News

DH announces major new training programme to expand psychological therapies workforce

An extra 3,600 psychological therapists are to be trained over the next three years to deliver the planned roll-out of the Improving Access To Psychological Therapies (IAPT) programme. Announcing the planned expansion of the programme, Health Secretary Alan Johnson said that at least 20 new IAPT services would be developed in the first year, and that all GP practices would have access to psychological therapies as the programme rolled out.

The *IAPT implementation plan* involves expanding the specialist workforce trained to deliver both low and high-intensity therapy. Training will focus on CBT – although the focus will broaden as the deficit is addressed. Counsellors and psychotherapists are likely to be among those training as high-intensity therapists. A total of £33 million has been allocated to the IAPT roll-out this coming year, rising incrementally by £70 million in 2009/10 and £70 million in 2010/11 to a total of £173 million.

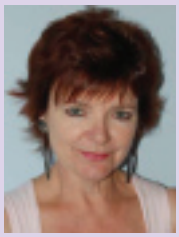
Speaking at the launch of the implementation guidance, Lord Richard Layard, co-author of the London School of Economics *Depression report*, said: 'This is great news and just what we've all been waiting for. This new service will bring relief from misery to millions of people'. Health Minister Ivan Lewis, said: 'This represents an historic transformation of mental health services in our country'. *Department of Health 26/2/08 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/dh_083150*

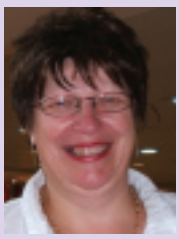
The truth about antidepressants

Antidepressants are much less effective than they appear from published data, according to the findings of a major new meta-analysis. Irving Kirsch and colleagues based their study on the full data – both published and unpublished – from 35 trials of four selective serotonin reuptake inhibitors (SSRIs), obtained from the US Food and Drug Administration under the Freedom of Information Act. The results showed that only those patients with the most severe depression demonstrated clinically significant benefit over placebo, according to National Institute for Health and Clinical Excellence (NICE) criteria. Further analysis showed that even this subset of patients were responding less well to placebo than patients with less severe depression, rather than responding better to antidepressants. The findings shine a spotlight on so-called 'publication bias' – the tendency of pharmaceutical companies to publish only the positive results of clinical trials and to ignore negative findings. The researchers concluded that there is little reason to prescribe new-generation antidepressants to any but the most severely depressed patients unless alternative treatments have been ineffective. *PLoS Medicine 26/2/08 http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371%2Fjournal.pmed.0050045 BMJ 8/3/08*

Delivering

Appropriately resourcing the workforce to Improving Access to Psychological Therapies consider the way forward





Equitable and timely access to evidence-based psychological therapies has the potential to improve radically the lives of many UK citizens; alleviating distress in individuals and families, promoting wellbeing and understanding of mental illness, reducing stigma, and supporting people in the workplace and to return to work. Although counselling, psychotherapy and psychology services have been available through the NHS for at least the last three decades, it has been only recently that these services have started to attract the degree of attention from service users and commissioners that they deserve. There are many reasons why access to psychological therapies is now regarded as a priority area. These include its effectiveness, demonstrated through the publication of National Institute for Health and Clinical Excellence (NICE) guidelines, patient choice in wanting greater access to talking therapies[1-4], and the socio-economic benefits on individuals' wellbeing and the nation's wealth in the form of its impacts on disability and welfare benefits, as recently argued by Lord Richard Layard[5-6]. The cost of mental ill-health on productivity in work and 'presenteeism' has been emphasised recently by the Sainsbury Centre for Mental Health[7] as exceeding the overall costs of disability and benefits.

It is perhaps worth questioning why psychological therapy services have failed to thrive in the past. Possible reasons include a lack of recognition of the efficacy of psychological treatments; inter-professional rivalries and a lack of clear leadership; few distinct models of service organisation and delivery; a myriad of qualifications, accreditation bodies and lack of statutory regulation; poor access to education and training in psychological therapies for NHS staff, and poor workforce information on psychotherapy delivery. Many of these issues are still relevant today, though an emphasis on ensuring equitable access to therapies is proving an effective force in removing these obstacles.

the IAPT programme

deliver stepped care is perhaps the major challenge in achieving the high aims of the (IAPT) programme. **Graham Turpin, David Richards, Roslyn Hope,** and **Ruth Duffy**

Indeed, the recent ministerial announcement of an initial investment in services rising to £173 million over the next three years for improving access to psychological therapies[8] is the successful realisation of concerted lobbying of the government by people who use the services, professionals employed within them, and associated policy makers.

The new IAPT services will be provided by a range of professionals, together with professionally non-aligned staff, particularly within the voluntary sector. They will be located across a range of primary and secondary care services; they will involve NHS and third sector providers, and it is likely that no single model of service delivery will satisfy either the individual requirements of local health communities or their commissioners. Although such a plurality of providers might raise concerns about possible service fragmentation, it should also be stressed that services will be commissioned through a strengthened NHS commissioning process, as envisaged by the Department of Health (DH) World Class Commissioning initiative[9]. Within this context, we offer a brief review of stepped and collaborative care services, which we believe will be a major organising principle around the development of IAPT services, despite local variations in service development and redesign. We also set out to examine the implications of the IAPT programme on the existing workforce within both primary care and more traditional psychotherapy services.

Models of service delivery

One of the most important determinants of access to psychological therapies, in addition to the resources that are invested, is how these resources are organised within models of service delivery. A major feature of IAPT services is the 'stepped-care model', which is represented in various different guises within recent NICE guidelines, and also forms the basis of the service specification recently published for the new IAPT Pathfinder sites[10]. The implementation of the model with respect to current service delivery is illustrated at both the Newham and Doncaster IAPT demonstration sites. We will briefly review the development of the Doncaster model, which was designed following reviews of three principle sources of evidence – the clinical effectiveness of low- and high-intensity variants of cognitive behaviour therapy (CBT), the organisational effectiveness of collaborative care, and the evidence for stepped care. These evidence bases were used to design a model of care that would explicitly reflect the philosophy of primary care and public health. Treatment had to be delivered according to these principles, and was explicitly focused on delivering care to high volumes of people. The Doncaster model had to be able to accommodate an expected referral volume of greater than 5000 patients per annum.

The clinical effectiveness of low- and high-intensity variants of CBT

The most recent reviews of psychological therapies conducted by NICE[11,12] recommend CBT for both depression and anxiety. Although CBT is not the only recommended psychological treatment, the skill set and clinical materials necessary for its delivery are much more readily available among clinical and educational providers than those for other alternatives (such as interpersonal therapy for depression). One advantage in choosing CBT at Doncaster is that variants have been developed that can be characterised as both low-intensity and high-intensity. This allows the same theoretically consistent and empirically valid treatment to be delivered in different formats and settings according to patient need and response. High-intensity treatments usually involve considerable therapist input, akin to traditional therapy models. In contrast, low-intensity treatments emphasise patient self-management, with much less contact between mental health workers and patients, for example by the use of guided self-help.

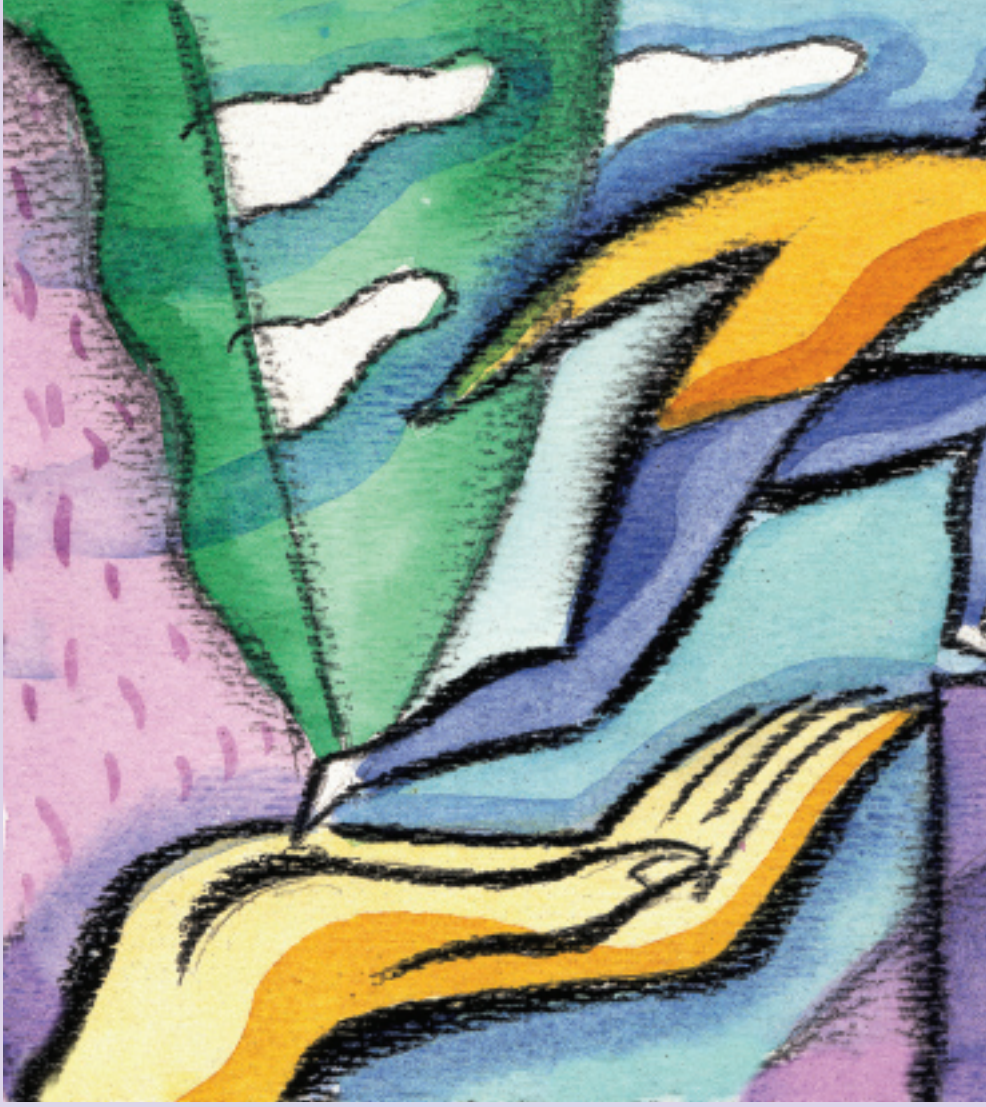
In randomised controlled trials, the controlled clinical effect size – ie the therapeutic 'power' of the treatment – for high-intensity CBT is large, ranging between 0.89 for depression[13] and 1.6-2.9 for anxiety disorders[14]. High-intensity CBT is therefore less effective in depression than anxiety disorders, with the effect size for depression just over half that for generalised anxiety disorder (1.7). The effect size for low-intensity CBT for depression (0.8) is very similar to that for high-intensity CBT[15], though low-intensity CBT is generally less effective and more variably effective for anxiety disorders (range 0.18-1.02)[16], excepting generalised anxiety (0.92).

The evidence for stepped care

Although evidence for the efficacy of some psychological therapies is strong, the evidence for organisational systems by which they are delivered is less so. NICE guidelines for depression and anxiety recommend that treatments should be organised along a 'stepped-care' model. Stepped care has two fundamental principles. First, treatments should always be the 'least restrictive', in that the burden on patients should be as low as possible while achieving a positive clinical outcome[17]. This principle is usually interpreted as the delivery of a low-intensity treatment, such as guided self-help, unless high-intensity treatments are indicated. Second, stepped care should be self-correcting[18]. This refers to the systematic scheduled review of patient outcomes to assist in

clinical decision-making using validated outcome tools such as symptom schedules. Although based on the common sense proposition that it is as harmful to over-treat as to under-treat common mental health disorders, NICE guidelines provide little evidence to support the implementation of stepped care.

A narrative review of stepped care[19] concluded that it has the potential to improve the efficiency of delivery of psychological therapy, but that the exact form of stepped care needed to maximise patient benefit was unclear. There are two possible ways that stepped care might be implemented. One, the pure 'stepped' approach, allocates a low-intensity treatment for all patients, and uses the scheduled review principle to 'step-up' patients who do not benefit from the initial intervention. In contrast, a 'stratified' approach initially allocates patients to interventions at different steps according to objective measures of their symptoms. Both approaches have benefits and disadvantages, and NICE hedges its bets by recommending both systems simultaneously[12]. Using the stepped approach, the danger is that some patients will be inappropriately allocated to a weaker 'dose' of treatment than required, and the duration of their contact with services will thereby be unnecessarily extended. Using the stratified approach, the danger is that services may take a very risk-averse approach and opt to over-treat many people, thus compromising the efficiency of the system as a whole. Bower and Gilbody[20] have noted that the benefits of stepped care may be compromised if complex assessment and treatment allocations require significant resources. Indeed, a stratified approach relies on the ability to accurately predict who would not benefit from low-intensity treatments – so-called 'aptitude treatment interaction'[17], the evidence for which is questionable at the very least. In practice, it might be that versions of stepped care attempt to achieve a balance between the two approaches, though the degree of emphasis on stepping or stratifying could alter system performance dramatically.



The evidence for collaborative care

The evidence for organisational models is much stronger in respect of collaborative care[21,22]. Collaborative care is a 'systems level' quality improvement approach, consisting of a multi-professional approach to patient care, a structured patient management plan, scheduled patient follow-ups, and enhanced inter-professional communication[23,24]. It has been comprehensively tested in depression management. A recent systematic review[25] found that the combined effect size for collaborative care in 36 studies was relatively modest, although the actual models implemented on the ground in these trials were extremely heterogeneous. Using meta-regression techniques to identify the critical components of this complex systems-level intervention, the review found that the effectiveness of collaborative care could be optimised by including within it the employment of case managers with a specific mental health training who also received regular expert supervision. Recent UK trials incorporating these effective ingredients, which included case managers who conducted most contacts on the telephone and who delivered a blend of medication management and low-intensity CBT achieved effect sizes of between 0.42 and 0.63[26,27].

Implications for the workforce

Many of the workforce challenges facing counsellors, psychotherapists and other professionals involved with the delivery of psychological therapies are being addressed through the 'New ways of working' projects for mental health[28-30]. Generally, these reports describe how new roles and responsibilities, more flexible working, new opportunities for training in order to broaden competencies in psychological therapies, and an overarching career framework for all staff who contribute to the delivery of psychological therapy services might contribute to enhancing the capacity and capability of the workforce. It is hoped to establish a 'New ways of working' project for counsellors and psychotherapists in 2008, and this has received support from the majority of the professional bodies whose members are affected (including BACP and UKCP). Some colleagues and I have recently written an overview of the issues involved[31],

STOCK ILLUSTRATION SOURCE/GETTY

including an estimation of workforce demand in relation to existing staff, skills mix and service redesign; career frameworks and new roles; and education and training capacity. More recently, the IAPT Workforce Team has published a practical IAPT guide to workforce development as part of its guidance for the new Pathfinder sites[10]. Rather than revisiting these issues here, we will focus instead on the specific challenges for the counselling and psychotherapy workforce.

Building capacity

Various independent estimates of the workforce to deliver the IAPT programme, based on Lord Layard's hypothesis, highlight the shortfall in existing numbers of psychological therapists and the need for future investment to increase the numbers of therapists[32-33]. Leaving aside the numbers of therapists required, the critical questions are: what types of therapists and what competencies are needed? Further, although new investment is necessary, if the demand for IAPT is to be effectively met, there is still the question as to how the existing workforce might be utilised in redesigning services. A major survey of the existing counselling and psychotherapy workforce in primary care, for which preliminary results appear elsewhere in this issue of *HCPJ* (see article, page 19), may shed some light on this.

IAPT services will require competent and qualified psychological therapists who are able to deliver evidence-based therapies, particularly CBT, at levels three to five within the stepped-care model. We envisage that many qualified primary care counsellors and psychotherapists will deliver these therapies, along with clinical and counselling psychologists. It will be necessary for some therapists to undertake further training in specialist psychological therapies in order to provide the range and depth of therapeutic skills needed. In order to ground the development of IAPT services around relevant competences underpinning evidence-based therapies, the IAPT workforce team, in conjunction with Skills for Health, initially commissioned the development of a set of CBT competences derived from the trials underpinning the NICE guidelines' development. Conducted by Tony Roth and Steve Pilling, this has recently been published by the DH[34].

Career frameworks

A key issue in recruiting competent psychological therapists is that there is currently no unified career framework for psychological therapy. Despite the impact of Agenda for Change and the current implementation of its knowledge and skills framework (KSF), different psychological therapy practitioners are represented by different job profiles that tend to reflect their professional roles and specific jobs within the workplace (eg counsellor, psychologist or nurse). While the outcome of Agenda for Change is not yet fully known, there are clear inconsistencies between and within different groups of practitioners in the bandings that have been determined. Many of the inconsistencies reflect the different attainments and qualifications associated with professional pre-registration training (ie for nurses, psychologists, medical practitioners) and levels of responsibility inherent in a practitioner's core profession. In addition, there are several new groups of workers who now contribute to the delivery of psychological therapy services, including primary care graduate mental health workers (GMHWs) and self-help support workers. Should these new workers be considered psychological therapists? What are their career pathways within the NHS? We know that the success of the GMHWs has been limited by a lack of clear career progression other than their applying for clinical psychology training[35]. Given the range of competencies and roles within the psychological therapies' workforce (from graduate worker to expert therapist and supervisor), we believe it would be appropriate for a career framework to be developed around the delivery of psychological therapy.

A further reason for developing such a career framework is the poor relationship between job titles and training in psychological therapy. The IAPT national workforce group[10] has identified many local audits of the training and qualifications of practitioners, which demonstrate a worryingly wide range of training experience and qualifications among people who consider that they are providing psychological therapy within the NHS, together with varying levels of access to expert supervision. Such training can range from one-day in-house workshops through to five-year part-time doctoral training. The situation is further aggravated by the current lack of statutory regulation of the counselling and psychotherapy professions.

In addition to scoping the competencies for psychological therapists and related healthcare workers in the course of developing a career framework, it will be necessary to identify other skills and competencies required to deliver a comprehensive and integrated psychological therapy service. These will include management and governance, supervision, training, audit, research and development skills and expertise. Other workers, such as GPs and other primary care staff, gateway workers, employment and accommodation support workers, and administrative support workers, including receptionists, IT and clerical support staff, would also contribute. People with experience of mental ill-health likewise have a role to play

> If fully and properly implemented, the IAPT programme should bring about improvements to mental health services of the same scale of magnitude as the closure of the old mental asylums and the move to community care

in supporting the process as staff members, trainers and auditors. It will be important that all workers are psychologically aware and understand the therapeutic ethos of such services.

Currently, Skills for Health is taking forward work around validating the KSF for mental health professionals[36], developing a set of National Occupational Standards (NOS) for psychological therapies, and establishing career frameworks for mental health workers and psychological therapists in particular. This work should ensure that a suitable career framework is developed. It will also be important to consider how the recently published NOS for counselling[37] fit with this process.

The critical role of supervision

If IAPT services are to be delivered safely and effectively, and to retain fidelity with the efficacy research that underpins the NICE guidelines, it is important that outcomes are regularly obtained, that IT systems are employed to enable clinical supervisors and therapists to effectively track and manage cases, and that effective systems of supervision and support are in place for therapists whether they are working with a high or low volume of clients. Services should also be routinely audited and evaluated, with strong clinical governance processes and frameworks in place. The IAPT workforce team has just completed some preliminary guidance on the importance of clinical supervision within services, and will be commissioning training courses to support the development of supervisors within IAPT services. Many of these issues have also been addressed in a recently published *Good practice guide for IAPT*, which is aimed at psychologists and forms part of the New ways of working project for applied psychologists[30].

Choice and equality

At a superficial level at least, there is an inherent tension reflected in the IAPT and choice agendas between traditional mental health services, characterised by diagnostic systems and drug treatments, and a broader psychosocial perspective. Psychologists, counsellors and psychotherapists, through the adoption of a wide range of psychological models and approaches, can provide mental health staff with a rich variety of explanations with which to understand psychological distress and disability and how they impact generally on communities, services, and service users and carers beyond the expression of individual symptoms and their amelioration. Such an approach underpins more socially inclusive services that attempt to address a range of social and psychological needs (such as employment, meaningful and valued work or volunteer activities, housing, and family and parenting issues), and may hopefully help to mend the broken communities within which many clients and service users currently live.

Equality of access, especially for black and ethnic minority (BME) communities, is also an area in which psychological therapists can contribute. People from BME communities experience particular difficulties accessing psychological therapy services. The barriers range from practicalities, such as the range of languages used for health information, through to attitudinal challenges faced by mainly eurocentric-focused health professionals in understanding the cultural diversity of both the expression and treatment of mental health problems[38-40]. Much has been published recently around race equality and discrimination within health services[41], which needs to inform the IAPT programme. With respect to the psychological therapies, there is an extensive literature around providing culturally sensitive counselling and therapy, much of it having been written in the USA, which ought to inform the practice of psychological therapists within the IAPT programme[42-44].

Summary

If fully and properly implemented, the IAPT programme should have a significant and considerable positive impact on the wellbeing of the population, and bring about improvements to the mental health services offered to the public of the same scale of magnitude as the closure of the old mental asylums and the move to community care. Appropriately training and supporting the workforce is one of the key challenges in successfully achieving this aim. ■

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Roslyn Hope is Director of the NIMHE National Workforce Programme and has led the programme of work on 'New Ways of Working in Mental Health' since 2003.

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