CAMHS National Workforce Programme, National CAMHS Support Service (NCSS)
6. Return to Work programmes, Department for Work and Pensions
7. NICE review of Depression guidelines
8. Design of additional national training curriculae / modules within IAPT

## Method of Working

Bi-monthly meetings of Co-Chairs with Workstream Leads (to be identified)  
Consultation workshops (via BACP Conference, Oct; NSP Conference, Nov)  
Separate Workstream meetings (schedule to be arranged)

## Governance Arrangements

Co Chaired by Roslyn Hope and Jeremy Clarke

Reporting to the:

- IAPT Programme Board via the IAPT Workforce Reference Group; and
- NWW in Mental Health National Steering Group

## **Appendix C1: Work streams**

### **1. The Evidence Base for Psychological Therapies: implications for policy and practice.**

#### *Purpose*

Consideration of how a broader range of NICE approved evidence-based interventions and their underpinning competencies, can be addressed through the further expansion of IAPT Psychological Therapy services.

#### *Terms of Reference and Membership*

The Terms of Reference and a list of members may be found on the New Ways of Working web site [[www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk)] under “New Ways of Working for Psychological Therapists”.

### **2. The size and nature of the Psychological Therapy workforce**

#### *Purpose*

To describe the size and nature of the Psychological Therapy workforce market and its associated trainings. This includes public private and third sector. To suggest and provide advice for mechanisms which will provide the ongoing provision of accurate workforce data.

#### *Terms of Reference and Membership*

The Terms of Reference and a list of members may be found on the New Ways of Working web site [[www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk)] under “New Ways of Working for Psychological Therapists”.

### **3. Developing a Career Framework for psychological therapists**

#### *Purpose*

To produce a Career Framework for Psychological Therapies, using evidence based competences and their related job descriptions. To describe accreditation arrangements for individuals and courses within the IAPT programme, and link to the process for developing a professional regulatory framework, consistent with the requirements of the Health Professions Council. To facilitate equitable and diverse recruitment, retention and career development opportunities for NHS practitioners involved in delivering a range of evidence based psychological therapies.

#### *Terms of Reference and Membership*

The Terms of Reference and a list of members may be found on the New Ways of Working web site [www.newwaysofworking.org.uk] under “New Ways of Working for Psychological Therapists”.

#### **4. How Psychological Therapists can work collaboratively in multi-disciplinary teams**

##### *Purpose*

Putting the user and carer experience at the heart of the work stream’s objectives, we aim to describe best practice models of multidisciplinary working for psychological therapists and models of effective care pathways using a stepped care approach. This will focus, for this stage of the work, on IAPT services and their interface with other services at both primary and secondary level.

##### *Terms of Reference and Membership*

The Terms of Reference and a list of members may be found on the New Ways of Working web site [www.newwaysofworking.org.uk] under “New Ways of Working for Psychological Therapists”.

#### **5. Children, Young People and Families**

##### *Purpose*

This reference group has been established within the programme to consider the specific context of services for children, young people and their families. The primary task is to inform the four workstreams to ensure that children and young people’s issues are integral in their work and that the products delivered by the programme effectively include children and young people’s services.

##### *Terms of Reference and Membership*

The Terms of Reference and a list of members may be found on the New Ways of Working web site [www.newwaysofworking.org.uk] under “New Ways of Working for Psychological Therapists”.

All full workstream reports are available from [www.iapt.nhs.uk](http://www.iapt.nhs.uk)



## Appendix D: Statement of Intent

This Statement of Intent confirms the Government's commitment to the principles that need to underpin the next stage of Improving Access to Psychological Therapies, in which:

**We will** tackle the stigma that often stops people seeking treatment for common mental health problems by

- Working with the Time to Change and Shift! awareness campaigns
- Encouraging PCTs to invite people to seek psychological therapy help when they need it
- Giving the NHS useful tools and guidelines for engaging people with psychological therapy services

**We will** work towards ensuring PCTs give all patients a choice of NICE-approved psychological interventions by

- Asking PCTs to offer appropriate choice of therapies as their IAPT services mature
- Developing training for other NICE approved interventions to support therapists' continuing professional development

**We will** demonstrate that psychological therapies offer care that is clearly explained and suited to individual patients' needs by

- Supporting services to collect patient reported outcome measures and discuss each person's progress with them
- Ensuring services collect data for at least 90% of patients and use it to check on service quality and improve commissioning

**We will** work with primary care services to achieve seamless, person-centred care for patients by

- Ensuring there's a GP in every multi-disciplinary IAPT team
- Improving the skills of all primary care staff in recognising and managing the care of people with anxiety and depression
- Supporting primary care clinicians to make evidence-based decisions when signing people off sick and to offer appropriate care while they are unable to work
- Helping Practice Based Commissioning groups recognise and address how patients' physical and mental health needs impact on each other

See also:

Secretary of State's November 2009 New Savoy Partnership Speech:  
<http://www.iapt.nhs.uk/2009/11/26/psychological-therapies-in-the-nhs/>

## Appendix E: Abbreviations

BABCP	British Association of Behavioural and Cognitive Psychotherapies
BACP	British Association for Counselling and Psychotherapy
BPC	British Psychoanalytical Council
BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCTA	Creating Capable Teams Approach
DWP	Department of Work and Pensions
IAPT	Improving Access to Psychological Therapies
NES	NHS Education for Scotland
NICE	National Institute for Clinical Excellence
NIMHE	National Institute for Mental Health in England
NOS	National Occupational Standards
NSCAP	Northern School of Child and Adolescent Psychotherapy
NSP	New Savoy Partnership
NWP	National Workforce Programme
NWW	New Ways of Working
NWW4PT	New Ways of Working for Psychological Therapies
OPMH	Older People's Mental Health
R&D	Research and Development
UKCP	United Kingdom Council for Psychotherapy