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# Good Practice Guide on the Contribution of Applied Psychologists to Improving Access for Psychological Therapies

*Guidance for psychologists, managers and commissioners produced  
by the IAPT Group of the New Ways of Working for Applied  
Psychologists Project*

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# I Foreword

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This report has been produced through the synthesis of two separate but linked pieces of work: New Ways of Working for Applied Psychologists (NWWAP) and Improving Access to Psychological Therapies (IAPT). The New Ways of Working for Applied Psychologists group was established in July 2005 and the work was completed in July 2007, as part of the National New Ways of Working Programme led by the National Institute of Mental Health in England. The roots of this project are clearly linked to the English NHS and related social care contexts. This has meant that those applied psychologists whose work is mostly involved with the Health and Social Care sectors (namely Clinical, Counselling, Health and Forensic) have been at the forefront of the work.

This background means that the NHS context dominates much of the thinking and considerably more work is required to think through in depth, the implications for the applied psychologists working predominantly in other contexts (e.g. education, prisons etc). It is also worth noting that the origins of the project arose from concerns about mental health services and this has influenced the scope of the work. However, there have been active attempts to adopt an inclusive approach and involve all the applied psychologies including representatives from Scotland, Wales and Northern Ireland so that lessons could be shared and the wider implications considered.

NWW emphasises the importance of the current workforce working flexibly, matching its skills and competences to the complexity of needs of the individual service user. The message here for Applied Psychologists is that the most senior and consultant psychologists need to use their skills not only to see people clinically, but also to support other staff with supervision, education and training and to support their organisation through involvement with service and workforce redesign, audit and evaluation and clinical governance.

NWW also means extending practitioner roles beyond their professional scope of practice, with appropriate education and development. This is where competence based training and development for psychological therapists comes in, both for psychologists and other practitioners, including nurses, counsellors and psychotherapists. Finally, NWW means bringing new people into the workforce into new roles to make use of the excess supply of graduates being produced annually, which in turn will increase access to services. The development of assistant and associate psychologists as recommended in the NWWAP report and the case manager role in the Doncaster national demonstration site are examples of such new roles.

The material in this report has been provided by psychologists working in the field and it represents a wealth of knowledge that will be invaluable to commissioners and providers, who are improving access to psychological therapies. The content highlights the contribution that applied psychologists can make in relation to IAPT. This is important for senior and middle managers, other clinical practitioners and commissioners so that they know what to expect and require of psychologists. By the same token, it signals to psychologists what positive practice is considered to be in practice. This may not always be what is occurring at present and therefore it offers challenges as well as opportunities to the profession.

NIMHE works equally with all professional groups to facilitate engagement and ownership of service and workforce change.

The enthusiastic involvement of a whole range of psychologists in producing this report has resulted in a significant contribution both to NWW and IAPT. I recommend it to you.

**Ian McPherson**

Programme Director, National Institute for Mental Health in England (NIMHE)

## II Perspectives of carers and service users

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There is no doubt that better access to psychological therapies is a top priority for people with mental health problems, and has been so for many years. This is evident from numerous reports and surveys (e.g. *We need to talk*; Mental Health Foundation, 2006) identifying the majority of service users' and carers' preferences for the talking therapies and their current frustrations accessing adequate services. What is not so often recognized is that better access to psychological therapies does not just mean prompt GP referral and short waiting times, but choice – of practitioner, setting and type of psychological approach. Improving access to psychological therapies requires that the *individual* needs of service users are acknowledged and addressed. If this does not happen, the time and resources of psychological services can be wasted

*A user's example:*

Ten fruitless sessions with another therapist, during which no rapport was developed, no aims evident and no progress made. More helpful sessions later received from an acute hospital.

To date, the lack of adequate resources for the provision of psychological therapies means that the experience of many clients who require such therapies has not been positive. The current experience of many service users is long waiting lists to access psychological services; usually being told what is available rather than being offered any choice or say in the matter; and there is also a lack of continuity between the different primary and secondary care services involved. Moreover, many people in great need are not made aware of the possibility of benefiting from the help of a psychologist.

*A user's example:*

I had mental illness for 25 years before a CPN suggested seeing a psychologist for this – no other health professional had ever suggested direct help from an NHS psychologist.

Those that are offered therapy frequently wait a very long time for this - much longer than is deemed acceptable for people with physical illness who need to see a consultant physician, a physiotherapist or to have an operation. The government has not seen fit to set maximum waiting times for seeing a psychologist, unlike in the rest of the NHS. Therapies are often structured to suit the needs of the trust and the limited resources available, rather than the individual and this can result in an insensitive and inflexible approach.

*A user's example:*

I was referred to the psychologist attached to my CMHT – no choice was given. By a stroke of wonderful luck, the psychologist has been brilliant and I would have chosen someone with his skills and approach – but this only happened by chance. Although the individual psychologist gave the maximum number of sessions allowed by the trust's policy, this was nowhere near enough and it took many complaints, including going to the Healthcare Commission, before I got the full extent of the help I needed. The outcome has been good – after many sessions from an expert psychologist I am managing without anti-psychotic drugs, having been taking them for most of the past 20 years.

Clearly the lack of sufficient resources and numbers of appropriately trained therapists contributes to this situation, but it is a case of false economy because of the adverse effect this has on service users, their carers and families, and may result in greater use of expensive services in the longer term.

*A user's example:*

The trust's restriction of psychology sessions led to a three month hospital admission with attendant costs and great difficulty for me in maintaining employment. There were personal costs – such as the impact on my children.

If a psychological intervention is not successful it would appear that too often a response is to 'blame' the client – they did not keep appointments, or they had a negative, obstructive attitude – rather than acknowledge that a particular therapy or therapist might not have been the right one for them. Not only

is this 'failure' written into a client's case file, but they may be also seen to have used up their *only* chance for therapy. There is insufficient consultation as to which psychological therapy is appropriate, whether a positive therapeutic relationship has been established and the extent to which practical and psychological difficulties have prevented the service user from accessing the therapy.

*A user's example:*

In seeking help for my child (for difficulties stemming from the impact of my mental illness on him), I had the experience of being written down as having 'failed' and 'blamed' by Child and Adolescent services. A stern letter was sent to us. No interest was shown by the service in why we had decided there was no benefit to be gained from continuing the sessions. In fact, the sessions were making things worse. The therapist appeared to have no interest or empathy, did not explain how she was trying to help, did not make any effort to develop a relationship and acted with disdain. I am amazed now that I did not complain, but I was not well versed in the ways of the NHS at that time.

Many randomised control trials, and hopefully the current IAPT demonstration sites, show a positive outcome for 50 to 70 per cent of service users accessing Cognitive Behaviour Therapy (CBT), but this also clearly demonstrates that a significant percentage of people were unable to benefit from this type of approach. This suggests that there should be a wider range of therapies available and the flexibility to be able to tailor these therapies to meet the specific needs of the service user.

*A user's example:*

I believe I have benefited so much from the psychologist I have seen because he has listened carefully to my view on what would help and has been very flexible about what type of approach to offer and use, with the aim of providing what is of most benefit, rather than a 'text book' approach. He has been prepared to keep changing tack if necessary ('trial and error') and to take 'well-judged risks' – with amazing results. I think this can only happen if the psychologist and service user can instantly get on well with each other, there is trust based on honesty and the psychologist is very well trained. In order to be flexible and keep trying different approaches to find what works for the individual, the psychologist needs to be multi-skilled, confident enough to admit 'I am not helping you with this approach', innovative in mixing a number of approaches and to have the flexibility in providing a sufficient number of sessions. Although I have been helped by CBT-type approaches, it isn't primarily the CBT that has helped; it is the trust in the psychologist, the continuity, and the understanding developed over a long period.

From a service user's perspective it is important that all staff demonstrate the values illustrated by the psychologist above regarding focusing on being person centred, honesty and open communication, and flexibility in approach. We believe that these values should be at the heart of New Ways of Working and are well grounded within the Ten Essential Shared Capabilities.

Finally, the concept of Patient Choice, which is now regarded as integral to other NHS services, needs to be incorporated particularly into mental health provision. In fact, it could be argued that choice is far more significant in this field given the vulnerable state of many service users. Choice and participation are not easy concepts to put into practice. The imbalance of power and knowledge as to what services are available, and the different levels of therapeutic interventions, puts the service user at a significant disadvantage. These obstacles can be compounded by services, which do not understand other cultures or the local communities that they serve, and as a result are culturally insensitive. Training can overcome some of these problems but the service has to be designed to respond flexibly to individual needs. One example is the setting for therapy. Any service needs to have sufficient flexibility to be able to use a variety of different settings in response to need. Another way to try and even out the imbalance, is for services to consider promoting and actively supporting service user groups and forums. These are likely to be an important part of achieving a service that meets the actual needs of its service users.

**Rob Good and Elizabeth Holford**

*DCP Users and Carers Liaison Committee*

## III Executive Summary/Quick Guide

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### Introduction

Ensuring adequate access to psychological therapies for people consulting their GPs in primary care is a key government priority as demonstrated by the Improving Access to Psychological Therapies Programme (MHChoice, 2007). Service users will obtain choice about the kinds of interventions (e.g. medication vs psychological therapy) that they require, and the provision of effective interventions to treat anxiety and depression has the potential for economic savings both in the form of reduced incapacity benefits, and offsetting costs associated with prescribing, diagnostic assessment of unexplained symptoms, briefer inpatient stays etc.

Better access to psychological therapies is associated with redesigning primary care mental health services to follow a stepped care model whereby patients assess least intrusive interventions, in a timely fashion but are stepped up to more intensive interventions or down depending on progress and need.

The purpose of this report is to outline some of the processes and examples of positive practice involved in designing and implementing IAPT services. In particular, it focuses on the contributions that applied psychologists, working with other staff and through provider organisations, can make to the success of the IAPT Programme. The report was co-ordinated by the NWW IAPT sub-group, and consists of a series of chapters commissioned from experts within the area of psychological therapies. In addition, a series of positive practice exemplars are included to illustrate how applied psychologists have contributed to service innovation and improvement.

### Contents of the Report

*Introduction to the policy context and the development of the IAPT Programme.* This provides the policy background to the development of the IAPT programme and outlines crucial information for those services contemplating service redesign. Perspectives from all four nations within the UK are covered.

*Graham Turpin and Roslyn Hope*

*The general contributions that applied psychologists can make to the challenge of service innovation and redesign in expanding access to psychological therapies.* Many trusts are appointing psychologists to Directors of Psychological Therapies: these appointments are usually at Board level. This contribution provides examples and illustrations that applied psychologists that can make to progressing a multi-professional approach to improving the governance and training of psychological therapies and awareness throughout the entire organisation.

*Kay MacDonald and Keith Miller*

*Care pathways and the service users journey: providing integrated services and commissioning?* A method describing care pathways for users of mental health services is reviewed. The integrated care pathways approach provides a focus for determining which psychological interventions are required, together with the different contributions and roles of mental health staff. It could also assist in the costing and resourcing of services.

*Roger Paxton, Rolland Self, Mike Lucock*

*Innovation in supporting community and primary care mental health.* This discusses innovative practice that can support improving access within primary care. A particular focus is how psychologists can enhance the skills of GPs and other primary care staff. Interventions including staff training, guided self-help, computerised CBT, brief protocolised therapies are reviewed.

*John Cape*

*Innovation and the provision of psychological therapies.* Many users presenting with common health problems may required more intensive therapies and may need to be stepped up from primary care to secondary care services. This chapter reviews the provision of these more intensive psychological interventions, typically employed in the research trials upon which much of NICE guidance is based.

*John Cape*

*Clinical governance, risk and the management of psychological therapy services: how can applied psychologists contribute?* Psychological therapy services comprise more than just the provision of therapy. This contribution deals with issues of governance, training, supervision, performance management and outcomes, audit, etc. and how psychologists, together with other senior members of the therapies team can maintain and enhance service quality.

*Robina Barry*

*Contribution of psychologists both to evidence-based practice and practice-based evidence.* Ensuring services are well-evaluated and enable the collation of practice-based evidence to inform the development of future clinical guidelines. A review of different research and evaluation approaches to psychological therapies is provided.

*Michael Barkham*

*Implications for the psychology workforce: new roles, education and training, career pathways and the roles of consultant psychologists.* Service redesign will require consideration of new roles (e.g. low intensity practitioners), plus the need to upskill existing staff in order to deliver the IAPT programme. The consequences of these training needs for both education providers and commissioners is dealt with.

*Graham Turpin and Roslyn Hope*

*Ensuring added value: commissioning advice for those securing applied psychology services.* What does psychology add to IAPT services and what should commissioners expect of consultant psychologists? Although applied psychologists are usually positioned with service providers, they may also act as a useful source of advice to those responsible for commissioning services involving psychological therapies.

*Tim Cate and Claire Maguire*

Overview of the impact of IAPT on the profession of applied psychology: opportunities and challenges. This final section assess the impact of the IAPT programme on the future of the applied psychology profession. Although the programme may create unprecedented opportunities for psychologists to engage with widening access to psychological therapies, there are also important impacts, especially for psychologists working outwith therapy provision. It will be important for commissioners to recognise the range and diverse contributions that psychologists make to users, carers and families spanning a broad range of care groups from mental through to physical health, and across the age span. A summary of the potential contribution of applied psychologists to the NHS reform agenda is summarised on page 9.

## Conclusions and areas for further consideration

### Recommendations for Psychologists:

1. IAPT presents an opportunity to enhance the quality of psychological therapies to service users within the NHS through expanding capacity and ensuring access to effective and appropriate therapies, as recommended within NICE guidelines.
2. For this to be successful, however, psychologists will have to embrace strong partnership working with other professions in promoting service innovation and redesign.
3. Psychologists need to lead in the promotion of new service models (i.e. stepped care) and the specification and development of integrated care pathways, which meet the varied and complex needs of service users.
4. Psychologists may need to re-evaluate their approach to assessments and triage to ensure that they meet the individual requirements of service users, are safe but also allow for sufficient access and do not contribute to bottle necks within the system.
5. Psychologists have a responsibility to work with local communities to ensure that psychological therapy services provide a range of interventions that are culturally appropriate and accessible by all members of the community.

### Recommendations for Commissioners and Providers:

6. Service redesign is key to the successful implementation of the IAPT programme and psychologists have important contributions to offer in helping services innovate and change.
7. Psychologists have a major role to play in implementing this programme and should be essential to its success. Accordingly, consideration should be given to the role of Consultant Psychologists in providing leadership at both the organisational level (i.e. Trust Boards) and within clinical teams.
8. A full range of interventions extending from guided self-help to the provision of formal therapy should be readily available within primary care and delivered by a range of practitioners (e.g. nurses, counsellors, graduate workers, voluntary sector employees). Psychologists have important roles in supporting such staff by the provision of expert consultancy, training, supervision, clinical governance and research/evaluation within psychological therapies.
9. For people with more complex or more intractable problems, there should be easy routes of access between primary and secondary care to ensure that these individuals receive more specialist psychological therapies, and with greater continuity.
10. Psychologists have a particular role to play alongside other senior staff in ensuring good clinical governance, and the safe and competent practice of all workers involved in the delivery of psychological therapy services.
11. The success of the IAPT programme will rest on its ability to demonstrate good clinical outcomes. Psychologists have an important role in advising local services as to routine clinical data collection, and how to guarantee and monitor good and appropriate clinical outcomes.
12. In addition to outcome measurement, it will be important to ensure that the IAPT programme remains up to date, and reflects developments in clinical guidelines, and contributes to the future evidence base supporting a potentially wide range of psychological therapies. It will be important that psychologists have the opportunity to employ their research skills and are actively involved in the evaluation of both national and local initiatives.
13. Psychologists can make useful and important contributions to the commissioning process by advising commissioners on aspects of needs assessment within local populations, specifying service models and availability of effective therapies, defining clinical outcomes and their measurement, and ensuring safe practise through clinical governance.
14. Psychologists also bring with them alternative perspectives to healthcare problems which transcend the traditional biomedical model and help to promote more community and socially inclusive policies, which incorporate a greater holistic view of service users and carers, including for example family and parenting issues, employment, housing and community integration, and social cohesion.
15. It is important to recognise the breadth of psychologists' contributions to social and health care, and that many psychologists work in settings away from primary care, with client groups not necessarily represented within the IAPT programme (e.g. psychoses, personality disorder, people with learning

disabilities or brain injury) and make major contributions through consultancy, neuropsychological and functional assessments, staff and organisational interventions, which are beyond the traditional role of the psychological therapist.

16. It will be important that recent attention given to primary mental healthcare does not detract from the contribution that psychologists may make in their other roles and interventions supporting services outwith primary care mental health. This also applies to the resources that support these services.

**Recommendations For SHAS and Education and Training Commissioners:**

17. However, if capacity and access is to be truly enhanced, significant additional resources will be required both in establishing additional services and the training of new staff.

**Recommendations for The British Psychological Society and Employers:**

18. The BPS through New Ways of Working for Applied Psychologists should consider supporting the establishment of new roles (i.e. such as formally trained psychology assistants) in order to enhance the contribution that psychologists (i.e. qualified and assistants) can make to enhancing capacity and access. It will be important to ensure that any new workers practise safely and this will require clarity around organisational structures, supervision and appropriate regulation.
19. It will also be essential that any new role is sustainable, integrates with career structures for both psychologists and other work roles within psychological therapy services, and allows for transferable recognition of training and experience for those wishing to go on and enter doctoral training as a psychologist.
20. The BPS through its post-qualification registers should assist psychologists in specifying the range and level of expertise in psychological therapies that they possess. Similarly, pre-registration training should result in clear and assessed competences (e.g. within CBT) which support the IAPT programme and other roles that psychologists adopt.
21. Finally, that the BPS promotes the IAPT programme by supporting and informing its members of this development, helping to promote new standards of training and upholding standards of regulation.
22. In addition, the BPS should seek to advise and inform the public of the benefits of psychological therapies and the contributions that psychologists can make to all aspects of health care.

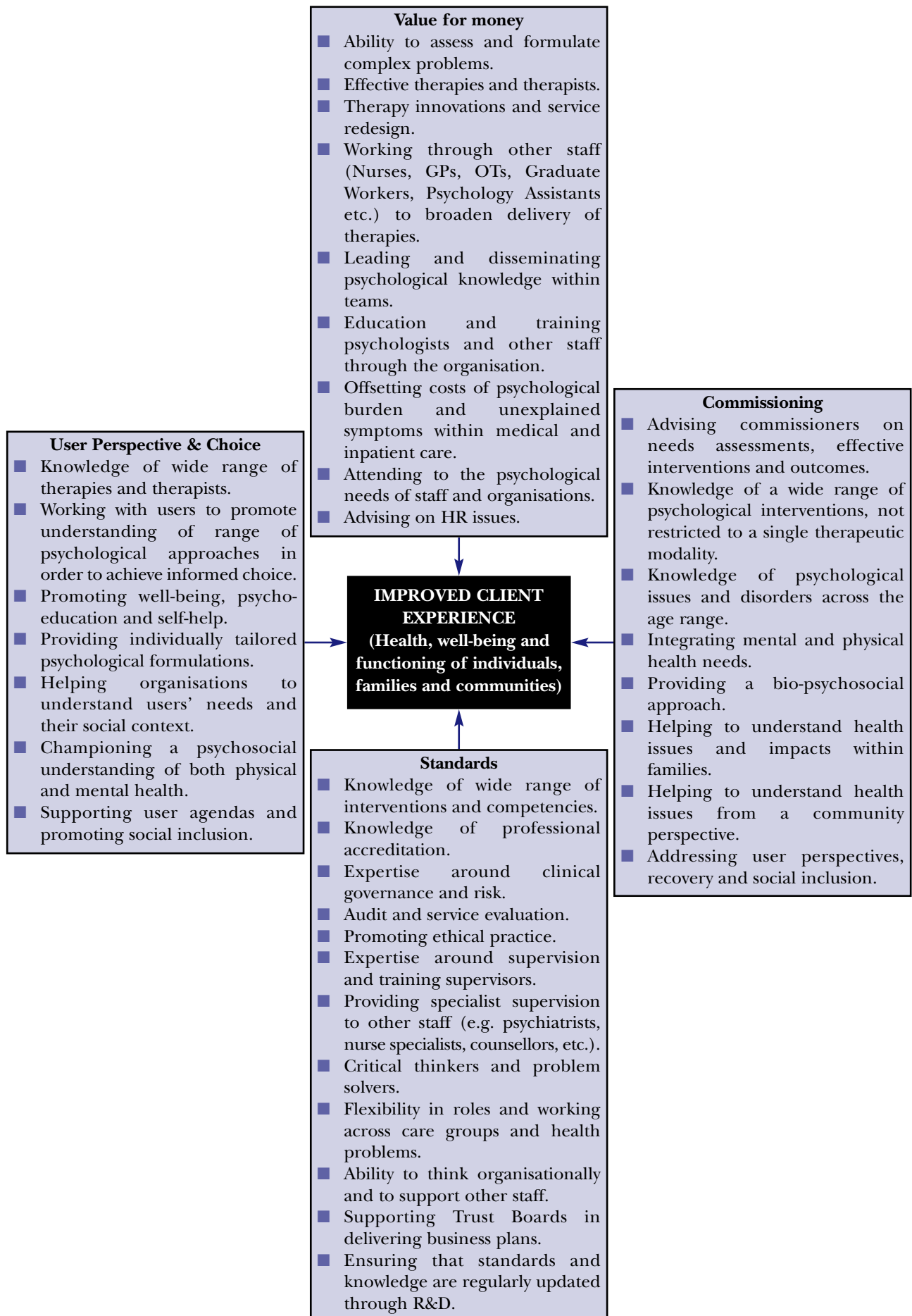
**Graham Turpin**

*Director, Professional Standards Unit, Division of Clinical Psychology, British Psychological Society.*

**Roslyn Hope**

*Director, National Workforce Programme, CSIP*

## Potential Contribution of Applied Psychologists to Implementing NHS Reform



# IV Good Practice Guide

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## 1. Policy context and the development of the IAPT programme

### 1.1 Introduction

Equitable and timely access to evidence-based psychological therapies has the potential to improve radically the lives of many UK citizens; alleviating distress, promoting well-being and understanding of mental illness, reducing stigma and supporting people in work or return to work. Psychologists and the British Psychological Society have striven to bring about such improvement in services for many years, and welcome the recent initiatives promoted by the Department of Health (DH) and the Care Services Improvement Partnership (CSIP) through their programme of Improving Access to Psychological Therapies (IAPT).

Psychology as both a discipline and a profession, particularly within the UK, has made major contributions to the research trials and the evidence base that underpins many of the developments surrounding IAPT. For example, the majority of NICE clinical guidelines in the area of common mental health problems has been compiled under the auspices of the joint Collaborating Centre for Mental Health of the British Psychological Society and the Royal College of Psychiatrists. The recent debates stimulated by Lord Richard Layard (2006) about the inequity of access to effective psychological therapies, such as cognitive behaviour therapies, and the negative consequences for both individuals and society has drawn intense interest from the BPS and its membership. Last year, a special seminar was organised (BPS web, 2006) to update and assess the IAPT proposals, and their impact on both the work of psychologists and the services that they deliver to service users. Moreover, IAPT has also been a focus of one of the working groups of the New Ways of Working for Applied Psychologists (NWWAP) project (BPS web, 2007). The IAPT programme itself has been extended beyond the two established demonstration sites to an additional ten Pathfinder Sites (MH Choices web, 2007). The purpose of this Good Practice Guide, therefore, is to promote increasing access and to summarise the contribution that applied psychologists can make to the design and delivery of IAPT services, given the current and future developments in service redesign and delivery.

It is important to recognise from the start that IAPT services will be provided by a range of professions, together with the involvement of 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. Within this context, the aim of this guide is to focus on the typical contributions that applied psychologists can make, in collaboration with other professions and organisations, in promoting service innovation and good practice. We will identify the impact that psychology has already made to the evidence base, the translation of research findings into accessible services, and the governance of these services to ensure effective and safe delivery, and to outline future roles for psychologists in contributing to the roll out of a national IAPT programme. We will draw attention to the effective use of psychologists within services and identify the added value that psychologists can have on service delivery but within a multi-professional context. We also set out to challenge current practice within psychology and psychological therapy services and where appropriate suggest new ways of working and areas for service redesign. The implementation of new service delivery models such as stepped care will require psychologists to review their stance in relation to both their traditional assessment role and also the skill mix within the profession. We will also draw upon the activities of the other working groups from NWW AP and in particular assess the impact of the development of new roles, career pathways, clinical leadership, multi-professional team working, and developments within education and training that might facilitate innovation within the IAPT programme.

In writing this guide we are aware of the variety of language that is used to capture psychological distress and wellbeing. It ranges from medically derived diagnoses, through clinical guidelines such as NICE, through to more socially inclusive descriptions of the difficulties and challenges faced by many service users. Where possible we have drawn on psychological as opposed to more biological frameworks, and have attempted wherever possible to use language which is the least stigmatising as possible.

The intended audiences for this guide are psychology practitioners and managers, primary and secondary care providers, and the commissioners of these services. An abbreviated guide comprising an executive summary and the key recommendations is also available. We have also sought advice from service users on the roles that psychologists can adopt to ensure equitable and efficient service provision, which meets their needs. This has been achieved through liaison with service users associated with the NWW AP and the Service users and Carers Liaison Committee of the Division of Clinical Psychology. We are also keenly aware that services, particularly those involving talking therapies, have to be culturally appropriate to both individuals and communities. We have used the Division of Clinical Psychology's Faculty of Race and Culture to advise us accordingly. As well as providing general guidance for the effective utilisation of applied psychology, we have also interweaved this document with some brief examples of good practice, which we hope will act as sources of innovation for both practitioners, managers and commissioners.

Finally within the rest of the UK, a parallel process has been undertaken to IAPT within England, whereby targets have been identified in order to expand access to psychological therapies. In N Ireland, the Bamford review of Mental Health and Learning Disability Services has just been completed. The findings are awaiting implementation and there is an understanding that a key issue would be the expansion of access to psychological therapies. The NI Department of Health is also in the process of establishing a mental health service framework, which will set performance indicators/targets for services to aspire to achieve. The idea of a policy/strategy akin to the English IAPT document is also being considered and the setting up of a regional group to develop such a model is envisaged later in the year. In preparation for this, the Department of Health has commissioned an initial scoping exercise regarding the availability of psychological services here and training opportunities. This is to be completed by the Autumn of 2007.

### **IAPT-relevant examples from Northern Ireland**

**Service:** Northern Health and Social Care Trust

**Area:** Belfast, Northern Ireland

**E-mail:** *brian.mccrum@northerntrust.hscni.net*

The Clinical Psychology department of the Northern Trust has developed a project that enables every GP in the Trust (over 280) to advise on access to a free online CBT-based course targeted at mild to moderate anxiety and depression. In conjunction with NHSSB Primary Care we have distributed guidelines on how to use Chris Williams' 'Living life to the Full' self-help course and have backed this up with an e-mail support system that gives advice and additional help to course users within two working days. Our department is also evaluating the project, exploring issues such as uptake, acceptability and effectiveness.

**Brian McCrum, Clinical Psychology Service Manager**

*Northern Health and Social Care Trust*

#### **Hear to Help Service (Belfast Trust)**

**Service:** Muckamore Abbey Hospital

**Area:** Antrim, Northern Ireland

**E-mail:** *petra.corr@belfasttrust.hscni.net*

**Telephone:** 028 94483410

The Hear to Help Service was established as a multi-disciplinary psychology led service in the North and West area of the Belfast Trust in 2005. It is a specialist service for people with learning disability and additional complex mental health needs. The service provides individual psychotherapy for a range of mental health conditions and traumatic life events. The service offers a range of treatment modalities including cognitive behavioural approaches, psychoanalytical psychotherapy and counselling. In addition the service also provides a comprehensive groupwork programme addressing issues relating to personal and sexual relationships, assertiveness and self-esteem. A debriefing service, consultancy service and an education and learning resource are also provided.

**Petra Corr** *Consultant Clinical Psychologist*

A similar situation exists in Wales, where Local Health Boards are tasked with strengthening mental health services within general practice to support whole system models of care, and specifically to provide additional tier one services in primary care (WAG, 2006). This includes access to psychological services within primary care within 12 weeks. The initiative also includes provision of gateway workers for screening assessments and signposting to other tier one services (e.g. voluntary sector). Other areas for development include fast-tracking to Community mental Health Teams, and the training of primary care staff in mental health.

### Positive practice in Wales

**Service:** Primary Care Counselling Service

**Area:** Cardiff and Vale NHS Trust

**E-mail:** *Jane.boyd@cardiffandvale.wales.nhs.uk*

#### **TOPSHAPE (Therapy Options Project Self Help and Promoting Empowerment)**

The TOPSHAPE project was consultant psychology-led one year initiative funded by Cardiff Local Health Board. The impact of implementing a modular and stepped care pathway based on NICE guidelines for mild to moderate depression, anxiety and OCD was explored. The project was implemented in four GP practices (population of 25,000) and offset savings on prescribing costs were monitored alongside effectiveness and client satisfaction. Counsellors offered CBT interventions and assessed and reviewed clients' engagement in a stepped approach to intervention. Clients were enabled to consider their needs in relation to the evidence base for effectiveness of interventions and make informed choice regarding a number of possible interventions as alternatives to medication.

Interventions included computerised CBT (Fearfighter and Beating the Blues), CBT, guided self help, stress control, walking for health, exercise referral. Counsellors were experienced primary care counsellors eligible for accreditation with the BACP (and trained to Masters level in the delivery of CBT). GPs were encouraged to use TOPSHAPE referral as an alternative to medication and to implement a stepped approach by engaging clients in a number of interventions including watchful waiting and bibliotherapy prior to referral to TOPSHAPE.

The project evaluation included standardised measures recommended by NICE for depression, anxiety and OCD, CORE, focus group and questionnaire evaluation. It demonstrated excellent clinical outcomes: high client, team and GP satisfaction. Clear protocol for 'new ways of working', support for team process/training led to positive partnership working with GPs, the primary care liaison nurse and assistant psychologist (cCBT support). Outcomes included offset savings on prescribing and GPs increased awareness and engagement of clients in appropriate interventions as alternatives to medication. One-to-one delivery of CBT remained popular choice for clients and mental health competencies were required to appropriately engage clients in the use of computerised CBT. Attitude change was reported regarding newer ways of working (e.g. cCBT, telephone review) for GPs, counsellors and clients. Counsellors found that 'triage' was difficult to case manage alongside one-to-one therapy suggesting that optimal development of primary care link/gateway workers would be to undertake assessment/review/signposting and implementing early strata/steps of care pathways alongside existing managed provision of primary care counselling.

**Dr Jane Boyd**

*Consultant Clinical Psychologist, Cardiff and Vale NHS Trust*

Scotland has its own Government, and a separate NHS with its own structures and an increasingly divergent policy context to England. Nevertheless, its Mental Health services face similar challenges to those south of the border. The most recent white paper *Delivering for Mental Health* (DfMH: Scottish Executive, 2006a) sets out the vision for promoting good mental health for everyone living in Scotland, and specifies the functions that are expected from services in order to achieve this. Health Boards will be required to demonstrate progress towards the implementation of the Mental Health Targets specified in DfMH, and on a number of related Commitments. For the purposes of this paper, Commitment 4 is key

*We will increase the availability of evidence-based psychological therapies (PTs) for all age groups in a range of settings and through a range of providers.*

In Scotland this increase in availability of psychological therapies is to be achieved within current resources. DfMH states that the Scottish Executive Health department (SEHD) will work in partnership with NHS Education for Scotland (NES), Health Boards and other service providers to increase the capacity within the current workforce to deliver psychological therapies, to support service change, and to ensure that the new resource is used effectively in practice. Specifically, NES has been approached by the Mental Health Division of the Executive to prioritise and fund an increase in the range and availability of training in PTs.

The SEHD have set limits to the task in the early stages by directing NES to focus initially on improving service capacity to deliver psychological therapies for the adult patient population in primary care with mild-moderate mental health problems (principally anxiety and depression). The NES Phase1 Training Plan (Scottish Executive, 2006b) outlines the work programme around this, and describes how the focus will widen out to other patient groups as the remit expands.

As in England, the expectation is that a matched/stepped-care model will be adopted as the most cost-effective way of delivering the service, although this will be adapted to local circumstances. Psychologists will have a key role in increasing access to psychological therapies in Scotland, but fully realising this role will require a considerable shift in working practices, very much in line with the recommendations in this document. Appreciating the imperative to modernise training, and capitalise on the untapped pool of talent emerging every year from the undergraduate psychology programmes, NES have developed a number of innovative training options. There is now a flexible route through Doctoral training, and two Psychology Masters-level courses producing Clinical Associates in Primary Care and in Child and Family.

### **A Primary Care-based and Primary Care-focused psychology service**

**Service:** NHS Fife Clinical Psychology Department

**Area:** Dunfermline and West Fife

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Health legislation in Scotland has promoted the decentralisation of much of healthcare and given a central role to Primary Care. This continues via the current organisational structure of the Community Health Partnership (CHP). The West Fife adult clinical psychology service, which serves the CHP population of 150,000, is both Primary Care-based and Primary Care-focused. Thus, as far as possible, the service is provided in GP surgeries, alongside the Primary Care Team. As well as clinical psychologists, the service employs cognitive-behavioural therapists and Clinical Associates (psychology graduates who have completed the MSc in psychological therapies for patients presenting to Primary Care). We have a skill-mix of staff working with each of the area's 19 Practices to facilitate a stepped care approach. In 2005, following funding from the Scottish Executive's Doing Well by People with Depression initiative, we developed and evaluated a triage system, which involved the rapid assessment, by an experienced clinical psychologist, of people referred with depression. As a result of this we have implemented a triage and assessment system for all patients referred. Following assessment, patients are offered an appropriate form of help from the options available. For many, this is therapy with one of the psychology team (e.g. an experienced clinical psychologist for patients with complex needs, or one of the Clinical Associates, if their needs are more straightforward). Group programmes are also provided. In some Practices, we work closely with mental health nurses, with referrals being made to 'the Practice's mental health team' and patients triaged to the most appropriate in-house service (which includes on-site psychiatry and counselling), or other services. The mental health nurses are supervised by one of the clinical psychologists.

The philosophy which underpins Community Health Partnerships requires that we consider the needs

of people who are not referred to the service. To do this, we arranged, some years ago, for a range of relevant books to be placed in local libraries. More recently, this has been developed into a book prescription scheme. We have also developed a website – [www.moodcafe.co.uk](http://www.moodcafe.co.uk) – which hosts a range of self help material and acts as a portal to information about local groups and services, as well as to interactive websites which help people to deal with common psychological problems. The latter has drawn upon resources developed by other sites involved in *Doing Well by People with Depression*. We work with GPs and others in the Primary Care Team to facilitate their use of these as part of a stepped care approach. Again in keeping with the philosophy of CHPs, we have good links with the voluntary sector through supervision and training.

Our service is represented at various levels of management within the CHP, e.g. myself and a colleague represent Primary Care (as opposed to clinical psychology) on the CHP Local Mental Health Partnership. This wider involvement has given clinical psychology greater influence to promote an awareness of psychological need and the role of psychology within the health service.

**Dr Frances Baty**

*Joint Locality Head, Adult Clinical Psychology  
Dunfermline and West Fife*

The advice and recommendations within this guide, therefore, have been developed in order to address a variety of different scenarios surrounding the implementation and roll out of the IAPT programme into the future within England and also to support parallel developments elsewhere in the UK. Where appropriate we have also included examples of positive practice from the devolved nations.

## **1.2 Policy context**

Psychotherapy and psychology services have been available through the NHS for at least the last three decades, but it has only been recently that these services have started to attract the degree of attention from both service users and commissioners that they deserve. Through the ongoing reviews of the National Service Framework (DH, 2004b; 2007a), the Director for Mental Health Louis Appleby has ensured that psychological therapies have a prominent position in the delivery of mental health services. There are many reasons why access to psychological therapies is now regarded as a priority area and these include its demonstrated effectiveness through the publication of NICE guidelines; patient choice in wanting greater access to talking therapies (DH, 2004a, 2006 a,b; Rankin, 2005; SCMH, 2006; Warner *et al.*, 2006) and the accompanying media attention (e.g. Pidd, 2006); and the socio-economic benefits on individuals' well-being and the nation's wealth, as recently argued by Lord Layard (CEP, 2006; Layard, 2006).

The policy context for improving access to psychological therapies has been already well-articulated by both Lord Layard (2006) and the IAPT Programme (MHChoice, 2007). In December 2004, an influential seminar hosted by the Cabinet Office Strategy Unit took place and Lord Layard (2004) presented a paper entitled *Mental Health: Britain's Biggest Social Problem?* (available from the website: [www.strategy.gov.uk/downloads/files/mh\\_layard.pdf](http://www.strategy.gov.uk/downloads/files/mh_layard.pdf)). This sought to emphasise the adverse consequences of the growing size of untreated mental health problems, particularly anxiety and depression, both on individuals' well-being and the economy. Layard cites that for people on incapacity benefit, the biggest percentage (40 per cent) suffer from a mental disorder and mental health problems are a secondary factor in at least a further 10 per cent. At the same time, access to treatment for mental health problems is desperately restricted. He calculates that of all people with mental illness, only 3 per cent have seen a psychiatrist and only 2 per cent a psychologist. The inability of primary care services to adequately address the needs of people with common mental health problems, other than the prescription of antidepressants has also been highlighted by the Sainsbury Centre for Mental Health (Hague & Cohen, 2005) and in the report *Five Years On* (Department of Health, 2004b). This is despite the fact that clinical guidelines published by NICE for many common psychological disorders advocate that evidence-based psychological therapies are frequently the treatment of choice, and in particular cognitive behaviour therapy (CBT) interventions (e.g. NICE, 2004). Essentially, Layard and colleagues powerfully advocate for a major investment programme into the provision of evidence-based psychological therapies, together with a process of service redesign and targeted commissioning.

The inter-relationship between health, work and well-being is also reflected in a major cross-departmental initiative between the Department of Work and Pensions, the Department of Health and the Health and Safety Executive (DWP, 2005). This strategy addresses wider issues about supporting people in work, enabling people to return to work following chronic illnesses, improving access to occupational health services – especially for small employers, promoting work as important and beneficial to well-being, promoting healthy workplaces and lifestyles at work etc. The provision of high-quality healthcare advice and, where appropriate, psychological therapy, is as an important component of this overall strategy. In particular, two DWP programmes *Pathways to Work and the Condition Management Programme* have enhanced individuals' confidence to return to work and early indications suggest that the *Pathways to Work* programme may secure between 8–10 per cent reduction in incapacity benefits. In addition, the Sainsbury Centre for Mental Health is currently co-ordinating the National Employment and Health Innovations Network (Information available from the website: [www.scmh.org.uk/80256FBD004F6342/vWeb/wpKHAL6MREVX](http://www.scmh.org.uk/80256FBD004F6342/vWeb/wpKHAL6MREVX)) which supports best practice for health and employment.

The intention to improve access and capacity within psychological therapy services cross cuts several other important health policy initiatives. Improving patients' choice of treatments within the NHS is crucial, not just between the choice of medication versus talking therapies, but on the choice of evidence-based therapies. The White Paper *Our Health, Our Care, Our Say* (DH, 2006a) also stresses the importance of choice, access and prevention. Similarly, various initiatives are taking place around developing primary care mental health services and developing systems of intermediate or collaborative care (Hague & Cohen, 2005). The later developments also coincide with the Department of Health's keen interest in developing service delivery models, particularly those that are epidemiologically based, address need, and follow a 'stepped care model' of service provision (Bower & Gilbody, 2005; Dietrich et al, 2004; Richards *et al.*, 2006; Simon *et al.*, 2001).

The organisation and governance of psychotherapy services has also been subject to review and scrutiny over the last decade by the Department of Health. A series of reports (DH, 1996; 2001; 2004a) culminating in *Organising and Delivering Psychological Therapies*, have helped to delineate the landscape of psychological therapies, to identify evidence-based guidelines, and to provide advice on improving the management and delivery of psychological therapy services. Psychological therapy services are also important for the reform of NHS mental health services and although they were not specifically identified within the Mental Health National Service Framework (NSF), the question of improving access was stressed in the NSF review – *Five Years On* (DH, 2004b). Indeed, the recent review of the mental health reform (DH, 2007) reinforces the importance of improving access to psychological therapies. Recently, guidance has been produced by CSIP (2006) about addressing mental health within primary care mainly through increasing access to psychological therapies. Indeed, detailed advice on how commissioners and providers can innovate psychological therapy services to achieve increased access has been recently published in the form outline service specifications, outcomes framework, workforce guide etc. by CSIP (MHChoice, 2007). We anticipate that services in the future will also have to contend with pressures from both service users and commissioners as to how they will need to be resourced and manage waiting lists for psychological therapies, and be able to implement targets such as the 18 week wait for treatment or their equivalent within a mental health and primary care context. Finally, the delivery of psychological services raises specific issues surrounding the clinical governance of services and also the regulation of individual practitioners. It is likely that the recent consultation on the regulation of non-medical professions will impact on developments in this area (DH, 2006b).

### **1.3 The Development of the Improving Access to Psychological Therapies Programme**

This programme is sponsored by the Department of Health and has been implemented by National Institute of Mental Health England, as part of the Care Services Improvement Partnership. It was launched in September 2005 and seeks to enhance access to psychological therapies, principally with respect to common mental health problems such as anxiety and depression, and initially focusing on adults of a working age but is planned to take in other care groups such as older adults, children and adolescents and people with long-term medical conditions or unexplained medical symptoms. The main aim of the programme is to articulate the arguments for a major investment in the provision of

psychological therapy services and to co-ordinate a series of national and regional demonstration sites designed to provide evidence on the effectiveness and feasibility of the proposed service improvements advocated for psychological therapies. Further information on the programme, the two demonstration sites at Doncaster and Newham and the newly announced Pathfinder sites is available at the following website: [www.mhchoice.org.uk](http://www.mhchoice.org.uk). The outcomes from the two demonstration sites are being evaluated internally by the London School of Economics and also in the longer term through a Department of Health R&D Service Development and Organisation (SDO) grant.

A business case has been prepared which describes the resources required to roll out the programme by the establishment of 200 new psychological therapy services throughout England over the next six years or so. Each new service would be based around a stepped care model and target people with common anxiety or depressive disorders, and would seek referrals from primary care and elsewhere. A typical service might be lead by a Director experienced in the provision and management of psychological therapies, and a team consisting of around 26 qualified therapists who would be responsible for providing a 'high intensive treatment' service, together with around 14 staff who would assist the therapists in the delivery of 'low intensity' services such as case management and collaborative care, cCBT, employment coaching and supported self-help. Neither high nor low intensity workers would be drawn from any particular profession but it would be expected that clinical and counselling psychologists, CBT therapists, counsellors and psychotherapists would be recruited for the former, and graduate mental health workers, psychology assistants, experienced volunteers, employment workers make up the recruitment pool for the latter. More specialised employment advisers and GPs with a special interest in mental health would also make up the teams. Staff within the teams would be recruited and trained according to the competencies required and these would include CBT and other evidence-based psychological therapies. It is hoped that training for practitioners in both low and high intensity interventions would be largely located within the new services but with support from local HEIs. It is important to emphasise that such a 'typical' service has been required in order to identify and cost the likely resources required. The service model implicit in these costings may not, however, be the model that is eventually rolled out or locally established. That will depend upon the extent of any new investment and the needs of the local health communities.

Currently, the IAPT programme is being extended to include ten additional Pathfinder Sites which will be commissioned locally by PCTs and others, together with support from the IAPT programme. Documentation to support the tendering of bids for these sites is available from the CSIP website (MHChoice, 2007) and includes detailed information on service specifications, outcome measurement and workforce development. It is strongly recommended that the current Good Practice Guide be read in conjunction with this advice.

### Evaluating Stepped Care

**Service:** SDO Research Grant

**Area:** Various sites

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#### **Developing evidence based and acceptable stepped care systems in mental health care: An operational research project**

A research team led by Professor David Richards, University of York, and funded under the NHS SDO R&D Programme, is evaluating the development and implementation of stepped care for psychological interventions.

In a first phase, the project is exploring the process of development and implementation of stepped care in four sites across the UK. In two of these sites, a triage assessment by a mental health professional allocates patients to an appropriate step in the local stepped care system. In the other two sites, GPs make the decision as to whether to refer a patient first to a less intensive intervention carried

out by a graduate worker or directly to a more intensive intervention carried out by a mental health professional. The research team is collecting data on pathways and flows of patients through each local stepped care system and using these to refine an operational modelling tool. The team is also exploring patients', staff and managers' experience of stepped care, including barriers and facilitators to implementation of stepped care, through qualitative interviews.

Ten further sites will participate in a second phase of the project. The research team will provide these sites with the modelling tool and an implementation manual developed in the first phase. The sites will use these tools to design and implement a stepped care system optimised for their local circumstances. The research will evaluate their experience through qualitative interviews.

## **2. The challenge of service innovation and redesign: The organisational contribution of psychologists at the board level**

Improving access to psychological therapies requires a multi-professional agenda if large scale and sustainable service innovation and redesign is to be achieved; the skills needed to achieve this are not unique to applied psychologists. Making an effective contribution at senior organisational levels is critical in producing systemic changes in models of service delivery, yet relatively few applied psychologists are in Board level positions with the opportunity to input effectively into service innovation and redesign.

In this section, key aspects of the contributions that psychologists can make are illustrated by two individual psychologists working as Directors of Therapy/Psychological Therapy within NHS Mental Health Trusts. It is argued that effective input at this level represents a key developmental target for senior applied psychologists. Changes in service design can affect all mental health practitioners within every care group and service. Access to psychological therapies needs to be viewed as 'core business' for the organisation, facilitating key corporate objectives and most importantly enhancing the service user and carer experience of mental health services.

Five key aspects of psychology's contributions are described, together with examples of positive practice from the two NHS trusts concerned: Sussex Partnership NHS Trust and Oxleas NHS Foundation Trust

### **2.1 Development of a Board level commitment to psychological therapy**

Improving access to psychological therapies needs to be embedded within the Board's strategic objectives and highlighted in the annual plan and corresponding key performance indicators. Initiatives to improve access are thus integral to services themselves and do not sit separately within psychology departments. The delivery of psychological therapies therefore becomes a shared organisational responsibility. This encourages services to redesign and creates care pathways for access to therapies using a multi-professional approach, which ultimately achieves greater access to psychological therapies.

#### *Oxleas Example:*

The Trust Board has endorsed a Psychological Therapies Strategy and action plans to operationalise this have been developed. The Trust has a multi-professional Psychological Therapy Project Board with representatives from all care groups and directorates. Making progress with this primary task as a director has enabled the psychological perspective to be incorporated into the Board's discussion of other key corporate objectives such as the achievement of foundation status and the development of workforce planning

#### *Sussex Example:*

Within the Trust's health and social care governance structures the traditional functions of the *Drug and Therapeutics Committee* have been separated into three elements – medicines management (Medical Director), psychological therapies (Director of Therapies) and NICE guidance (shared between the two roles). The requirement to report this activity at board level ensures that psychological therapies are delivered in an integrated way in line with other interventions, which have historically been more prominent.

## **2.2 Professional Leadership and the development of governance frameworks**

*Sussex example:*

The Director Therapies is professionally responsible for leadership and governance of all applied psychology staff, therapists (including medical and non-medical psychotherapists, counsellors and art psychotherapy), and occupational and vocational services staff. In addition to ensuring best practice, this enables the director to articulate a vision with regard to New Ways of Working alongside other professional lead directors and to define how new roles can be embedded both throughout the organisation and between professional groups. The value of having vocational and OT staff within the directorate of therapies has become increasingly important and has enabled assurance that the vocational strategies are strongly linked with the IAPT agenda in line with the national demonstration sites.

The Director of Therapies is also responsible for the strategic development and practice of psychological therapies for all staff, including medicine, nursing and social care staff. It is this multi-professional agenda which allows the greatest opportunity for improving access to therapies. This is being achieved through developing new working structures for staff with clear governance arrangements for the practice of therapies, and also through the promotion of educational and training frameworks. The role of applied psychologists within this multi-professional approach is pivotal and requires clear definition of roles with service managers to ensure there is capacity for psychologists to supervise and support others in the delivery of psychological therapies.

The development of governance frameworks for the practice of therapies requires the identification of all practising therapists (qualifications, capacity to supervise etc.). Identifying this group of staff has had the impact of increasing the capacity to provide supervision to less qualified staff and thus improve access to therapies by enabling a larger staff group to provide less intensive forms of therapy. We have four therapeutic modality governance groups, which have developed standards of practice, training recommendations and practice networks (CBT, Psychotherapy, Family & Systemic and Integrative). In addition, core standards for supervision and audit are being developed to ensure best practice and consistent measurement of outcome. See section six for further discussion of governance issues.

## **2.3 Promotion of specific innovative projects at an operational level**

*Oxleas example:*

Each care group and directorate within the Trust has a representative on the Psychological Therapy Project Board (PTPB). There is a requirement that the representatives liaise with senior staff to develop at least two specific projects within their care group or directorate.

Some of the projects being developed in Oxleas are shown below:

### **Adult Mental Health**

- Psychological Therapy for psychosis
- Psychological therapy for women with personality disorder

### **Adult Learning Disabilities**

- Psychological Therapy and Autism
- Healthcare assistants and Person Centred Care

### **Forensic**

- Day treatment for people with personality disorder

### **Children and young people**

- Psychological Therapy for psychosis
- Psychological Therapy for children with depression

### **Older Adults**

- Psychological therapy for depression

This project-based approach enables easier targeting of resources with the intention of allowing multi-professional groups and senior service managers to be given clear examples of the utility of a psychological

approach. It also stresses the need to develop psychological initiatives which involve all staff and all care groups. This encourages service redesign and the development of psychological mindedness in all staff working for the organisation.

## **2.4 Education and training**

*Sussex example:*

A multi-professional training framework for psychological therapies has been developed. Within the framework, three main competency levels are described: foundation skills (understanding therapeutic principles and applications for most clinical staff/volunteers and service users/carers), intermediate skills (provision of structured therapy and supervision skills: for staff in services where specialist competencies are required), and advanced skills (formal therapies: where training is likely to meet requirement of BABCP; UKCP etc.). Training programmes for large numbers of staff in foundation skills in CBT, eating disorders, solution focussed therapy and the STEPPS (Systems Training for Emotional Predictability & Problem Solving) programme for personality disorders have significantly increased the competencies of staff to deliver therapies.

This structured approach has required psychologists to define their competencies and training requirements in psychological therapies in line with other staff who may have developed postgraduate skills and registration exceeding those of newly qualified psychologists. A major challenge is accommodating the multiple approaches common to a significant number of psychological therapies staff and ensuring that this competencies approach captures those who have had a significant amount of clinical practice, which has not been supported by a formal post-graduate qualification in some form of specific therapy. Figure 1 illustrates one approach to the problem of designing education and training that fulfils the needs of the entire workforce within the trust. There has been increased demand for psychologists to supervise staff with newly acquired skills at the foundation and intermediate levels. Further discussion of IAPT education and training issues is to be found in Section 8.

## **2.5 Evidence based practice and practice based evidence**

Psychologists are well placed to fulfil this role given their doctoral training in research (see also Section 6).

*Sussex example:*

A psychologist has been recently appointed to the post of research director and part of the role will be to facilitate research to promote evidence based practice of psychological therapies. A minimum data set (including CORE) has been developed to ensure consistent measurement of outcomes and provide data for performance measures to inform the commissioning process.

*Oxleas example:*

The Trust has an evidence-based initiative centred around the work of the psychological therapies project board. This has forged partnerships with local undergraduate psychology courses as well as developing the more established links with clinical psychologists in training to encourage the systematic collection of evidence about the projects commissioned by the PTPB. The children's services have convened a conference on models of psychological treatment for children with depression and harnessed the interest of multi-professional groups to make the routine collection of outcome data part of the work of the teams within CAMHS. All other care groups are participating in a Trust-wide conference introduced by the Chief Executive designed to showcase the innovative work across all care groups in the Trust.

For further information contact:

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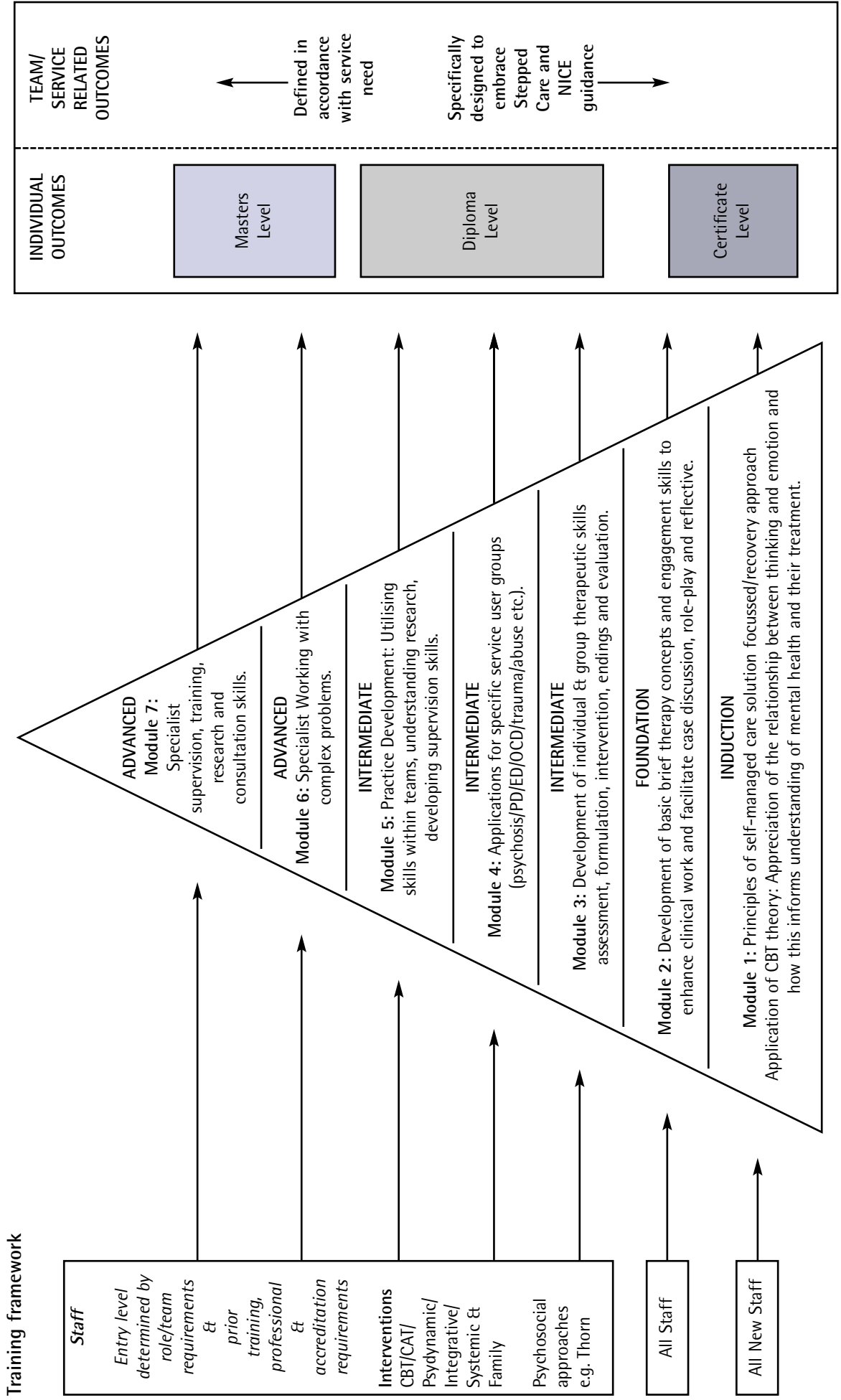
*kay.macdonald@sussexpartnership.nhs.uk*

**Keith Miller**

Director of Psychological Therapies, Oxleas NHS Foundation Trust

*keith.miller@oxleas.nhs.uk*

Figure 1: Developing competencies to improve access to psychological therapies



### 3. Developing improved care pathways

A means of improving access to psychological therapies is through the integration of psychological services within the wider fabric of all services, within efficient care pathways. This systematic approach embeds New Ways of Working in service redesign. Achieving this requires a shared language of individuals' needs and clinical problems that is logically connected with treatment and care interventions, and acceptable to service users, carers, the range of clinical professions and commissioners. In addition, these integrated psychological services should be described and provided in ways that allow them to be costed and therefore appropriately resourced.

There may be various ways of achieving these requirements, for example, by embedding the contents of NICE guidance and Policy Implementation Guides, which make clear reference to psychological skills within care pathways. An example is an approach that has been developed by Roland Self and colleagues in South West Yorkshire Mental Health NHS Trust for adult mental health services. This involved the development of a clinical decision support tool (CDST). The CDST allows a standard assessment of service users into one of thirteen empirically derived and clinically meaningful care groups with linked multidisciplinary care packages developed through statistical cluster analysis combined with expert multidisciplinary reference groups. The assessment system through which people are allocated to care groups is based on an extension of HoNOS. The thirteen described care groups include mild/moderate neurotic disorders through to severe and enduring psychosis with ninety-five percent of service users successfully fitting a group.

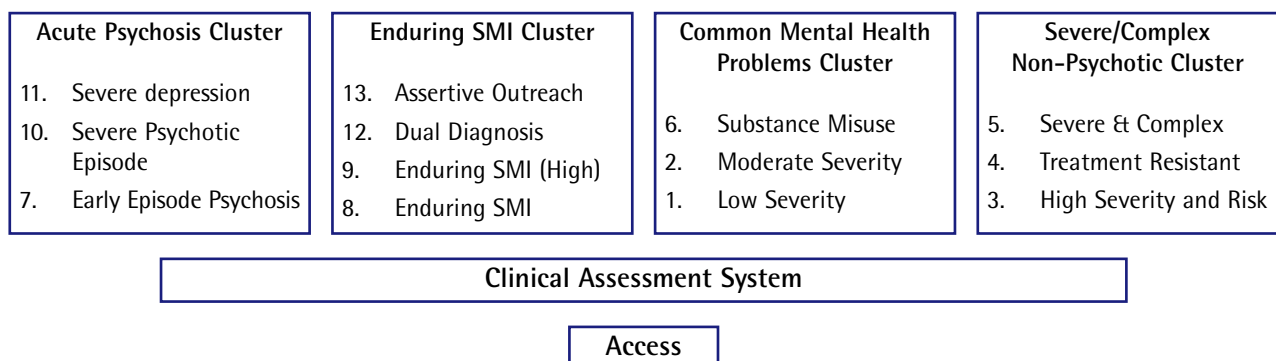
#### 13 Empirically derived care groups based on service user needs

1. Acute Non-Psychotic (Low Severity)
2. Acute Non-Psychotic (Medium Severity)
3. Non-Psychotic (High Severity)
4. Non-Psychotic Disorder of Over Valued Ideas
5. Non-Psychotic Chaotic and Challenging Disorder
6. Drug and Alcohol
7. First Episode Psychosis
8. Chronic Severe Mental Illness Group
9. Chronic Severe Mental Illness Group (High Symptom Group)
10. Severe Psychotic Episode
11. Severe Depression
12. Dual Diagnosis
13. Assertive Outreach

Care groups are not based on diagnosis but they do fall within broad diagnostic groupings. Within this the care groups vary according to increasing severity and complexity. For example, an anxiety disorder could be found within groups 1, 2, 3 and 4 with more simple and perhaps transient disorders in care group 1 and more enduring disorders such as avoidant personality disorder in care group 4.

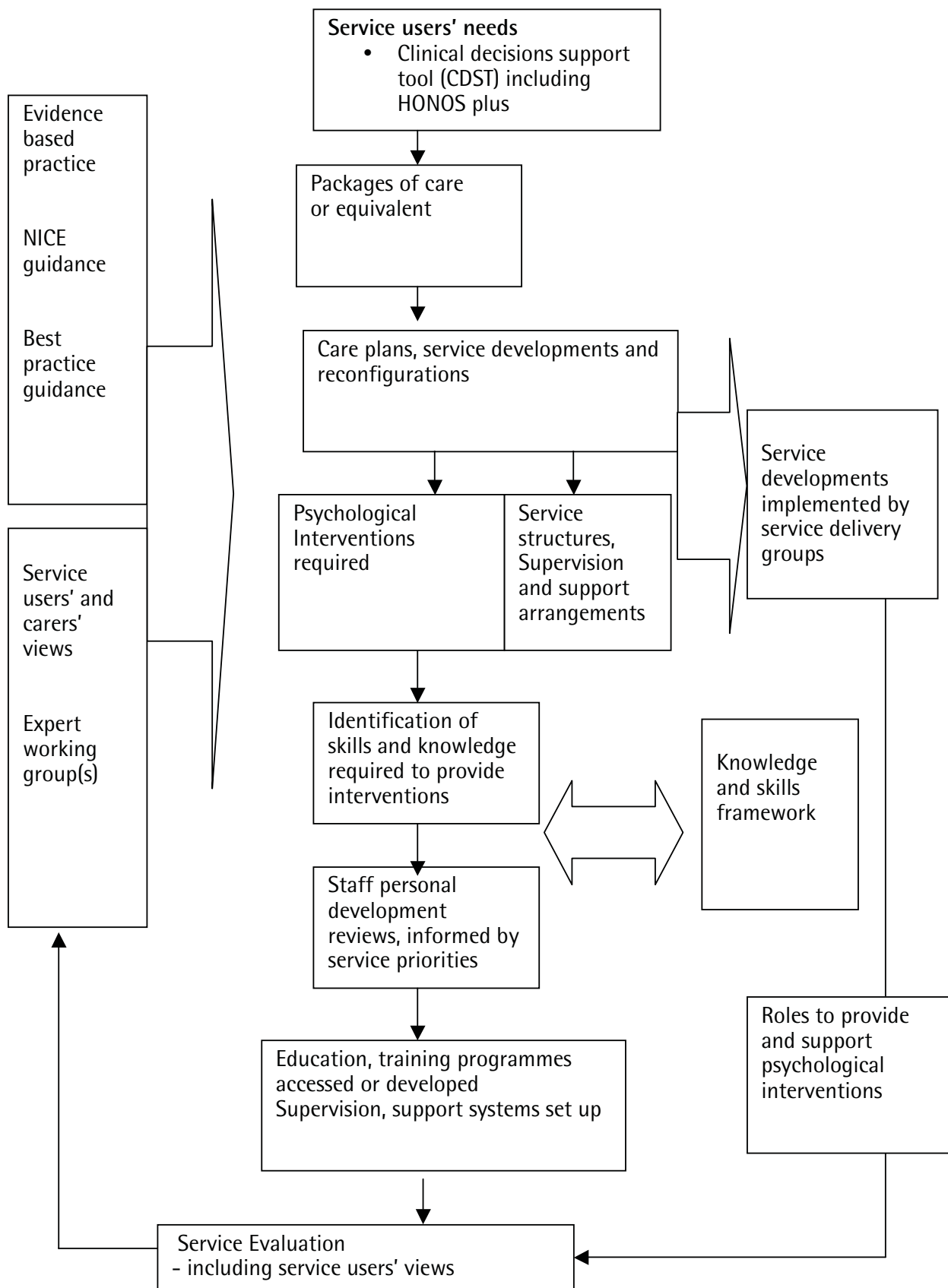
How this approach can affect service design and development is demonstrated below. Packages of care for service users with similar needs and therefore requiring similar interventions can be grouped into service clusters with each service cluster containing the range of skills necessary to meet the needs of these people.

Figure 2: Distribution of Packages Within Service Clusters



The figure below, taken from the South West Yorkshire Mental Health NHS Trust psychological interventions strategy, illustrates this further with the identification of psychological interventions required within each package of care, workforce planning and the identification of staff personal development and training needs.

Figure 3: Process for identifying and developing psychological interventions and training requirements



This system of care packages and pathways has now been replicated and found to be acceptable and useful in six other Trusts in the North of England, and the work of these two development phases has been published (Dent, 2006; Self *et al.*, 2007). As a result of this work the approach has attracted considerable interest in mental health trusts across the country with many already using it to clarify and redefine their services. The DH has indicated that it will now support a third phase of this work. Central aims should be firstly to adjust and update the care packages so that they are based on the most recent evidence and compliant with available NICE guidance and policy implementation guides; secondly, to replicate further the reliability and validity data on the system through a wider evaluation involving approximately ten Trusts throughout England; and thirdly to develop a costing system that reflects as accurately as possible the full costs of each care package. The system is currently used on a daily basis within part of the South West Yorkshire Mental Health NHS Trust, where it is being implemented along with a psychological interventions strategy, and its use is continuing in the other Trusts involved in the development work so far. Completion of the next phase should generate an overall framework of value to commissioners, service managers, practitioners, and of course, service users and carers.

This pathways and packages of care approach encourages practitioners to specify the aims of interventions (e.g. relapse prevention, reduce risk of self harm, maximise social functioning), the activities to be provided within them (e.g. assessment, enabling, therapeutic interventions), and promotes the identification of psychological interventions required within each package, consistent with NICE guidance. Examples of psychological interventions identified are low intensity interventions such as guided self help, signposting and case management for the 'acute non-psychotic (low severity)' group and brief psychological therapies, such as CBT, counselling and problem solving therapy, for those in the 'acute non-psychotic (medium severity)' group. Clients in the non-psychotic (high severity) group require longer term psychological therapies and a wider range of therapies should be available, as recommended in the NICE guidance for depression for example.

### **Guided Self-Help for Common Mental Health Problems in a Primary Care Mental Health Team**

**Service:** Primary Care Liaison Assessment Treatment and Training (PLATT) Team

**Area:** Wakefield locality of the South West Yorkshire Mental Health NHS Trust

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Individuals receive an assessment carried out by a primary care mental health clinician within the team and a number of options are available, including sign posting, brief psychological therapy or guided self-help provided by two graduate mental health workers (GMHWs). These are both psychology graduates and had completed a postgraduate certificate in primary care mental health at the University of Huddersfield, which included a 30 credit module on CBT based guided self-help.

The guided self-help intervention is appropriate for individuals presenting with mild to moderate anxiety, depression, phobias, stress or sleep problems, with a relatively recent onset (within the last two years). Following the clients agreement to be referred for the intervention, they are given appropriate readily available self-help material such as that available from the Northumberland Tyne & Wear NHS Trust (<http://www.ntw.nhs.uk/pic/?p=selfhelp>). The clients are asked to bring this material to their first session.

The guided self-help intervention involves two 60 minute sessions and one 30 minute session with the GMHW. The first session involves a discussion of the problems the client has been experiencing and agreement of goals the client would like to achieve. The facilitator then works through the self-help material with the client to identify helpful techniques that may enable the client to achieve one or more of their goals. The second meeting is three weeks after the first and involves a review of the techniques and a discussion around how these can be refined/changed to bring the client closer to achieving their goals. The client will be offered a third appointment two weeks later to briefly review the client's progress and decide if further more intensive intervention is required.

This 2+1 model of guided self-help using brief self-help material is intended to empower clients and increase access to psychological help for people experiencing mild to moderate common mental health problems.

This intervention has been designed to accommodate a randomised controlled trial to investigate the effects of facilitation in conjunction with self-help material written for common mental health problems. Following assessment and the initial provision of self-help materials, clients are randomly assigned into one of two groups. One group commences the intervention within three weeks of their assessment and therefore complete the entire intervention after eight weeks. The other group is given the opportunity to work on the self-help material without guidance for a period of eight weeks before receiving the guided self-help intervention. The trial therefore compares guidance vs no guidance in the use of self-help materials over eight weeks. Scores on the CORE-OM (used routinely in the service) give an indication of progress made throughout the intervention, with measures taken at initial assessment and before and after the guided self help intervention. A qualitative evaluation is also being carried out to determine the impact of the intervention on the clients' functioning.

**Professor Mike Lucock**

*Associate Director of Psychological Therapies Research,  
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It is important to identify the different types and levels of psychological interventions required, from foundation psychological skills required of the whole workforce to formal psychological therapies. It is also important to consider the levels of training and experience appropriate for different types of intervention and different levels of severity, chronicity and complexity. Applied psychologists trained in a range of therapeutic models are well placed to provide therapy for more complex problems, whilst psychology graduates with appropriate training could provide the low intensity interventions such as guided self-help. This approach encourages service providers to identify the skills required to deliver packages of care and training and service development requirements to ensure these interventions are provided and adequately supported, through for example, clinical supervision. It should also help commissioners understand the need for such functions to support the direct delivery of psychological therapies.

To summarise, this pathways and packages approach supports the following:

- It gives a clearer understanding of the need for psychological services within all packages of care.
- It clarifies how psychological therapies and other psychological services such as supervision, training and consultation fit within packages of care.
- It supports the identification of different types and levels of psychological interventions and therapies required within packages of care.
- It helps identify supervision and training requirements.
- It helps clarify the roles of the different professional groups and team working within each package of care.
- It enables the costing of various components of packages of care, including psychological therapies.
- It provides a shared language to enable commissioners and providers to agree service specifications and contracts.

All providers of mental health services need this or a similar system to support clear communications, linking interventions to client needs and effective and cost-effective care. Developing or adopting such a system requires inclusive and collaborative working. Applied psychologists can contribute to both the clinical and organisational aspects of implementing new systems and to their evaluation. However, it is essential that this implementation is not just a psychology initiative or even a wider clinical project. Successes so far have depended on whole organisation commitments, with the active participation of chief executives and finance directors as well as clinical staff Rees *et al.*, (2004) illustrated this point, describing disappointing implementation of new care pathways apparently due to insufficient high level organisational commitment. This further emphasises the importance of psychologists working at an organisational level as stressed in the previous section.

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### **Extending Primary Care Counselling and Counselling Services**

**Service:** Primary Care Counselling and Psychology Service

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#### **High quality brief therapy available in the patient's local GP surgery**

The Oxford Primary Care Counselling and Psychology Service provides clinical psychology and counselling input to General Practices in Oxfordshire. Its aim is to improve access to psychological therapies for people with mild to moderate psychological problems in the patient's own GP surgery which is more convenient, and less stigmatising than other venues.

The psychologist/counsellor takes direct referrals from the practice. Following an assessment, patients may be offered brief psychodynamic counseling or one of a range of CBT interventions including:

- self-help literature (mostly a series of booklets developed by psychologists at the Oxford Cognitive Therapy Centre)
- an intensive programme of therapy for people with agoraphobia and panic (the Lupina project),
- individual brief therapy
- a choice of psycho-educational groups (run in community venues, sometimes in the evening, to improve accessibility for those who work).

The service is also planning to pilot a computer-based CBT package.

Staff also offer consultation and advice to GPs and other members of the primary care team, contribute to teaching and training programmes and supervise psychologists and counsellors in training. The psychologists also supervise counsellors seeking to gain experience in CBT.

The service constantly collates activity data and clinical outcome data. The data demonstrates a high level of activity and good clinical outcomes for high numbers of patients with clinically significant problems.

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## Primary Care Mental Health Service Developments in Lincolnshire

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The Primary Care Service in South West Lincolnshire was redesigned to incorporate the development of a Single Point of access in each health community, the Choose and Book Project and the need to address the significant waiting times for Primary Mental Health services. The new service commenced in January 2005 and has the following features:

- A Triage service – all non crisis referrals of working age adults are seen face to face by an experienced mental health professional within a maximum of 2 weeks from referral
- Waiting times for follow on treatment have been significantly reduced – maximum is now typically 3 weeks for a CMHN, 4 – 6 weeks for counselling and 2 – 3 weeks for Graduate Mental Health Worker and Occupational Therapist This compares favourable with pre-Triage service waiting times which could be up to 24 weeks for counsellors and 17 weeks for CMHNs
- A broader range of treatments is offered.
- Greater choice for service users in terms of date, time and place of assessment/treatment.
- Improved liaison with GPs.
- Surveys of all key stakeholders (Service Users, staff and GPs) have all been very positive.

The Trust has received additional funding from the PCT and is in the process of rolling this model out across Lincolnshire in order to extend the benefits to all Service Users. The service has also recently been integrated with Psychological Therapies, and work is underway to develop a fully integrated stepped care service model.

**Dr Carol Brady**

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Trust Professional Lead for Psychological Therapies

Lincolnshire Partnership N HS Trust

## 4. Innovation in supporting community and Primary Care Mental Health

Primary Care Trusts face a major challenge in responding to the needs of their populations with depression and anxiety. Developing public health and primary care interventions to meet the most common problems and prevent the need for more intensive and expensive interventions is a key task. The training of applied psychologists, bringing together the perspective of a clinician on the needs of individual patients with the public health perspective of dealing with population needs, can assist PCTs in this task.

Population level interventions for depression and anxiety can usefully be described at three levels:

- Community interventions outside health settings.
- Enhancing the skills of GPs, health visitors and other primary care staff in psychological management.
- Enhancing primary care management of depression and anxiety through addition of workers providing brief supportive interventions.

These can be thought of as successive levels of prevention, interventions at each level preventing mental health problems from developing/deteriorating further (Dozois & Dobson, 2004), or as levels of stepped care, with the least intensive intervention being tried first before more intensive and expensive interventions (Bower & Gilbody, 2005).

### 4.1 Community interventions outside health settings

Community health promotion and prevention interventions are commonly divided into those that are 'universal', available to the whole population, and those that are 'targeted', designed for specific at risk groups. Examples of universal interventions designed and evaluated by applied psychologists are:

- Self-help resources in libraries: Working with local libraries to stock and promote well-validated self-help books for anxiety and depression, usually based on cognitive-behavioural principles (Frude, 2004).
- Reading groups: Training librarians to co-run reading groups for local residents where books are selected and discussed from existing 'Books on Prescription' schemes.
- Computerised cognitive behaviour therapy (NICE, 2006) in libraries monitored by librarians and supervised access through libraries to websites with self-help programmes for depression and anxiety (Andersson *et al.*, 2005; Ybarra & Eaton, 2005).
- Psycho-educational groups: Running large scale psycho-educational groups advertised to the general public on managing mood and self-confidence, held in community and adult education venues (Brown *et al.*, 2000). Similar interventions have also been introduced into primary care settings (Kellett, Clarke & Matthews, 2007a; Kellett, Clarke and Matthews, 2007b; Kellett *et al.*, 2004; Kellett, Clarkson & Matthews, 2005; White, 1998; Kellett *et al.*, in press). A particular example of positive practise is the *Doing well by people with depression* programme from Scotland (Scottish Executive, 2006c).
- Providing cognitive therapy to children through school nurses (Stallard *et al.*, 2006a; Stallard *et al.*, 2006b).

It should be stressed, however, that the sole provision of self-help in the form bibliography without the guiding support of a mental health professional, may not be effective for people with clinical levels of distress (Bower *et al.*, 2001; Hirai & Clum, 2006).

Examples of targeted interventions designed and evaluated by applied psychologists are:

- Young men's suicide prevention: Developing mental health promotion materials aimed at young men who do not generally attend services and using this material with young unemployed men as part of the 'New Deal' programme.
- Tamil initiative (Gilleard *et al.*, 2007): Developing self-help material based upon NICE guidelines in Tamil and training Tamil speaking workers as tutors to run mental health courses (including dealing with loss, managing conflict, learning to de-stress/relax, managing your anger, etc.).
- Self-help groups: Setting up and supporting local self-help groups for people with anxiety and depression linked with national self-help organisations (Bright *et al.*, 1999).

## **Delivering psychoeducational cognitive behaviour therapy within Primary Care; a low intensity/high volume approach to increasing access**

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Due to the large numbers of clients being referred from Primary Care and the reliance on the traditional one-to-one therapy delivery mechanism, long wait times for assessment and intervention was a common problem. It was decided to take a practice-based evidence approach to piloting and evaluating the delivery of Jim White's large-group psychoeducational approach in one of the four mental health sectors to increase the speed of access without compromising the quality of the eventual delivery mechanism. The pilot team contained a Consultant Clinical Psychologist, Consultant Psychotherapist (screening and delivery of the group) and an Assistant Psychologist (evaluation role).

The large group format entailed the delivery of six sessions of psychoeducative cognitive-behavioural therapy across the span of Primary Care referrals. Sessions are didactic and therefore clients are expected simply to attend and engage with the self-help material that supports the structure of the programme. The group was delivered in a community setting rather than on Trust premises, to reduce stigma and enhance uptake and participation of clients. The initial evaluation illustrated that levels of satisfaction were high with the approach and that outcomes were similar to those achieved by individual therapies of a matched duration, indicating that quality issues were being met and evidenced.

The success of the initial evaluation enabled the programme to be rolled out across the four sectors and to be integrated into the nascent stepped care model within Primary Care. Groups therefore now run consecutively across the year, at varying community venues and also at various times of day, in the effort not to exclude working clients. Staff from other disciplines have also been trained in the delivery of the programme to facilitate coverage. Access to psychological therapies is therefore much more rapid, with greater numbers of clients being able to be treated at any one time. A major advantage of the programme is that individual follow-ups from the groups identify clients who have not benefitted, who are then offered access to the various one to one therapies (CBT, CAT and psychodynamic). The low volume/high intensity individual therapies therefore do not get overwhelmed with clients who would do well in such an approach, but could do equally well within a less intense intervention. The group acts as a filter mechanism for those clients that can make use of lower level interventions and signposts those clients who need a more intensive approach to the right treatment. The group is constantly evaluated and plans for the future of the programme include the delivery of the groups by graduate mental health workers, whilst more experienced/senior staff oversee the programme, manage risks and ensure the governance of the programme.

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**Linda Matthews**

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### **4.2 Enhancing the skills of GPs and other primary care staff in psychological management**

GPs and the primary health care teams provide the greatest volume of NHS care for depression and anxiety (Goldberg & Huxley, 1992; Hague & Cohen, 2005). Primary care not only provides the main or sole help for people with acute problems, but also supports significant numbers of people with chronic depression and anxiety whom other services have tried and failed to help. The listening, advising and counselling of GPs and primary care staff is a key psychotherapeutic resource which needs to be effectively and appropriately supported by PCTs.

The kinds of training, facilitation and supportive initiatives currently being undertaken by applied psychologists for primary care staff are:

- Guidelines and templates: developing and assisting practices in implementing screening systems, management guidelines and electronic templates to guide GP and primary care team assessment and treatment of depression and anxiety.
- Short-training courses for local GPs in psychological management skills and facilitation of GP case discussion groups about psychological problems.
- Training and supervision of health visitors in screening and listening visits for women with postnatal depression.
- Training of district nurses in identification of depression.
- Training and support of community matrons in the care of people with complex comorbid health needs.
- Training community pharmacists to distribute self-help DVDs and general advice to support people who have been newly prescribed antidepressants.

#### **4.3 Enhancing primary care management of depression and anxiety through addition of workers providing brief supportive interventions**

The recent evidence-base for a range of brief interventions for depression and anxiety, which can be facilitated by staff without extensive training in mental health, provides new opportunities for enhancing primary care management of these problems (Bower, 2002). The new graduate primary care mental health workers (PCMHWs) and pre-existing assistant psychologists are NHS staff well suited to carrying out these brief interventions (Department of Health, 2003). Key interventions are:

- Guided self-help for depression and anxiety based on cognitive-behavioural principles (Bower *et al.*, 2001; NICE, 2004a).
- Computerised cognitive behaviour therapy (NICE, 2006).
- Behavioural activation and other brief protocolised cognitive-behavioural interventions.
- Signposting and facilitating access to local community, voluntary organisation and educational resources which might support people with psychosocial problems (Grant *et al.*, 2000).

These may be carried out as stand-alone brief interventions, or as part of a collaborative care plan in close liaison with the patient's GP (Genischen *et al.*, 2006; Simon *et al.*, 2000). They may be designed on a practice population basis, so that all patients with anxiety and/or depression meeting specific criteria are automatically seen by the worker to discuss brief interventions, or on an individual referral basis.

Applied psychologists can advise PCTs in specifying the roles of PCMHWs, prioritising the brief interventions to be undertaken, allocating workers between practices, and supervising their work. In a number of PCTs, a primary care mental health coordinator, often an applied psychologist, takes on this role for the PCT in addition to developing and coordinating other PCT initiatives in public and primary care mental health.

Examples are:

- A team of PCMHWs providing guided self-help and signposting/facilitation to community resources to practices across the PCT (including, where practices cannot accommodate a worker, the PCMHW seeing the practices' patients in a neighbouring practice), managed by a PCT employed primary care mental health coordinator.
- Developing and implementing a practice protocol whereby all the practice's patients newly identified with depression are seen by the practice PCMHW and offered brief interventions including, if prescribed antidepressants, support with medication adherence.

## Graduate Primary Care Worker projects

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### Two Graduate Primary Care Worker projects

The BME project was conducted by 2 (Psychology) Graduate workers in collaboration with the BME lead of the Trust. Their aims were to increase the awareness of local women in the BME population to the recognition of mental ill health and possible stress triggers. They put the project plan together and made a start on data collection using Focus Groups. However they both moved on to other posts as Graduate Workers do – Trainee Clin Psych and Research Assistant.

The Graduate worker employed by Derwentside PCT led a very successful project in collaboration with local voluntary groups supporting the mental health needs of caregivers. One vital element of the project was to establish an evidence-based caregiver assessment tool as part of standard practice in primary care. Then to link the caregiver to local support networks. This Graduate worker moved to another post in the region but I believe his commitment to the project aims will have moved with him.

Both Graduate Primary Care Mental Health worker projects demonstrated the potential of the role, particularly if the post-holder is supported by training and assessment of project management skills. Neither of the examples given would have been possible within the resources provided by higher level staff in primary care or local trusts Commissioners need to understand that these posts should be enhanced and the concept not allowed to fail through lack of resources. The wastage of quality psychology graduates also needs to be addressed. The newly proposed NWW career structure for Psychological therapists has picked up on this important issue and should include Graduate workers in the career pathway.

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## Service redesign

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### **Service redesign for Primary Care Mental Health around the introduction of new roles**

Over the past two years we have developed a new primary care mental health service based on an innovative multi-professional model. We have been successful in obtaining new investment of approximately £800,000 a year from the Buckinghamshire PCT and Buckinghamshire County Council joint commissioner to establish a multi-professional PCMH service for Buckinghamshire. This originally covered three PCTs which have now merged into one.

The service incorporates the new workforce roles Gateway Worker (GWW), Graduate Mental Health Worker (GMHW), Community Development Worker (CDW) and Support Time and Recovery Workers (ST&R) providing psychological and social interventions and community engagement for people with common mental health difficulties.

The service started in March 2006 and so has been operational for more than a year now, and has had more than 1,400 referrals. All referred have a common assessment from a qualified mental health professional and then are either signposted or provided with a service by the three locality PCMH teams. A range of individual and group programmes have been developed for common mental health difficulties (depression, anxiety, self esteem, stress, etc.). These include guided self help, one-to-one CBT and brief groups (CBT for anxiety, stress, depression and mindfulness based-CBT). We have just started a trial of cCBT at our Healthy Living Center offering a range of cCBT programmes with GMHW support. We have also established an award winning book prescription scheme in local libraries. ST&R workers carry out brief social interventions for people with common mental health difficulties with social needs including housing, benefits, employment and socialisation. The CDWs work with the teams and local communities doing projects to improve access for BME, gypsy and traveller community and homeless people.

We work closely with the local Mental Health Trust and local counselling services with agreed protocols for single assessment and smooth transfer of work. We are developing work with our GP colleagues and expect to produce an internet-based resource pack for them in the next three months to facilitate achievement of QOF and step 1 care for common mental health problems.

The service is managed by an Operational Manager and clinical leadership is provided by the Psychological Therapies Lead, who is a Consultant Clinical Psychologist who supervises all GWWs. Another clinical psychologist working in the service provides supervision for GMHWs. GWWs include trained psychological therapists, counselling psychologists and clinical psychologists from the UK and abroad, but we also have community mental health nurses and an OT. The ST&R workers do not have a formal mental health qualification but have personal experience of mental health. To facilitate the development of the new workforce roles all staff receive regular individual and group supervision and a comprehensive CPD programme.

Two audits have been completed so far which show that the service is accessible and responsive: 95 per cent of referrals accepted for assessment, 80 per cent opt in, 95 per cent attend assessment 67 per cent are offered intervention by the teams and 29 per cent are signposted or referred on usually to community services such as counselling, Relate CAB etc.; only a small percentage need to go to secondary care. We also take 25 per cent of referrals direct from CMHTs which, with our single assessment process, means they can come to us for assessment without waiting or repeating any previous assessments.

**Dr John Pimm**

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## **The Lupina Project: Providing a service to a client group which previously had no access to psychological therapies using psychology graduates as therapists**

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Agoraphobic and panic patients are often severely disadvantaged when it comes to accessing CBT, as many are housebound and highly avoidant. The Lupina Project was set up by a consultant clinical psychologist experienced in working with this client group and was initially funded by the Lupina Foundation (a charitable trust). Owing to its success, it is now commissioned by the local PCT.

The project offers flexible access to cognitive-behavioural therapy (CBT) for patients with chronic panic disorder and agoraphobia. Psychology graduate volunteers are trained in CBT for panic disorder and supervised in groups by a consultant clinical psychologist. Volunteers carry out joint assessments with a clinical psychologist before embarking upon individualised clinical interventions. They offer both to see patients at home and to carry out behavioural experiments in feared situations (e.g. in busy supermarkets).

Initial evaluation of clinical outcomes indicates that, with specific training and supervision by experienced psychologists, psychology graduates working with this client group can achieve better results than routine care on anxiety measures.

Clinical outcomes indicate that 96.2 per cent of those who have completed therapy had significantly improved on measures of the frequency and severity of agoraphobic thinking, depression, generalised anxiety and interpersonal anxiety. 92.5 per cent reported significantly reduced agoraphobic avoidance scores. Patient satisfaction is high, with a dropout rate of approximately 10 per cent, significantly lower than local rates for primary and secondary care psychology referrals. Most of the volunteers go on to train as health care professionals within the NHS.

### **Dr Alison Croft**

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Wherever possible, local systems for providing brief interventions should be linked with local systems for provision of psychological therapies and more intensive interventions so that patients can have timely access to each according to need. This can either be through an initial triage assessment, or through protocols for stepping up from brief interventions to psychological therapy. In triage assessment systems, an applied psychologist or other mental health professional in primary care undertakes an initial assessment and allocates the patient to an appropriate step or tier – brief intervention, brief psychological therapy or longer psychological therapy – as appropriate (Paxton *et al.*, 2000). In protocolised stepped care systems, all patients (with defined exceptions) are initially offered brief interventions and are only stepped up to psychological therapy and more intensive interventions if still needed and wanted after the brief intervention has been completed (Bower & Gilbody, 2005).

### **4.4 Summary**

Primary Care Trusts face a major challenge in responding to the needs of the large numbers of people with common mental health problems such as depression and anxiety. Applied psychologists have developed a range of innovative community interventions outside health settings, approaches to enhancing the psychological management skills of GPs and other primary care staff, and brief supportive interventions deliverable by graduate mental health workers and similar staff, which can assist PCTs in meeting this need.

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## 5. Innovation in delivering psychological therapies

The NICE depression and anxiety guidelines (NICE 2004a, NICE 2004b), following common practice, distinguish three levels of intensity of psychological therapies:

- Brief psychological therapies (6 – 8 sessions).
- Standard research trial length psychological therapies (16 – 20 sessions).
- Longer and specialist psychological therapies.

The increased intensity of psychological therapy is associated with the problems seen, becoming progressively more severe and intractable.

Brief psychological therapies are commonly provided in primary care and standard and longer psychological therapies in secondary care. This division, although it came about more from historical circumstances than by design, has a logical basis. Most people seen for brief psychological therapy receive all their mental health treatment in primary care and hence the key liaison relationship for the treating psychological therapist is with the GP. By contrast, people with more severe problems needing longer psychological interventions are

- more likely to also be seeing other mental health professionals and so require significant liaison in secondary care; and
- more likely to require specialist psychological therapy skills that a generic psychological therapist seeing all cases in primary care would not have.

However, there are advantages to continuity of care rather than passing patients between therapists and organisations when they are found after brief treatment to need more psychological therapy, and much standard length psychological therapy can be equally well delivered in primary as in secondary care if there is appropriate space and premises in primary care.

### 5.1 Brief psychological therapies

NICE guidance for depression recommends brief 6 – 8 session CBT, counselling and problem solving therapy (NICE, 2004a). The majority of brief treatment currently provided in primary care is counselling or eclectic psychological therapy, although some practice counsellors and applied counselling and clinical psychologists in primary care provide CBT. Ideally, those providing brief psychological therapies should be able to provide more than one type as a number of people will benefit from one type of psychological therapy but not another, and usually there is only a single counsellor or psychological therapist in a practice. However, while applied psychologists and some recently trained primary care counsellors have been trained to provide more than one type of psychological therapy, this is not the case for the majority of existing primary care counsellors in post (DH, 2001; Stiles *et al.*, 2006). There is a need for PCTs and practices to audit the training and skills of primary care based psychological therapists and to provide training and supervision to supplement skills where needed. Further discussion as to how New Ways of Working may assist with skills mix and education and training issues, associated with the IAPT workforce is discussed in Section 9.

In some areas, primary care counsellors are organised as a managed service provided by the PCT, local Mental Health Trust or other provider, rather than being employed by or contracted on a self-employed basis to individual practices. Such an arrangement ensures appropriately qualified staff are appointed, and systems are in place for their supervision and professional development, and for implementing service innovations and linking the provision of brief psychological therapies with other psychological and mental health interventions provided locally. The coordinator/manager of many such services is an applied psychologist.

Provision of brief psychological therapies in primary care is usually, and appropriately, conservative – delivering standard brief psychological therapies to individuals. There are a number of innovations developed by applied psychologists and others, which promise to further enhance the efficiency of brief primary care psychological therapy:

- Expert self-help clinics: ultra-brief cognitive behavioural interventions in primary care using self-help materials delivered by well trained applied psychologists and cognitive behaviour therapists (Lovell *et al.*, 2003).

- Two-plus-one interventions: 3 session complete therapies, comprising 2 treatments sessions and one follow-up session a couple of months later (Barkham *et al.*, 1999).
- Client determined treatment length: allowing patients to determine when to be seen, which leads to reduced treatment length (Carey & Mullan, 2007).
- Intermittent treatment: allowing patients to drop in on an 'as needed' basis rather than having a prescribed number of treatment sessions (Cape & Millar, 2006).

## 5.2 Standard research trial length psychological therapies

Sixteen to twenty session psychological therapies are those for which there is the largest evidence base, as research trials of psychological therapy have generally been of this length. They are Type C psychological therapies in the nomenclature of the Department of Health Psychotherapy Review (1996), following protocols of specific types of therapy in contrast to the eclectic Type B psychological therapies common in brief psychological therapies in primary care. The training of applied psychologists in psychological therapies follows such Type C evidence-based protocols.

There are two general approaches to the design of services for the provision of standard length psychological therapies, each with their advantages and disadvantages:

- Locality based services: allocating applied psychologists and other psychological therapists on a locality basis, linked with other locality based mental health services, has advantages in terms of better liaison with and responsiveness to local GP practices and needs and in terms of improved joint work with other mental health services. It also allows for the possibility of vertical integration whereby the locality based practitioner provides both brief and standard length psychological therapies, linked with local GP practices, allowing continuity of care when people need to be stepped up.
- Centrally organised services: concentrating psychological therapy resources in a central pool allows patients to be matched to the most suitable type of psychological therapy. It can also allow the patient choice of therapist (by gender, age, ethnicity) and type of treatment. Group treatments are also easier to organise: there is both sufficient throughput to collect together enough appropriate people for specific types of a group and a resource base of skills between therapists to run groups of different types.

Key to designing psychological therapy services is finding ways to combine elements of locality and centralised approaches to maximise advantages and minimise disadvantages of each.

The evidence base for group psychological therapies is limited compared to individual psychological therapies, but the available evidence suggests that group approaches are often as effective as individual treatment (McDermut *et al.*, 2001). The efficiencies of group approaches for standard and more intensive treatments are self-evident, but are often not sufficiently exploited.

## 5.3 Longer and specialist psychological therapies

Key mental health problems requiring longer and specialist psychological therapies are:

- Intractable depression and anxiety (unresponsive to medication and standard length psychological therapies);
- Personality disorders;
- Schizophrenia and bipolar disorder.

Specialist knowledge and skills are required for these problems, both understanding the nature of these disorders and competence in the provision of the appropriate specialist psychological therapy. In addition, staff providing psychological therapies for these problems need to have understanding of and experience in working in the complex multiprofessional and multiagency mental health services where these groups are receiving treatment. Concomitant specialist medication management, enhanced care coordination and management of risk and episodic mental health crises are the norm in treating such problems. In view of the range and depth of skills and experience required, applied psychologists are the most common staff group providing such longer and specialist psychological therapies in the NHS.

There is emerging evidence that specialist psychological therapy provision – treating sufficient numbers of people with specific problems in the appropriate specialist psychological therapy – can improve clinical outcomes in the same way as specialist surgical and medical interventions. This is likely to be a

function of both the skill acquired by the individual clinician and the quality management processes in the specialist service. Innovative specialist services of this kind are:

- Services providing dialectical behaviour therapy for severely self-harming patients.
- Intractable depression clinics where skilled CBT from applied psychologists and skilled medication management from psychiatrists is brought together in a common clinic.

In addition to the provision of specific interventions, as illustrated above, psychological therapy services require the organisation and management sufficient to provide effective training, supervision, governance and audit/evaluation functions. These are discussed in Section 10.

#### **5.4 Summary**

Staff providing psychological therapies in primary care need to be trained and supported in delivering the evidence-based psychological therapies which are most effective and efficient for commonly presenting problems. For people with more complex or more intractable problems, there should be easy routes of access between primary and secondary care to ensure that these individuals receive more specialist psychological therapies, and with greater continuity.

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## 6. Clinical governance: Risk and the management of psychological therapies

The escalating demand for psychological therapies backed by the growing evidence-base, NICE guidelines, the user movement and Government health policy provides applied psychologists with unprecedented opportunities to influence service provision. However, the speed of growth and the sudden development of psychological therapy skills amongst other professional groups present challenges to trusts in managing risk and clinical governance.

Many commissioners and managers are not fully aware of the governance implications of the lack of statutory regulation for psychological therapists. There are a range of bodies that accredit different forms of therapy or different professional groups but many people practice therapy who do not necessarily belong to these organisations. Similarly, many staff claim to be practising 'counselling' or 'CBT' who have not acquired sufficient formal training or supervision to do so.

At the moment most trusts will accept that clinical and counselling psychologists are experts and are qualified. However, with respect to Type C psychotherapies, identified within the Department of Health Psychotherapy Review (DH, 1996), this is not the case unless psychologists have gone on to do further training. In the future, clinical and counselling psychology training courses may need to define more clearly the competencies in psychological therapies that their graduates possess, and also if possible link them to accreditation in at least one therapeutic approach. Nevertheless, the British Psychological Society has recently agreed that the training made available nationally to clinical and counselling psychologists, does meet the sufficient standard for graduates to be provisionally registered on the BPS's post-qualification Register in Psychologists Specialising in Psychotherapy. Registrants who are provisionally registered will be able to achieve full membership after a minimum of two years if they have acquired and been assessed in the appropriate CPD and supervision experience.

### 6.1. Applied Psychologists Contribution to Managing Risk

Trusts are increasingly aware of their liability in terms of effective interventions. The lack of funding for NICE recommended medicines escalates them up the risk register. The increasing litigiousness of service users means it is only a matter of time before someone sues a trust for failure to provide a recommended psychological intervention. The growth of Foundation Trusts with an eye to the market, and Commissioners with an eye on effectiveness and outcomes, means that the potential risk to trusts of not delivering NICE guidance recommendations is becoming ever important. Unfortunately, many mental health staff may be providing counselling or 'support' with no proven benefit or informed by an appropriate evidence-base, to people who may not benefit, whilst other patients do not receive the appropriate services for their needs.

Applied Psychologists are best placed to have an overview of knowledge about effective psychological interventions, and to lead and champion their development. Trusts ensure their safety by having governance systems in place that demonstrate the 'processes' to deliver safe and effective services. Applied psychologists currently have the most credibility to lead those systems. Their input is key to ensuring good governance at every level of service provision.

1. **Direct clinical work:** Promoting the psychological model: Applied psychologists need to demonstrate clinical credibility through role modelling direct clinical work. In addition, psychologists need to share their knowledge of a wide range of psychological therapies and how they might be governed with other staff. Similarly, other professional groups may acquire the knowledge of a psychological therapy without acquiring a truly psychological model. Such models stress individual formulation, attention to complexity and the ability to flexibly apply psychological theories to clinical problems. From newly qualified staff onwards, this is the role of all applied psychologists.
2. **Governance of psychological therapists:** The governance of psychological therapies is not profession bound. Any member of any professional group can be trained in a psychological therapy. Professional leadership is separate to governance of psychological therapies. All Trusts should have a multi-disciplinary, multi-model Psychological Therapies Advisory Group (or equivalent) chaired usually by an applied psychologist (see DH, 2004a) whose role is to manage governance of anybody regardless of professional group who is delivering a psychological therapy.

3. **NICE/NSF guidance's:** Part of the remit of the above should be to make recommendations as to best practice based upon interpretations of NICE guidance's and national strategy.
4. **Management: At Management team/Board level:** The DH document highlights the need for strong and effective leadership of those who provide psychological therapies and it outlines the structures to facilitate that. As illustrated in Section 2, applied psychologists should have a senior position at Trust Board or equivalent level in raising the profile of psychological therapists and ensuring their governance. Any trust which develops psychological therapy provision without this is putting themselves at risk.
5. **At Team level:** To ensure good governance the recommended model is psychological therapy teams. Within these it is possible to offer a range of therapy approaches contained within strong supervision structures and pathways (supported by case management) that enable the allocation of clients according to complexity to the most appropriately skilled staff member. This enables Trusts to employ lower banded/skilled staff within a mixed skill framework led and supervised by applied psychologists and others, who provide supervision, consultation as well as seeing the more complex cases. Further information on applied psychologists and team working is provided elsewhere within the NWW AP report.
6. **Supervision:** It is not enough simply to increase numbers of trained staff; they need supervision to enable them to practice effectively. Applied psychologists should be developing their roles not only in direct provision of supervision for other staff, but in leading policy development and standards for supervision of psychological therapies. Further information on clinical leadership and supervision is provided elsewhere within the NWW AP report.
7. **Case management:** The psychologists role in teams gives the opportunity to case-manage and supervise other staff to ensure that cases are appropriately managed.
8. **Audit:** Applied psychologists have skills in research which make them eminently well placed to lead audit and the development of outcome measures. They should be leading by example by opening their own practice up to scrutiny via audit, and leading the development of audit systems and tools for other professions. Audit needs to focus on both process and outcomes, but should also address issues of access and particular equality issues including the specific needs of Black Minority Ethnic communities. An example of an audit tool is provided below.
9. **Performance monitoring via outcomes and targets:** Applied Psychologists are frequently more knowledgeable due to their doctoral training than other professional group in terms of their understanding of research/outcomes/audit and measurability. The movement amongst trusts and commissioners towards the development of outcome measures and performance management gives a key role for psychologists in leading this development. As discussed in the next section, applied psychologists can make a significant contribution to the development of outcome measures for psychological therapies, and in defining who is qualified to deliver a psychological therapy.
10. **Targets:** These have been based largely on face-to-face contacts. NWW AP gives an opportunity to introduce more meaningful indicators since it has emphasized that consultant psychologists should possess higher level skills of supervision, training and consultation. It is essential, therefore that future indicators or targets should reflect these activities. These should also be applicable for other staff groups who deliver psychological interventions. This development should be an urgent priority so that they are available for trusts' performance management teams and to commissioners.
11. **Training: External:** Applied psychologists have a key role in provision of training to ensure governance of psychological therapies. Psychologists should be proactive in developing and expanding accredited courses in psychological therapies (see section 9), in conjunction with other staff, local universities and SHAs. But crucial to this, is the provision of organisational commitment to systems that ensure ongoing supervision for staff that complete these courses.
12. **Training: Internal:** There is an ongoing need for internal training, both to local health courses and to local staff both in primary and secondary care. Such local training initiatives should embrace foundation courses into psychological approaches and awareness for all primary and secondary care staff (see Section 2) through to more specialised courses for trained staff around specific psychological models and formulation.

**Robina Barry**

*Director of Psychological Services*

*South Staffordshire Healthcare Foundation*

## Clinical governance and audit of psychological therapy sessions and case notes

**Service:** Clinical Psychology Service

**Area:** South Staffordshire Healthcare Trust

**E-mail:** *robina.barry@ssh-tr.nhs.uk*

### Peer Review Audit Checklist

Clinician:

Client number:

Date:

**The audit group should consider the following points in discussion with the psychologist(s) responsible for the care of the identified patient.**

Is there evidence of a clear description of the purpose of the involvement

Is there evidence that the service user has been offered choice (e.g. appointment time, therapeutic approach)

Is there evidence of appropriate assessment relating to the purpose

Is there evidence of a psychological problem formulation

Is there evidence of the model used to inform practice

Is there evidence that the intervention is consistent with the formulation

Is there evidence that the approach has been discussed and agreed with relevant parties including referred person if capable

**N.B. This should include liaison with appropriate parties. Every effort should be made to include the referred person and a record made where not possible**

Is there evidence that the notes reflect the progress of the agreed intended intervention

Is there evidence in the notes of the rationale of any significant changes in the intervention

Is there a good reason for the psychologist to still be involved with this person?

**Discussion point:**

Are there any alternative approaches which the peer review group think might have been considered?

**Dr Robina Barry**

*Director of Psychological Services*

*South Staffordshire Healthcare Foundation*

## **7 The contribution of Applied Psychologists to building both evidence-based practice and practice-based evidence**

### **7.1 Evidence-based practice in psychology (EBPP)**

Evidence-based practice in psychology has been defined as ‘the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences’ (APA, 2006). In this context, the origin of EBPP is with the patient and asks what research evidence – from evidence-based practice via trials data and from practice-based evidence via routinely collected data – will support the psychologist in their endeavours. Hence, the term is broad and inclusive. In this context, applied psychologists have a central role in designing, implementing, and disseminating evidence focusing on access to psychological therapies and their effectiveness in routine service delivery settings and, crucially, relating this evidence to findings obtained from (a) traditional efficacy trials (i.e., explanatory trials) focusing on how and why a treatment approach works and (b) practical clinical trials (i.e., pragmatic trials) where the focus is on acquiring information needed to make service delivery decisions (Tunis, Stryer, & Clancy, 2003). Adopting this broad base approach will enable applied psychologists to identify where differences in evidence exist and, crucially, use this information to help inform future clinical guidelines.

In mapping out any available evidence, it is important to note that the absence of evidence in relation to an intervention or component of treatment is not synonymous with evidence for the ineffectiveness of such interventions or components: they are simply untested. However, applied psychologists have an important role in implementing procedures that will help secure such evidence in the future using appropriate research methodologies to achieve this objective.

### **7.2 Need for mixed methods and a pluralistic approach**

A single research methodology cannot build a science of the psychological therapies. The diversity of human nature requires diverse research designs but they need to be both rigorous and relevant to the question being asked. Research evidence might derive from clinical observation, qualitative research, systematic case studies, single case experimental designs, process-outcome studies, effectiveness research (i.e., interventions as delivered in naturalistic settings), and efficacy research (i.e., randomised controlled trials). Applied psychologists are uniquely placed in being able to give advice on the value of a mixed methods approach.

Although primary emphasis is currently placed on data focusing on treatment efficacy (i.e., does a treatment work), there is an increasing need for an equivalent focus on clinical utility (i.e., the applicability, feasibility and usefulness of the intervention in the settings in which it is to be offered). Hence information is required on areas such as:

- Generalisability of effects across differing and diverse client groups, practitioners, and clinical settings.
- Feasibility of delivering the interventions in everyday routine settings.
- Costs associated with delivering the interventions.

### **7.3 Building an evidence base where it is currently lacking**

A number of research areas have been identified for priority attention where available evidence is lacking in relation to the psychological therapies (APA, 2006). Examples include the following:

- Generalisability and transportability of interventions shown to be efficacious in controlled research settings.
- Efficacy and effectiveness of interventions with underrepresented client groups.
- Distinguishing common and specific factors involved as mechanisms of change.
- Effectiveness of psychological interventions that are widely practiced and based on integrative models for which there is no current evidence from controlled trials.
- Describing the practice of practitioners who yield consistently very good outcomes.
- Development and testing of practice research networks.
- Effects of feedback on treatment progress.

### **7.4 Incorporating practitioners, clients, and the therapeutic relationship**

Guideline development has traditionally been build around client diagnosis and treatment approach. Efforts need to be expended in collecting and incorporating data relating to practitioners themselves, patient characteristics, and the therapeutic relationship (Norcross, 2002). For example, the contribution

to outcomes of practitioners is an area of central importance and emerging evidence of the variation amongst practitioners identifies this as a subject requiring attention in the collection of data from trials and routine practice. Crucially, data is required that is drawn from large samples of practitioners. Similarly, although clients are often identified as a single entity in terms of diagnosis, in other respects there is considerable variability and data needs to be collected to reflect this diversity. Finally, the central role played by relationship factors between clients and practitioners requires systematic data collection. For example, data is needed on components of 'empirically support therapy relationships' (e.g., the alliance, goal consensus and collaboration) in order to build on and extend the existing evidence base in this area and ensure it is viewed as being equally important along side evidence regarding specific therapeutic techniques (Norcross, 2002).

### **7.5 Collecting data for practice-based evidence**

In routine NHS settings, building a relevant and robust evidence-base can be progressed through the systematic adoption of measurement systems (e.g., CORE System: Mellor-Clark & Barkham, 2006; IAPT Outcomes Framework: MHChoice, 2007). The introduction and maintenance of effective measurement systems needs to be conceived as an organisational intervention which will change the culture of the service and requires the following:

- Clear leadership from management
- Identifying a champion(s) for the implementation and involving key stakeholders
- Clear process of consultation aimed at developing a 'bottom-up' approach to the adoption of measurement
- Practitioners having a sense of ownership in the process, implementation, and yield
- Prioritising the process of measurement implementation over that of the specific choice of measure(s)

Four levels can be identified in rolling out an outcomes or measurement system (NIMHE, 2005): (1) measurement, (2) monitoring, (3) management, and (4) benchmarking.

### **7.6 Measurement**

Requirements at this level include IT software to support data entry, feedback as well as networking within the service. Staff should be trained in how best to engage clients in the endeavour of contributing data systematically in order to convey a culture in which data collection is accepted and valued because it underpins the effort to obtain complete data sets as possible – that is, the complete caseload for all practitioners. Clear leadership is crucial enabling staff to own the process and gain from the subsequent yield.

### **7.7 Monitoring**

The resources required for monitoring comprise the analysis of data and the development of feedback reports. Monitoring can occur at multiple levels:

- Overall service level – service managers can monitor waiting times, intake profiles of clients, throughput, the duration of psychological therapy, and outcomes for their service as a whole as well as for individual practitioners
- Supervisor and individual practitioner level – where access is only available to their own clients
- Individual client level – by using session-by-session measurement which forms part of a tracking system to provide feedback as to whether a client's progress is 'on track' and signal for action to be taken if the client is not 'on track'.

For effective monitoring to occur, there needs to be additional rich contextual information and awareness of the need to adjust for case-mix.

### **7.8 Management**

Management involves changing aspects of service delivery in light of accumulated evidence from routine practice. The more complete and rich the data, the better the evidence-base for implementing change.

### **7.9 Benchmarking**

Benchmarking can be carried out *either* within a service or *between* services, or both and its primary objective is to drive up quality. Comparisons within services address issues focusing on the diversity of

outcomes in a single service and understanding the reasons for such variance. Comparisons between services address issues focusing on relative effectiveness – that is, does service A broadly match service B? Greater stability will be achieved by benchmarking against data which is pooled or aggregated from multiple and similar services – that is, data which might be deemed to be nationally representative.

### **7.10 Future guidelines**

The effectiveness and impact of NICE guidance is under review (House of Commons Health Committee, 2007). Future guidelines would benefit from considering evidence derived from practice clinical trials as well as explanatory clinical trials together with evidence focusing on access and delivery of services in routine settings including the contribution of practitioners, clients, and a range of common factors. The yield will be clinical guidelines which are based on a robust and relevant evidence-base and yet allow for the necessary flexibility regarding the selection of treatment choice.

### **7.11 Summary and conclusions**

Applied psychologists have a key role in advocating, supporting, and implementing the building of robust and relevant evidence bases for the psychological therapies, particularly in routine service settings. In particular, they can help ensure that methods and systems exist for the collation of quality data from routine service settings that tap the complex nature of delivering psychological interventions. The benefits of such an approach will be the availability of more representative data regarding health care decisions that can then be reflected in future guidelines on accessing and delivering psychological therapies.

### **Michael Barkham**

*Until 31 August 2007*

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## **8. Implications for the psychology workforce: New roles, education and training, career pathways and roles of consultant psychologists**

Many of the workforce challenges facing both applied psychologists and other professions involved with the delivery of psychological therapies, are being addressed through the New Ways of Working projects for mental health (2005; 2007a,b). Generally, these reports describe how new roles, new responsibilities, more flexible working, new opportunities for training in order to broaden competencies in psychological therapies, and an overarching career framework for all staff contributing to the delivery of psychological therapy services, might all contribute to enhancing the capacity and capability of the primary and secondary care workforce around mental health and IAPT. An overview of the issues has been recently published (Turpin *et al.*, 2006) and included discussion of the following: estimating 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 Guide to workforce and training issues as part of the guidance provided to the new Pathfinder sites (MHChoice, 2007). Rather than revisiting these issues, we will focus instead on the specific challenges for the applied psychology workforce and how the work of the New Ways of Working in Applied Psychology project may help resolve them.

### **8.1 Building capacity**

Various independent estimates of the required IAPT workforce derived from Lord Layard's hypothesis, highlight the shortfall in existing therapists and the need for future investment to increase the numbers of therapists (Glover *et al.*, 2007; Boardman & Parsonage, 2007). This is also consistent with the BPS's own workforce analysis (BPS, DH & HO, 2005; Lavender & Paxton, 2004). However, the critical question is what type of therapist and which competencies are required? Moreover, although new investment will be necessary if the demand for IAPT is to be effectively met, there is still the question as to how the existing workforce might be redeployed in redesigning services, which might more effectively tackle the traditional long waiting lists and inequalities associated with referral to psychological therapies. A major development in attempting to meet demand is the introduction of stepped care models of service delivery (see section 1). Rather than relying on one-to-one therapist contact, these models identify a range of therapeutic interventions that vary along a continuum, which reflects intensity of treatment, length of treatment and the skills and competences of the therapist required to deliver the appropriate interventions.

In particular, it is suggested that capacity might be increased significantly by training graduate workers and others, including the voluntary sector, to provide a range of services such as cCBT, supported self-help, bibliotherapy, case management, medication management and collaborative care, brief CBT interventions such as behavioural activation (see section 4), particularly around steps 2 and 3 of the model. Support and expertise around employment and return to work, and social inclusion will also be required. These interventions are characterised as being relatively brief, requiring less intensively trained therapists, and hence ought to be able to increase access through what has been characterised as high volume and low intensity interventions (Turpin *et al.*, 2006). It is envisaged that these therapies will be provided by a range of workers employed around AfC Bands 4–6 and may include psychology assistants, graduate workers in primary care, or case managers such as those developed at the Doncaster Demonstration site. Through the work of the New Roles group of NWW AP, a significant development in the career structure of applied psychologists has been identified which is the expansion and formal training of psychology graduates to fulfil these and other related roles. It is envisaged the role of the psychology assistant or associate would become a tier of psychological delivery in its own right but under the management and supervision of qualified psychologists. This will require training programmes for psychology assistants and senior assistants/ associates, to enable them to take on the roles of the low intensity practitioners envisaged in the IAPT programme. Good practice exemplars of such schemes are the psychology Associate project in the North East or the Gloucester CBT training for PCMHGWs. In addition, the Training Models group of NWW AP have identified a range of training models which might support the development of these new roles. It will be important for existing providers of applied psychology training to consider how new training courses might be developed that are aimed at psychology assistants and to consider ways of crediting such trainings through APL or APEL within doctoral training for those assistants who chose to progress their careers through this route.

## Training staff in CBT

**Service:** The Primary Care Assessment and Treatment Team

**Area:** Gloucester

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The Primary Care Assessment and Treatment Team (PCATT), formerly known as the Primary Mental Health Service, offers mental health services to the majority of the 85 GP surgeries located in Gloucestershire. Interventions are offered using a stepped care approach, where a patient ideally starts at the least intensive intervention, stepping up only in accordance to patient need. Following NICE Guidelines, treatment choice is CBT at Steps 1, 2 and 3 of Stepped Care Model. At Step 1 we offer CBT Books on Prescription, information, education and training to Primary Health Care staff. At Step 2 we offer telephone guided self help (T-CBT) for anxiety and depression, Stress Management Courses in local colleges and CCBT (Beating the Blues).

For 'moderate' presentations, at Step 3 we have trained 12 Graduate Mental Health Workers in core CBT skills. The Foundation course was funded by Skills for Health and Wyeth Pharmaceuticals and trained a total of 24 practitioners in core CBT skills. The Oxford Cognitive Therapy Centre (OCTC) was commissioned to deliver the course and evaluate trainee competence. Through the training GMHW are able to provide more intensive CBT to patient's experiencing common mental health problems, primarily delivered over the telephone or face to face, between 8 and 18 weeks. Two further Foundation Courses are scheduled to start in April and October 2007, training a total of 72 staff in core CBT skills. CBT Master Classes are scheduled on CBT for specific disorders from May onwards.

Evaluation methods included tape recordings of work at the beginning and end of course rated blind by Expert CBT therapists using the Cognitive Therapy Scale (CTS), and a Case Report. The impact of the course on competence was impressive with improvement across all domains, and significant improvement in use of behavioural and cognitive techniques, guided discovery and the setting of homework.

The course has greatly improved access to Psychological Therapies. Each Graduate Mental Health Worker has an average case load of 16 patients for an average of 12 sessions, thereby greatly increasing the potential of patients having access to CBT who otherwise would not. Clinical effectiveness is good as measured by CORE and patient satisfaction high. Their enthusiasm, ambition to develop themselves and adherence to protocol makes them a fabulous group of staff who offer a pragmatic solution to the thorny issue of improving access to psychological therapy.

As a Clinical Psychologist, my role has been to train, supervise and provide protocol and operational policy guidance to the work of the GMHWs. Our greatest challenge is to retain this workforce through appropriate recognition of their contribution as skilled practitioners, with proven competency in CBT, making an enormously valuable contribution across stepped care by improving access and reducing referrals to secondary care. A more apt and descriptive job title and a career pathway are urgently required. Clinical Psychologists and other Senior Psychological therapists have a critical role in the training and supervision and role development of this new workforce.

**Alison Sedwick Taylor**

*Consultant Clinical Psychologist/Cognitive Therapist*

### 8.2 Competent therapists

IAPT services will also require competent and qualified psychological therapists who are able to deliver evidence based therapies, particularly CBT at levels 3 to 5 within the stepped care model. We envisage that many qualified clinical and counselling psychologists will deliver these therapies, especially within the early stages of their careers. However, it will be important that training criteria and assessment procedures on doctoral programmes within the future will have a far greater transparency as to the psychological therapy competences that graduates possess following the completion of their courses. It

will be necessary for some applied psychology graduates to undertake further training in more specialist psychological therapies in order to provide the range and depth of therapeutic skills required. The work of the Careers group of NWW AP should inform the nature of career progression particularly for newly qualified staff and their role and contribution to IAPT services. The British Psychological Society may have a role in accrediting and organising further specialist trainings in psychological therapies which might be incorporated in the professions CPD programme and would supplement registration on the post-qualification Register of Psychologists Specialising in Psychotherapy. It should be emphasised, that as well as providing therapeutic skills, applied psychologists should also contribute to the development and functioning of teams as recommended by the Teams working group of NWW AP.

### **Maximising access to trauma focused-psychological therapies for post-traumatic stress disorders (PTSD) sufferers**

**Service:** Traumatic Stress Service, University Hospital of Wales, Cardiff

**Area:** Cardiff & Vale, NHS Trust, Wales

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Due to the high demand for evidenced based trauma focused psychological therapies for individuals suffering from traumatic stress symptoms to our NHS traumatic stress department. We have piloted a brief group training/clinical supervision programme for mental health professionals in prolonged exposure (CBT) for treating PTSD. Trainees have included psychologists, mental health nurses, GP's, midwives (with counselling training), dentists (with CBT training) and junior psychiatrists on SHO rotation scheme.

Following 6–8 weekly 1.5 hours group training (4-6 individuals), which includes psycho-education, role-play, instruction in prolonged exposure manuals including video clip role plays, and relevant journal articles on CBT for PTSD. Trainees are encouraged to take on an individual PTSD sufferer from the single trauma waiting list, for weekly TF-CBT, and access group clinical supervision weekly for 1.5 hours with an experienced psychotherapist experienced in CBT.

Following a practice based audit of the trainees case notes and pre and post clinical self-report measures for traumatic stress and depression. Our trainees successfully reduce traumatic stress symptoms to sub-clinical levels and depression from moderate to mild. This training is well received and valued by the trainees and filters into their other areas of work.

The benefit for the Cardiff and Vale NHS traumatic stress department is our single trauma waiting list is approximately only four months for TF-CBT from referral. There is an obvious cost saving running small group training/clinical supervision. Once trainees have completed therapy with their PTSD sufferer, they become absorbed into our local psycho-social disaster plan as trauma counsellors, capable of delivering an early intervention TF-CBT following a major disaster in our locality.

**Neil J. Kitchiner**

*Cognitive and Behavioural Psychotherapist and Honary Teaching Associate,*

*Department of Liaison Psychiatry & Traumatic Stress Studies, Cardiff & Vale NHS Trust*

### **8.3 Safe and effective psychological therapy services**

Many sections of this guide have stressed the importance of roles and contributions by psychologists to the organisation and management of psychological therapy services which falls outside the remit of direct therapeutic engagement with service users. These pertain to supervision and training other staff, clinical governance and management, research and development, clinical leadership and service innovation. Although not exclusively, we believe that consultant applied psychologists through their doctoral training and subsequent training via CPD, possess many of these skills and as recommended by the DH (2004a), and ought to be in a position to lead and innovate psychological therapy teams and services. Psychologists have experience of supervising psychology assistants, graduate workers, trainee psychologists and qualified staff from a variety of backgrounds. Their broad knowledge of different levels and modalities of

psychological therapies place them in a good position to offer training and supervision. The exemplar from Cardiff illustrates how psychologists through supervising other qualified staff have established a PTSD clinic whereby staff are trained and supervised, and a clinical service delivered but at the expense of limited sessions of an experienced psychologist. Again the NWW AP Careers group, together with the work around improving and consolidating the role of the National Assessors in consultant psychologist appointments, should help applied psychologists realise their potential in these respects.

#### 8.4 Summary

We believe that the work of the NWW AP project provides some of the critical components for the delivery of a flexible and effective IAPT workforce. In particular, the provision of formal training and a career framework for psychology assistants, together with clearer roles for both newly qualified and consultant psychologists ought to ensure that the psychology workforce has both the capacity and capabilities to help services deliver effective and accessible psychological therapy services. A possible career framework for staff delivering psychological therapy services has been proposed by the NWW AP IAPT subgroup and is illustrated in Figure 4.

**Graham Turpin & Roslyn Hope**

*IAPT Workforce Team, CSIP*

Figure 4: A possible career structure for psychologists and other practitioners working into IAPT

KSF Band	IAPT Career Structure	Psychology Career Structure	COMMENTS
9	HEAD OF SERVICE Tension between increased specialisation with more complex cases vs more general responsibilities: leadership/management/governance	HEAD OF SERVICE Tension between increased specialisation with more complex cases vs more general responsibilities: leadership/management/governance	
8c/8d	CONSULTANT THERAPIST Leadership key at this level Specialist/trainer/supervisor	CONSULTANT PSYCHOLOGIST Leadership key at this level Specialist/trainer/supervisor	Further specialised psychotherapy/ leadership training may be required
8b/8a	EXPERIENCED THERAPIST/ SUPERVISION Supervisor	EXPERIENCED PSYCHOLOGIST/ SUPERVISOR Supervisor	Supervisor training required
7	QUALIFIED THERAPIST/ PSYCHOTHERAPIST Therapist/ Practitioner	NEWLY QUALIFIED PSYCHOLOGIST Therapist/ Practitioner	Accreditation/regulation required at this level
6	TRAINEE THERAPIST (Probably existing professional) P/g diploma/masters	TRAINEE PSYCHOLOGIST Working towards doctorate	Some form of regulation required for all workers supporting psychological therapists
	SENIOR Low Intensity WORKER KSF/ P/g diploma	SENIOR ASSISTANT/ASSOCIATE KSF/ P/g diploma	Sustains career progression
5	QUALIFIED Low Intensity WORKER  P/G certificate or EQUIVALENT	PSYCHOLOGY ASSOCIATES/ ASSISTANT  P/G certificate	Relate therapist or similar person from voluntary sector  Nongraduates?
4	Low Intensity TRAINEE Degree/ PG CERT	TRAINEE ASSISTANT Degree	Nongraduates?
1-3	STR Recovery worker and other staff NVOs	Undergraduate volunteers (unpaid)	Nongraduates Training in psychological awareness

## 9. Commissioning advice: Ensuring added value to IAPT services through the involvement of applied psychologists

Consultant psychologists are able to assist Commissioners working in partnership to deliver IAPT due to their knowledge of service delivery systems and breadth of understanding of types of psychological therapies and range of presenting clients. Psychologists in leadership positions can deliver appropriate governance frameworks and advise commissioners on quality assurance. They can be used to develop care pathways and to advise on appropriate needs assessments, assessment tools, and interventions. Where appropriate Commissioners should consider seconding an applied psychologist to advise on commissioning frameworks and bids.

Service provision should be based on an assessment of local population needs to inform levels of service provision and needs to be co-ordinated to provide choice, be socially inclusive, and respect the diversity of the population. Psychologists working with Public Health Departments can help identify specific priorities for Practice Based Commissioners (PBC) based on indices of social deprivation etc. They can also help define care pathways, particularly when clients present with complex problems, and ensure that an appropriate range of services is available to meet the needs of the local health community. Psychologists are well placed to advise particularly around transitions between services either due to age or disorder (physical vs mental health needs) due to their generic training across all major NHS care groups.

The location of services is also an important consideration and PBCs will require advice on how services can be delivered locally and in the least stigmatising settings. Commissioning decisions should focus on outcomes rather than process and in particular, services need to be able to demonstrate acceptability, accessibility, equity, effectiveness, efficiency, and safety. Further information on an IAPT outcomes framework which has been developed for the Pathfinder Sites is now available (MHChoice, 2007).

Involvement of service users and carers in service design, delivery and evaluation to facilitate better access to a wider range of psychological therapies is critical in achieving appropriate outcomes. Psychologists have good experience liaising and facilitating the participation of carers and service users in service design (Hayward & Harding, 2006; Hayward *et al.*, 2006).

Commissioners will need to develop a clear understanding of how service users and stakeholders are engaged in an organisation's work, and explore how these mechanisms could add value to the contract, or other services and try and avoid fragmentation of services which may well have an adverse effect on the care pathway delivery for patients.

Commissioners should utilise consultant applied psychologists more fully, especially those who can think and operate psychologically at a strategic level and apply this skill across new larger health trusts. This implies the need for leadership to be clinically responsive and meaningful at a local level. Psychologists who are trained to work with a range of care groups, physical and mental health problems, and clients of all ages, are well placed to offer leadership and advice especially around specialist services (e.g. learning disabilities, neuro-psychology) that might be commissioned by groups of practices. Similarly, psychologists traditionally have good knowledge of secondary care services and can help PCTs consider how services can be better integrated and also target the needs of clients seen in primary care with more complex disorders (i.e. personality disorder, bipolar disorder and psychosis). Such clients present significant risk issues for primary care staff and psychologists can assist in providing supervision and governance frameworks. This is particularly important where a plurality of provision is being employed (i.e. Independent/Third/voluntary sectors) and commissioners require advice around the governance of these services and whether they are safe, and also provide value for money and are fit for purpose.

Clinical Leadership is defined as '*facilitating evidenced-based practice and improved patient outcomes through local care*' (Millward & Bryan, 2005). This type of leadership (i.e. influencing others) is independent of the person's position within an organisation. The development of front-line, 'clinical leadership' capacity and capability is considered critical in the development of integrated teamwork, that is reflective and actively manages team processes to improve effectiveness (Millward & Bryan, 2005). The role of applied psychologists will be critical in achieving these aims and can improve team effectiveness and staff satisfaction.

Major stakeholders will need to be provided with clear guidance on the commissioning process, including the design of commissioning pathways, which are easy to follow and which will ensure fair play across all sectors of provision. Commissioners are encouraged to work in partnership with providers to facilitate best practise. Commissioners are also encouraged to consider seconding experience consultant psychologists to offer advice in the development of appropriate commissioning frameworks and service delivery.

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Tees, Esk and Wear Valleys NHS Trust

**Claire Maguire**

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## 10. Overview

We have sought to describe and emphasize the contributions that applied psychologists have made to the development and provision of psychological therapy services. Whilst this review has been conducted under the auspices of New Ways of Working in Applied Psychology, many of the innovations and positive practice exemplars have arisen from a long tradition of psychologists, particularly clinical psychologists, in contributing to service innovation and redesign. In this final section we would like to re-iterate some of these points but also discuss the impact of the development of the IAPT programme on the applied psychologists more generally, and particularly for those delivering psychological interventions outside of traditional psychological therapies and to other care groups.

### 10.1 Psychologists role in innovation and service development

Psychologists have contributed significantly to the evidence base upon which many of the NICE guidelines have been based upon. Indeed, the BPS through its own sponsored Centre for Outcomes, Research and Effectiveness (CORE) has led to the production of clinical guidelines through NICE within the areas of mental health, and also through its own Briefing Papers and Good Practice guides throughout mental and physical health care across the range of client groups. In addition to contributing to both fundamental and applied research that has led to recognition of the effectiveness of psychological therapies, applied psychologists have also been engaged in issues of service delivery and redesign as exemplified by stepped care and care pathways development (see sections 3–7). Clearly the contribution of applied psychology is not exclusive and that many other professions including psychiatry (e.g. Bower & Gilbody, 2005) and nursing (e.g. Richards *et al.*, 2006) have all made significant contributions. Nevertheless, we believe that psychologists through their training at both undergraduate and doctoral levels, have the necessary skills, in addition to direct therapeutic competences, which result potentially in service innovation and clinical leadership, if appropriately supported and developed within the services in which they are deployed. The IAPT programme will need to be dynamic and responsive to ensure that future advances in psychological therapies are exploited to the full and that services do not stagnate based upon the Randomised Control Trials and clinical guidelines of yester year. Evidence based practice and practice based evidence (see section 8) as promoted by applied psychologists have a critical roles to fulfil in the future development of services. For commissioners, applied psychologists ought to be able to identify the outcomes necessary to improve the lives of service users; for providers, applied psychologists ought to ensure that services are innovative and competitive.

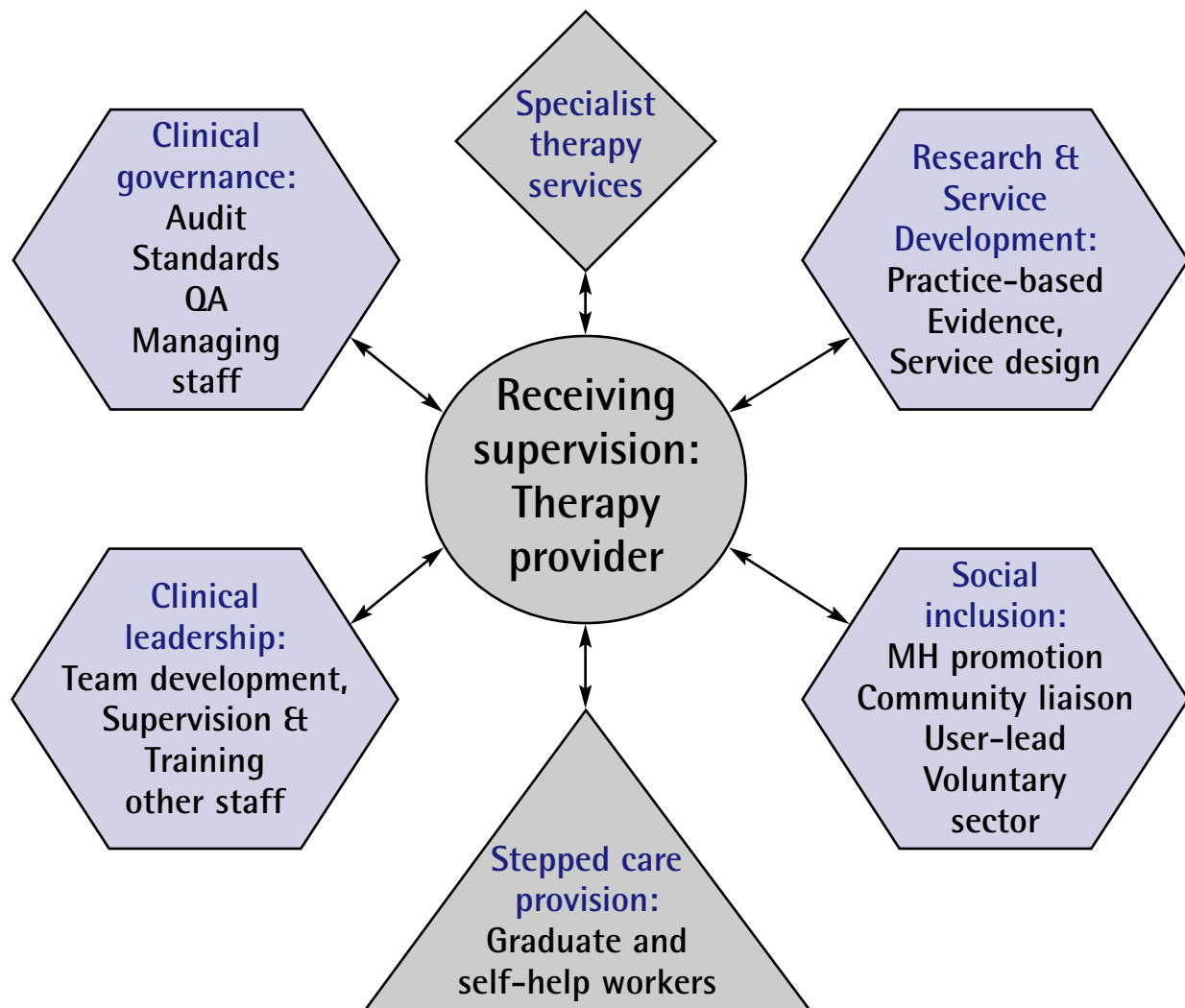
### 10.2 Psychologists are not just therapists.

It should be recognised that effective psychological therapy services are more than just a collection of competent psychological therapists engaged in direct client work. Processes such as training, supervision, clinical governance and audit are essential if services are to be delivered effectively and safely. We would argue that this distinction between an effective service and the effective therapists and practitioners who may make up the service, is also mirrored by the roles and contributions that psychologists, in particular have to make. Although many applied psychologists such as clinical and counselling psychologists, together with psychology assistants, possess the required therapeutic skills necessary for the delivery of therapy, they can also contribute to these other functions as we have argued elsewhere in this guide. To further emphasise, the contributions that applied psychologists ought to be offering services, we have summarised both therapeutic and organisational roles in Figure 5. The grey boxes represent the contributions that psychologists have to offer the direct delivery of psychological therapy services either as high intensity IAPT therapists, supervising low intensity psychology assistants or providing more specialised therapy services to those clients with more complex or enduring mental health problems outwith the IAPT programme. The purple boxes, in contrast, emphasise the additional roles that applied psychologists have to offer therapy services which we believe are as important as the therapy provided.

### 10.3 Providing a more socially inclusive and equitable perspective of mental health.

At a rather superficial level, 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 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 service users

Figure 5: Contributions of Applied Psychologists to Delivering Safe and Effective Psychological Therapy Services



and carers beyond the expression of individual symptoms and their amelioration. Such an approach underpins more socially inclusive services, which attempt to address a range of social and psychological needs (i.e. employment, meaningful and valued activities, housing, family and parenting issues), which hopefully may help to mend the broken communities within which many clients and service users currently live.

Equality of access, especially for Black Ethnic Minority (BME) communities is also an area where psychologists 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-focussed health professionals understanding the cultural diversity of both the expression and treatment of mental health problems (Nadirshaw, 1999; Williams, Turpin & Hardy, 2006). Much has been published recently around race equality and discrimination within health services (see DH, 2007b), which needs to inform the IAPT programme. The BPS has also published guidance around training staff to work in more culturally sensitive ways (Patel *et al.*, 2000), together with the challenge of recruiting more ethnically diverse psychologists (BPS, 2004). With respect to psychological therapies, there is an extensive literature around providing culturally appropriate counselling and therapy, much of it having been written in the US, which ought to inform the practice of psychologists and psychological therapists within the IAPT programme (Maxie *et al.*, 2006; Hays & Iwamasa, 2006; Hays, 2001).

#### **Psychologists specialise and work across a range of care groups**

Commissioners and those responsible for the deployment of applied psychologists need to be aware that the training of applied psychologists, and particularly clinical psychologists, is designed to prepare them to work through a range of psychological interventions and across a wide range of care groups. Moreover,

other applied psychologists are specifically trained to work within certain settings and contexts such as educational psychologists and schools; forensic psychologists and prisons; and health psychologists and working towards health promotion and behavioural health interventions.

The current focus on primary care and the welcomed enthusiasm for IAPT may have a cost for psychologists and also a undesirable longer-term impact on psychological healthcare and service users, especially those outwith IAPT. Commissioners may only think of applied psychologists in terms of therapists delivering psychological therapies working specifically with anxiety and depression within the context of the IAPT programme. Indeed, a recent workforce survey of applied psychologists (BPS, DH & HO, 2005) working within health and social care, showed that only 31 per cent were working in adult mental health services. Moreover, the recent trend for the deployment of psychologists, even within mental health, has been away from primary care and anxiety/depression problems within secondary care, to the provision of psychological treatments for people with complex problems (i.e. psychoses, bipolar disorder, eating disorder, personality disorder) as indicated also by NICE guidelines and also revealed as a scarce and inequitable resource by the Health Care Commission last year (Healthcare Commission, 2006).

Moreover, many applied psychologists work into services for older people, children and adolescents, people with learning disability, neuropsychological impairments or physical disability, or physical health conditions and long-term physical conditions (BPS/DCP Care Group Briefing papers – [www.bps.org.uk/publications/publications\\_home.cfm](http://www.bps.org.uk/publications/publications_home.cfm)). With many of these care groups, although psychological interventions and therapy are important, other roles such as detailed psychological and neuropsychological assessments, functional analyses, staff training, carer education and support, organisational interventions are just as, if not even more important, to the effective delivery of psychological services with these particular client groups. It should also be stressed, that the importance of psychological interventions such as Cognitive Behaviour Therapy, as recognised by IAPT, would need to be expanded to include family therapy, solution focussed therapy, couples and marital therapy etc within these other care groups. Although many of these other aspects are taught within generic doctoral training, particularly for clinical psychologists, these more specialist skills and roles associated with these other care groups are acquired as a result of CPD and supervised experience working within these other services. There are two important consequences, therefore, of the impact of the IAPT programme generally on the work of psychologists. Firstly, it is also important that psychologists and psychological services other than IAPT are supported and developed in the future to meet the needs for psychological healthcare of other client groups and in other service settings than just IAPT. Secondly, when services are being redesigned, care should be taken to recognise the individual skills and experiences of applied psychologist, and it should not be assumed that these are necessarily interchangeable: an applied psychologist who has specialised working with older people may require significant additional CPD and supervision, if they were to transfer to a primary care mental health service.

## **Introducing CBT into CAMH services**

**Service:** Cambridgeshire and Peterborough Mental Health Partnership NHS Trust

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### **Introduction and Evaluation of a Child-Focused Cognitive-Behavioural Therapy Clinic within a CAMH Service**

The CBT Clinic was introduced during November 2004 within the existing parameters of the Peterborough: CAMH Service, with the main aim to provide treatment for children and young people between the ages of 6 and 18 years, who presented with mental health difficulties for which a CBT informed treatment approach suggested a positive outcome. This also formed the referral criteria for the clinic. A further aim was to provide training and supervision opportunities. The clinic incorporated the services of a Clinical Psychologist, 3rd and 1st year Trainee Clinical Psychologists, a Specialist Registrar and two Assistant Psychologists. The Clinical Psychologist individually supervised all clinicians, in addition to hour-long peer group supervision sessions, which were held once fortnightly.

Young people seen by the CBT clinic were either referred internally or taken from the existing treatment waiting list. Twenty seven children and young people were referred to the clinic over a 12 month period, presenting with the following difficulties: anxiety, depression, deliberate self-harm and chronic fatigue. To monitor progress and outcome of therapy, children and young people were asked to complete an age appropriate assessment measure relevant to their difficulty, at pre and post treatment intervals. To gauge peoples' opinions of the service, children and parents were also asked to complete the Experience of Service Questionnaire (ESQ). Overall, children and young people seen by the clinic appeared to have benefited, and responses from the ESQ indicated that they and their parents were satisfied with their therapy. The introduction of the clinic allowed for CBT, as part of a range of therapies offered within Peterborough: CAMHS, to be offered in a more formalised manner. It also made the referral process more straightforward for colleagues.

Service development, in collaboration with the Primary Mental Health Worker Team, is envisaged as a next step in order to improve access to CBT for children and young people in primary care, experiencing mild to moderate mental health difficulties.

**Dr Niel McLachlan**

*Consultant Clinical Psychologist*

## Improving access to psychological therapies in physical health intermediate care

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Intermediate care services provide residential and community based rehabilitation for people with complex physical health needs, facilitating discharge from hospital and preventing unnecessary admission. The service has grown to cover a broad range of physical health conditions and chronic diseases, and works closely with other health, social care, and voluntary agencies. Salford Later Life Psychology Service has been an integral part of intermediate care services since they were set up. Many people with physical health problems have adjustment issues, or coexisting mental health needs, including dementia, major mental illnesses and substance abuse problems.

Psychology and counselling are the only mental health presence in intermediate care services, but resources are limited (1.7 wte clinical psychologist, 0.5 wte assistant psychologist, 0.5 wte counsellor), and due to financial constraints, have not increased as intermediate care services have grown. As a result the team have worked proactively to develop new ways of working to enable psychological perspectives to be integrated into the care of a larger number of clients.

Promoting psychological understanding through generic working: Psychology services take part in joint generic assessments and provide advice and support at single point of entry to intermediate care. Psychology services have also taken an active role in developing the single assessment process used throughout Salford, in order to promote awareness and effective identification of psychological/mental health needs by all staff.

Education and training: Training has been provided for intermediate care staff on topics ranging from communication skills, understanding and coping with 'challenging' clients, and identification of common mental health problems and adjustment difficulties. A programme of staff development has also targeted understanding and primary management of psychological problems associated with particular health issues e.g. falls, COPD (see also below).

Guided self-help: Materials have been developed around fear of falling and COPD, and health and social care staff in Salford have been trained to incorporate these materials in their work with clients.

Consultancy: Psychology services have used mobile phone contacts and bookable consultation slots, as well as joint visits to assess more complex clients. This helps staff to develop psychologically informed formulations, to aid appropriate intervention and management strategies, and ensure timely referral to specialist services.

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## Promoting access to psychological services for Older People

**Service:** Southwark Primary Care Psychology Service for Older People

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### Shifting referral patterns for Older People's Mental Health care

This service was set up as a pilot project, with funding from the Guy's & St. Thomas' Charitable Foundation, following an audit which demonstrated that older people were significantly underrepresented in primary care referrals for psychological therapy across a number of South London boroughs. In keeping with the National Service Framework for Older People, age discriminatory eligibility criteria were removed from such services in 2003, but little change was noted in subsequent referral patterns.

Over the last two years a small team of staff (one part time Clinical Psychologist and a full time Counselling Psychologist) have worked closely with local primary care teams and the primary care psychology service to raise the profile of older people's mental health and the value of psychological assessments and therapies for this group. They have established strong relationships with the local community and with minority ethnic groups by visiting day centres and third sector initiatives for specific older groups. A comprehensive range of age appropriate self help materials have also been designed and circulated.

Some Primary Care Practices have agreed to participate in a psychological screening for older people considered to have a higher risk for mental health needs. 70 per cent of older people offered this screening assessment have accepted. A stepped care model is being used to help those who are identified as needing further input, enabling the service to evaluate the utility of 'watchful waiting' and self help literature of older people with anxiety and depression. Older people can also be directed towards other local services and community resources where appropriate.

#### Outcomes:

- Referral rates have steadily increased and the service is currently receiving over five times the number of referrals that were being made at the start of the project.
- Referral rates for BME older people are now representative of the local population.
- 85 per cent of referrals are for anxiety or depression and a further 10 per cent are for concerns over mild cognitive impairment and memory loss.
- Clients reports of wellbeing improve significantly
- An average effect size of 1.0 is reported using the CORE-OM

## **Design of a Learning Disability Inpatient Service to ensure a psychological approach throughout the service**

**Service:** Learning Disabilities Community Team

**Area:** Jarrow, Tyne and Wear

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South Tyneside Learning Disability Clinical Psychology Service is involved in the design of an inpatient mental health service to be reprovided locally involving a new build. This includes chairing the Service Design Group looking at wide ranging clinical aspects of the service from nursing roles and establishment to daily routines and cooking of meals.

Through the involvement of Clinical Psychology in all aspects of planning, psychological principles are being employed to ensure that the whole service provides an environment that is as psychological as possible. Detailed conversations are taking place about nursing roles within the unit to allow for appropriate choice about the structure of a person's day whilst they are an inpatient. This includes thought about how much routine is necessary in someone's day (is it necessary to get up at 7.30 if you have nothing to do until 11.00, for example) and whether it is possible to enable people to cook a proportion of their own meals and to choose when and where to eat them.

A whole systems approach is being employed to consider the most effective way to look at the assessment and treatment/therapy for a person. In the past, inpatient admissions have been seen as a discrete episode in a person's life, not helped by services provided 20 miles away. Work is underway to consider assessment and treatment as functions that are undertaken when they are needed by a person and their family and where they are most appropriate, if necessary including an inpatient admission that continues any assessment or treatment already underway.

The involvement of Clinical Psychology in innovations such as this service should ensure that not only can people access psychological therapies when and where they need them, but they can access services that are set up in a psychologically therapeutic way.

### **Fiona MacDonald**

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## An Innovative Approach to Chronic Pain Management

**Service:** North Cheshire Chronic Pain Rehabilitation Service

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The North Cheshire Chronic Pain Management service was subject to a significant (psychology-led) re-design and operational overhaul in 2005, following service review and subsequent new commissioning directives and service remits agreed. It was firstly re-branded a Rehabilitation service and then service delivery moved from acute hospital to community base setting (to reflect the broader ethos that would underpin the service). New referral pathways were operationalised to facilitate broader referral access to the service (as opposed to the historical pain consultant only service access), inviting referrals from a variety of primary care and hospital services (including inviting referrals from mental health services and GPs where the requisite criteria are met). A direct referral pathway from the service to local mental health service was also negotiated. These actions were aimed at facilitating improved access to appropriate care for patients, as well as socialising greater inter-service working and consultancy opportunities (thereby broadening psychological formulation opportunities that might indirectly influence care of patients across the local health economy). Within 12 months, 50 per cent of referrals received by the service were via these new referral routes created.

A broader assessment model was also implemented with a systematic and triaged assessment model promoting different tiers of interdisciplinary assessment, based on needs identified at screening, with broad psychological needs being assessed for and intervention offered then being tailored to needs identified (e.g. promoting individual psychological or interdisciplinary intervention arrangement, group intervention allocation and/ or cross-service working where more complex psychological difficulties indicate the benefit of such arrangement). As part of this work a multi-theoretical perspective is adopted in formulating each individual patient's needs, with any within-service intervention arranged then synthesising analytic, interpersonal and cognitive behavioural principles and techniques, as best meets identified needs.

Relatively high referral rates of patients to mental health services for cross-service working or for appropriate triage to have illustrated the level of complex psychological (and psychiatric) needs that frequently overlap with or underpin chronic pain difficulties – needs which broader psychological assessment and a less programme driven approach can highlight and cater for.

### **Dr Mark Griffiths**

Consultant Clinical Psychologist

North Cheshire Chronic Pain Rehabilitation Service

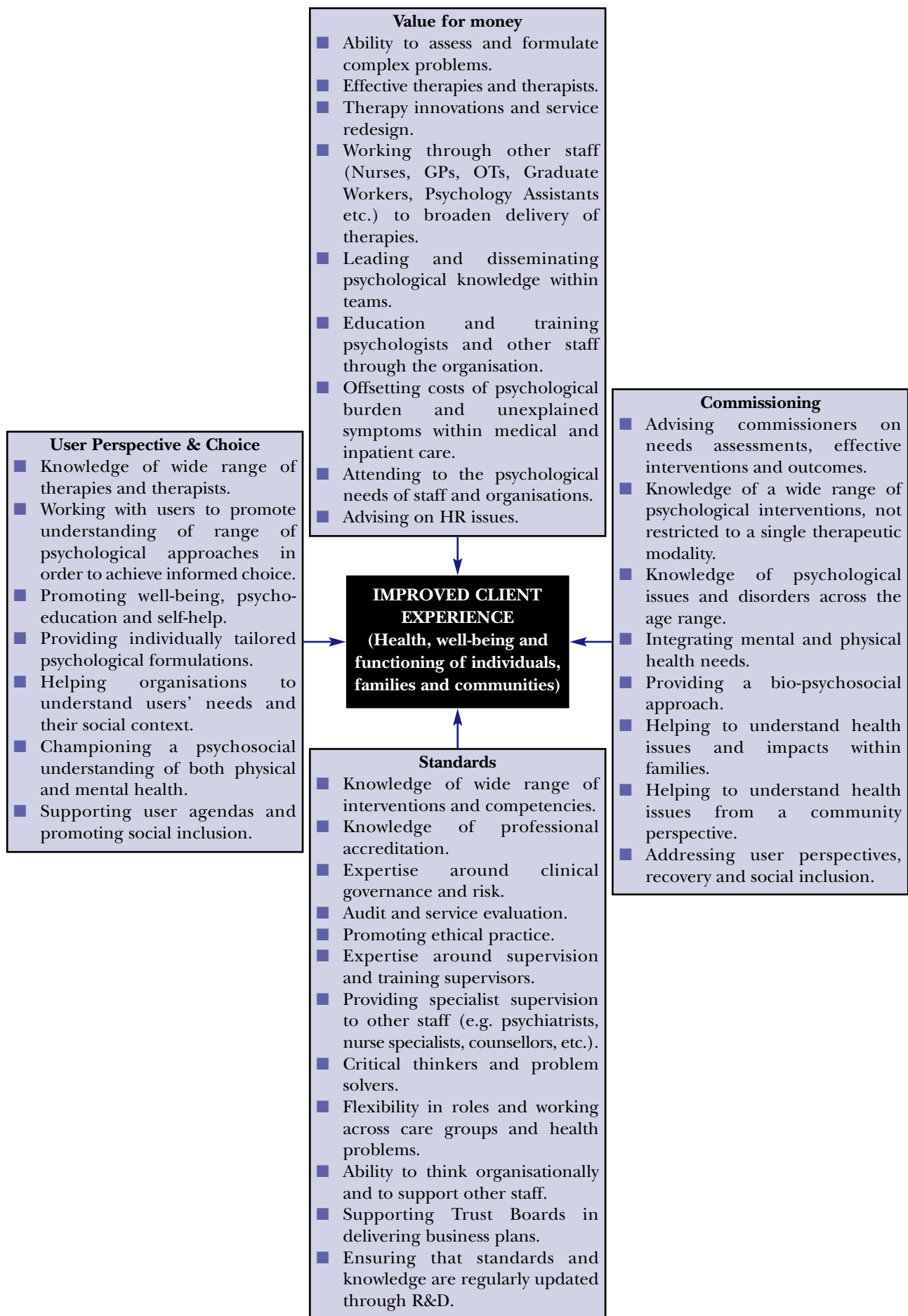
### **New Roles and Added value of Applied Psychology**

A wide range of roles and functions which applied psychologists potentially have to offer users and service providers have been described in this report. To summarise these, we have organised them in relation to the principles of NHS Reform (DH, 2005) and indicated the contributions that psychologists offer users, providers and commissioners in delivering services which adhere to clear standards and demonstrate value for money. These are summarised in Figure 6.

### **Summary**

In conclusion, the greatly focused attention on access to psychological therapies that has been promoted by the IAPT Programme presents exciting opportunities for the profession of psychology. To achieve this potential, psychologists will have work collaboratively with other professions and staff, service managers and commissioners to review and redesign existing services. Psychologists have expertise and specific roles acquired through their postgraduate training, which ought to be used strategically within psychological therapy services in order to capitalise on their 'added value'. This is an opportunity and a challenge for psychology.

Figure 6: Potential Contribution of Applied Psychologists to Implementing NHS Reform



## Conclusions and areas for further consideration

### Recommendations for psychologists:

1. IAPT presents an opportunity to enhance the quality of psychological therapies to service users within the NHS through expanding capacity and ensuring access to effective and appropriate therapies, as recommended within NICE guidelines.
2. For this to be successful, however, psychologists will have to embrace strong partnership working with other professions in promoting service innovation and redesign.
3. Psychologists need to lead in the promotion of new service models (i.e. stepped care) and the specification and development of integrated care pathways, which meet the varied and complex needs of service users.
4. Psychologists may need to re-evaluate their approach to assessments and triage to ensure that they meet the individual requirements of service users, are safe but also allow for sufficient access and do not contribute to bottle necks within the system.
5. Psychologists have a responsibility to work with local communities to ensure that psychological therapy services provide a range of interventions that are culturally appropriate and accessible by all members of the community.

### Recommendations for commissioners and providers:

6. Service redesign is key to the successful implementation of the IAPT programme and psychologists have important contributions to offer in helping services innovate and change.
7. Psychologists have a major role to play in implementing this programme and should be essential to its success. Accordingly, consideration should be given to the role of Consultant Psychologists in providing leadership at both the organisational level (i.e. Trust Boards) and within clinical teams.
8. A full range of interventions extending from guided self-help to the provision of formal therapy should be readily available within primary care and delivered by a range of practitioners (e.g. nurses, counsellors, graduate workers, voluntary sector employees). Psychologists have important roles in supporting such staff by the provision of expert consultancy, training, supervision, clinical governance and research/evaluation within psychological therapies.
9. For people with more complex or more intractable problems, there should be easy routes of access between primary and secondary care to ensure that these individuals receive more specialist psychological therapies, and with greater continuity.
10. Psychologists have a particular role to play alongside other senior staff in ensuring good clinical governance, and the safe and competent practice of all workers involved in the delivery of psychological therapy services.
11. The success of the IAPT programme will rest on its ability to demonstrate good clinical outcomes. Psychologists have an important role in advising local services as to routine clinical data collection, and how to guarantee and monitor good and appropriate clinical outcomes.
12. In addition to outcome measurement, it will be important to ensure that the IAPT programme remains up to date, and reflects developments in clinical guidelines, and contributes to the future evidence base supporting a potentially wide range of psychological therapies. It will be important that psychologists have the opportunity to employ their research skills and are actively involved in the evaluation of both national and local initiatives.
13. Psychologists can make useful and important contributions to the commissioning process by advising commissioners on aspects of needs assessment within local populations, specifying service models and availability of effective therapies, defining clinical outcomes and their measurement, and ensuring safe practise through clinical governance.
14. Psychologists also bring with them alternative perspectives to healthcare problems which transcend the traditional biomedical model and help to promote more community and socially inclusive policies, which incorporate a greater holistic view of service users and carers, including for example family and parenting issues, employment, housing and community integration, and social cohesion.
15. It is important to recognise the breadth of psychologists' contributions to social and health care, and that many psychologists work in settings away from primary care, with client groups not necessarily represented within the IAPT programme (e.g. psychoses, personality disorder, people with learning disabilities or brain injury) and make major contributions through consultancy, neuropsychological

and functional assessments, staff and organisational interventions, which are beyond the traditional role of the psychological therapist.

16. It will be important that recent attention given to primary mental healthcare does not detract from the contribution that psychologists may make in their other roles and interventions supporting services outwith primary care mental health. This also applies to the resources that support these services.

**Recommendations for SHAS and education and training commissioners:**

17. However, if capacity and access is to be truly enhanced, significant additional resources will be required both in establishing additional services and the training of new staff.

**Recommendations for the British Psychological Society and employers:**

18. The BPS through New Ways of Working for Applied Psychologists should consider supporting the establishment of new roles (i.e. such as formally trained psychology assistants) in order to enhance the contribution that psychologists (i.e. qualified and assistants) can make to enhancing capacity and access. It will be important to ensure that any new workers practise safely and this will require clarity around organisational structures, supervision and appropriate regulation.
19. It will also be essential that any new role is sustainable, integrates with career structures for both psychologists and other work roles within psychological therapy services, and allows for transferable recognition of training and experience for those wishing to go on and enter doctoral training as a psychologist.
20. The BPS through its post-qualification registers should assist psychologists in specifying the range and level of expertise in psychological therapies that they possess. Similarly, pre-registration training should result in clear and assessed competences (e.g. within CBT) which support the IAPT programme and other roles that psychologists adopt.
21. Finally, that the BPS promotes the IAPT programme by supporting and informing its members of this development, helping to promote new standards of training and upholding standards of regulation.
22. In addition, the BPS should seek to advise and inform the public of the benefits of psychological therapies and the contributions that psychologists can make to all aspects of health care.

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