Organising and Delivering Psychological Therapies

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Best Practice Guidance

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**Description**  
Supports improvements in the delivery of psychological therapy services. Highlights issues of access, waits, and how to improve care pathways. Draws attention to the needs of service users and carers and to the training and support needs of staff.

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What does the report contain?

• The report is written for a range of stakeholders, including commissioners, providers, employers, trainers and practitioners.

• It aims to provide an impetus to review and improve the delivery of psychological therapy services.

• It highlights issues of access to psychological therapy services, waiting times and how to improve care pathways.

• It highlights the needs and interests of service users and carers.

• It emphasises the importance of mainstreaming psychological therapies; of strengthening choice; and of co-ordinating services.

• It highlights issues relating to training.
1. Psychological therapies are part of essential health care. There is overwhelming evidence for their effectiveness in treating a wide variety of mental health problems and illnesses.

2. The lack of adequate psychotherapeutic and counselling services is consistently cited by users of mental health services when asked how they would like to improve the care they and their families receive.

3. The term ‘psychological therapies’ covers a wide range of different models, including psychodynamic, cognitive behavioural, arts-based and systemic approaches. No one therapy, or one group of practitioners, is able to provide effective treatment for the range of difficulties experienced by people with mental health problems.

4. In many mental health services psychological therapy provision is patchy, uncoordinated, idiosyncratic, potentially unsafe, and not fully integrated into management systems.

5. To redress these difficulties a number of actions need to be considered at different levels. These include:

   a) Improving access to therapies to avoid long waiting times, multiple assessments and restricted geographical availability

   b) Involving users in choosing the most appropriate therapy for their condition and situation. This in turn requires psychological therapy services to provide more effective information about their services and how they can be accessed, to both users and potential referrers

   c) Defining clear ‘care pathways’ to psychotherapeutic help for different psychological conditions. Thus, for example, in primary care patients suffering from depression which has failed to respond to simple measures, should be able to be easily referred for a
Executive Summary

course of cognitive behaviour therapy, either in the primary care setting, or through a simply accessed secondary care facility.

d) Attention to the psychotherapeutic needs of different groups and situations: for example, older people, in-patients on acute psychiatric wards, those with learning disabilities, ethnic minorities.

e) Systematic training in psychological therapies for mental health professionals; this should be based regionally and in each mental health trust on a training-needs assessment that considers the gaps in service for clients and the developmental requirements of local professionals. On returning to the work setting trained professionals should be supported in order to practice and disseminate their new skills.

f) Co-ordinating different parts of psychological therapy services and offering clear leadership, both professionally and managerially. This is best achieved through a Psychological Therapies Management Committee (PTMC) in which inter-professional rivalries can be mitigated, and where there is a clear relationship to the overall management structure of a Trust.

g) Overseeing via the PTMC the delivery of evidence-based treatments that are coordinated, appropriate to the client’s condition, regularly audited, safe, supervised, equitable, comprehensive, and delivered by well trained professionals.

6. The practical implications of these recommendations at various levels including trust management, commissioners, higher education institutions, and professional organisations is described at the end of the report (see pages 40-43).
1 Introduction

The importance of psychological therapies

1.1 This report was commissioned by the Mental Health Care Group Workforce Team (MHCGWT) to assist thinking about the most effective way to organise and develop effective psychological therapy services and to inform training commissioning.

1.2 Psychological therapies have an important place amongst the range of treatments available as part of comprehensive, user-centred mental health services. As the evidence base for their effectiveness has grown, so has their popularity with service users and carers. The aim of this report is to help local commissioners and providers develop such services, and organise and manage them more effectively. Put very simply: the aim is to help translate national policy to improve standards of mental health treatment and care into local action.

1.3 Accepting the recommendations of this report may require a change of attitude towards psychological therapies in some localities. A key premise of the report is that psychological therapies should no longer be regarded as optional. Nor should access to effective psychological therapies be constrained by the vagaries of local geography and history. The report argues that psychological therapies are fundamental to basic mental health care, and can make a highly significant contribution to outcome and user satisfaction. Its recommendations are based on a range of well-established scientific evidence, but also on professional consensus and the views of service users.

1.4 The report highlights the fact that therapists from all professional backgrounds can make a valuable contribution to the provision, teaching, research and development of effective psychological therapies. Those with a clinical or professional background include psychiatrists, psychologists, psychotherapists, nurses, social workers, occupational therapists, counsellors, arts and drama therapists, child psychotherapists, and family therapists. Those without a formal qualification, and, increasingly, service users and carers also have a valuable contribution to make.
Policy

2.1 This report builds on ‘NHS Psychotherapy Services in England: Review of Strategic Policy’ (Department of Health, 1996) and the 2001 evidence based guideline ‘Treatment Choice in Psychological Therapies and Counselling’. The Review, the first of its kind to be published in England, collates evidence for the effectiveness of psychological therapies and offered practical guidance about how to drive forward the evidence based practice agenda.

2.2 In the five years since publication of the Review, psychological therapy services have grown. However, a number of challenges to effective delivery remain:

- Psychological therapy provision is a multi-professional and multi-agency endeavour. Psychiatrists, psychotherapists, psychologists, counsellors, nurses, social workers, and many other groups are involved all of whom need to communicate and coordinate effectively with one another.

- There is a wide gap between research on psychological therapies and its everyday practice.

- Although the importance of involving service users and carers in the design and delivery of psychological therapy services is more widely recognised, knowledge about how to do this effectively is limited.

- There are many different models for delivering effective care. The absence of a ‘right way’ to organise services may be a cause of slow progress in some areas.

2.3 These challenges exist in a context in the NHS of difficulties recruiting and retaining staff; a lack of standardised information about staff numbers; and widely different rates of pay and terms and conditions for
those delivering psychological therapies (which includes counselling). At the same time, demand for psychological therapies is high and such approaches are extremely popular with service users and carers.

2.4 In policy terms, there should no longer be any doubt that psychological therapies have a place alongside drug treatments in the range of effective treatments. The mental health national service framework (NSF)\(^3\), 1999, lists psychological therapies among the range of effective treatments for people with a range of mental illnesses, including those with severe and enduring mental illness.

2.5 The NHS Plan (2000)\(^4\) and Priorities and Planning Framework (PPF) for 2003-6\(^5\) set out a number of proposals for new teams and services to fast-forward the mental health National Service Framework (NSF) and modernise services. Effective delivery will depend, in part, on provision of psychological therapies. For example, effective psychological therapies for common disorders are addressed specifically in the PPF (2002) target to develop new workers in primary care\(^6\). In addition, assertive outreach teams are being established to support the most vulnerable\(^7\); early intervention teams are improving access to treatment and care for young people experiencing the first signs of a psychotic illness. Crisis and home treatment teams are starting to provide alternatives to hospital care, and essential support is being provided for those who are involved in providing care at home. All these contain a significant psychological therapy component.

2.6 Although specific recommendations about which psychological therapies to deliver are not made, it is clear that a comprehensive, accessible service is the overarching aim. This would provide for different levels of need and at different points in a person’s life:

- For acute adjustment disorders that may be short term - such as reactions to bereavement, divorce, and other life events. When people experiencing bereavement or divorce require psychological therapies such provision will normally be best suited to delivery in primary care.

- For longer term more complex reactive disorders, such as post-traumatic stress disorder, where services are usually provided in a specialised setting.
• For specific problems such as depression, anxiety, eating disorders and somatic complaints. Services should be provided across primary and secondary care settings.

• For people with psychosis and their families, including people with early psychosis who may have additional phase of illness and age-specific needs. Here, close working with specialised early intervention teams is desirable.

• For long term co-morbid conditions (e.g., psychiatric and medical conditions) where psychological therapy can be supportive in adjusting to illness. Here, close links with psychiatric liaison teams and psychological medicine services are desirable.

• For complex cases involving long-term psychological problems such as personality disorders that impair the user’s life and are resistant to change. Links with specialised services, including prison and probation services, and close working with mainstream psychiatric services are desirable.

2.7 A mental health workforce is therefore needed with the competence and the organisational strength to deliver effective and appropriate psychological treatments, backed by good ethical and supervisory support and within the framework of clinical governance.

Access

2.8 Users of mental health services consistently place access to psychological therapies at the top of their list of unmet needs and although counselling is now increasingly available in and through primary care services, demand still exceeds supply. For service users, the key need is for unimpeded and timely access to appropriate, effective, psychological therapies. Despite this, service users seeking psychological therapies wait too long to be seen and sometimes a local service is not available.
2.9 The description of Mrs A's experience in the above example is not untypical. In addition to the requirement for re-assessments, waiting times can extend to months and sometimes years. Furthermore, it is well known that access to psychological therapy is commonly delimited by factors such as age, disability, ethnic minority status and diagnosis. Thus, people with a learning disability are commonly thought unsuitable\textsuperscript{10} for psychological therapy; people with a severe mental illness may be thought too seriously unwell\textsuperscript{11} to benefit; older people are not able to access general adult services\textsuperscript{12}; and teams commonly believe they lack the skill to support someone with a personality disorder\textsuperscript{13}.

### Choice

2.10 A wide range of interventions can be classified as 'psychological therapy'; psychological care forms a component of the work of a wide range of health and social care. However, “One of the most striking findings of our investigation has been the degree of confusion surrounding the meaning of the term ‘psychotherapy’” (Parry, 1996). Although talking treatments and psychological therapies of all types are popular with service users, there is still widespread ignorance and confusion. This makes choice difficult to exercise. More and better information are essential pre-requisites for choice and engagement with treatment, and although more information is now available, partly due to more widespread information published by the Department of Health\textsuperscript{14}, and elsewhere on the internet, there is still room for significant improvement at local level. In later sections of the report some examples are elaborated.

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**Case Study**

Mrs A had a history of recurrent depression and self-harm; antidepressants had not really helped her. Her GP referred her to the practice counsellor who felt, in view of her previous history of suicide attempts, that she should be referred to secondary services. The Community Mental Health Team undertook a further assessment interview. Then, Mrs A was passed on to the Clinical Psychology Department for Cognitive Behavioural Therapy. After another assessment, and in view of the possible history of personality disorder, Mrs A was referred to the Consultant Psychotherapist for long-term analytic therapy. He thought she would benefit from a twice-weekly group. The group leaders undertook a further assessment and placed Mrs A on a waiting list. Mrs A was eventually taken on for therapy, some 9 months later and after 5 assessment interviews.
The organisation of services

2.11 In 1996 Parry\textsuperscript{15} offered a definitional framework to describe more clearly the ways in which psychological interventions are offered:

Type A - psychological treatment as an integral component of mental health care.

Type B - eclectic psychological therapy and counselling

Type C - formal psychotherapies.

2.12 This framework not only reflects the way that psychological therapies are delivered, but also the way that services are organised. For example, psychological therapy practitioners offering type B and C psychotherapy tend to work in relative isolation. The counsellor working single-handedly in a GP practice or in private practice is an example of this. Practitioners working in departments of psychology and/or psychotherapy (types B and C) are also examples. Those delivering psychological therapies as a component of mental health care are more likely to be based in multidisciplinary teams (community mental health teams, community learning disability teams, child protection teams, etc) or in highly specialised multi-disciplinary settings (such as prison, special hospitals, education, and the Criminal Justice System).

2.13 Thus, there is widespread diversity in the local arrangements for organising services, and local commissioners and employers need to be flexible to match services to local needs and resources. But although there is no national template, and no firm evidence that one way is better than another, there are now well established pointers to good practice that will help local services be confident they are supporting staff effectively to deliver better treatment outcomes for service users and carers. For example, well-defined care pathways to psychological therapy need to be established to minimise the need for multiple assessments and to minimise waiting times. Good organisational practice will also minimise the risk of staff burnout. In later sections of the report, best practice is elaborated to include the needs of different age groups as well as the needs of people with specific conditions, whatever their age (e.g., people with learning disabilities; people with personality disorder; people who are deaf, etc).
A capable workforce

2.14 A co-ordinated training strategy for psychological therapies is an essential part of developing a psychologically literate mental health workforce. Staff involved in the delivery of psychological therapies of all types (A, B and C) need to be trained and well supported. Mental health professionals frequently express the wish to develop expertise in psychological therapies as part of their continuing professional development. They commonly report they lack the skills they need. Such training and support can therefore also be helpful as part of an effective strategy to recruit and retain staff. A balance needs to be struck between in-house training, which can enhance psychological awareness and general psychotherapy skills for the local mental health workforce; and schemes to maximise scope for cost-effective delivery of specific interventions which may need to be more centralised if resources are scarce.

2.15 Just as care pathways are needed for service users, so clear career pathways to specialised training in psychological therapies are needed for professionals. With care pathways for specific disorders as a starting point, it is possible to outline the areas of greatest need for evidence-based training and how best to deliver it. Individuals able to undergo training will need support to return to the workplace; support to practice the skills they have acquired and transmit that expertise to colleagues rather than be overwhelmed with routine work. Trusts, Professional bodies such as the RCN and RCPsych, and WDCs as well as service managers need to think about how to support an integrated approach to training and clinical practice within individual specialities and at an inter-disciplinary level.

Leadership

2.16 Good leadership is essential to the delivery of effective psychological therapy. Indeed, much development and innovation in the organisation of psychological therapy services in the past owes to the vision of individual leaders. However, psychological therapy services also need clear management. In this way, individual practitioners’ needs for support, supervision, and training, can be balanced with service needs for more effective partnerships between providers, including CMHTs, acute wards, early intervention services, ethnic minority services, services for people with learning disabilities, for older adults, and others.
2.17 Strategic Health Authorities and Training Commissioners need to have an overall picture of the place of psychological therapies in mental health work. Stakeholders – ‘product champions’ – need to be able to set out clearly and convincingly the arguments for investing resources and manpower in psychological therapies. This will help Trusts to place psychological therapies in the forefront of treatment methods for mentally ill service users.

Performance

2.18 There are a number of criteria against which the success of psychological therapy services can be judged (Parry, 1992). They include the following:

- **Acceptability** – does the service meet service users’ requirements, are they satisfied with it, does it offer choice?
- **Accessibility** – is the service easily accessed by those in need and does it offer an appropriate range of interventions?
- **Equity** – is the service available equally to all those who need it irrespective of factors such as ethnicity, age, social class?
- **Effectiveness** – does the service deliver results and is it safe? Is the right range of services available?
- **Efficiency** – is it cost-effective, maximising volume and quality within available resources.

2.19 Systematic information is not currently captured centrally about waiting times for psychological therapy, but the Commission for Health Audit and Inspection (in future, the Healthcare Commission) hope, in collaboration with the Department of Health, to develop an indicator for inclusion in the trust performance indicator set in the near future. In the following sections, this, and other ways to assess services are considered alongside issues relating to the range of services that should ideally be provided.
Acceptable, user-friendly services

This section emphasises the importance of involving service users and carers in decisions about their care, and of providing information about psychological therapies to enhance engagement and choice.

3.1 Mental health service users generally advocate the value of self-help, and support from peer networks. They see themselves as experts in assessing the content and delivery of treatment programmes and have a valuable input to make to service planning, development and delivery. This is one reason the National Institute for Mental Health appointed a new Fellow to lead on ‘Experts by Experience.’ This fellowship is one of a series being established to bring a national profile and focus on service user and carer involvement at all levels in mental health services in the NHS and social care.

Recommendation

Ensure that providers and commissioners of psychological therapy services are able to obtain help and information from the NIMH (E) programme about user perspectives on best practice in the delivery of psychological therapies.

3.2 Psychological therapies, no less than other services, depend for their effectiveness on a good alliance between therapist and patient. Ideally, service users should have clear guidance as to the range of services on offer and the most effective form of treatment for their condition, according to the evidence, and be offered a choice, except where evidence contradicts.
3.3 Within the mental health sphere, the delivery of effective and acceptable services also involves stigma. For psychological therapy services to be maximally effective they will ideally be located in non-stigmatising environments. For example, hard to reach young adults (such as those that self-harm) may be deterred by an appointment system. They may be better served at least for initial consultations by walk-in services in sports or leisure centres.

3.4 However, only service users themselves can comment meaningfully on this and involving users in the design of services is very important. What do psychological therapy service users say they want? Two recent studies provide some important pointers to the answer.

**The Cassel project**

3.5 The Cassel Hospital in London provides inpatient and outpatient psychotherapy service for people with complex and enduring psychological disorders. The text box below summarises the views of service users gathered during a workshop as part of a user/provider project designed to examine service impact.

3.6 The work at the Cassel points to the importance of clear communication as a fundamental starting point in the delivery of acceptable psychological therapy services. Information is also an essential precursor to engagement and choice.

3.7 Service users want staff who can communicate a sense of optimism whilst being realistic, and they want staff who can understand the importance of boundaries. Service users wanted co-ordination between assessment and treatment programmes and individually tailored care packages. They wanted their feedback listened to and acted on, as well as continuity of care and continuity of staffing. The participants at this workshop agreed that if staff and service users share an interest in evaluating outcomes, then this is likely to strengthen clear communication.

**Recommendation**

Look at the booklet ‘Choosing Talking Therapies’ written in collaboration with service users and carers published by the Department of Health17. It explains what talking therapies are and is designed to help service users know the questions to ask.
3.8 Importantly, the Cassel project also identified features of psychological therapy services that users found specifically unhelpful. These included:

- The availability of services only in office hours;
- Lack of continuity of staff;
- Staff inflexibility in relation to particular theoretical models;
- Lack of appropriately trained staff;
- Patients being ‘rewarded’ for being ill – i.e. risk-related responses from staff rather than a more holistic approach.

**Recommendation**

Involve service user groups in the planning and evaluation of psychological therapy services and develop a checklist of features against which performance can be measured. User involvement in services also helps to ensure that appropriate information about the service is available in a meaningful format and from a service user’s perspective.

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**The psychotherapy and learning disability project**

3.9 A second recent report prepared by the Royal College of Psychiatrists on psychological therapy and learning disability, included interview material from people in therapy about what they did and did not like about their therapy. An interview study was undertaken in one of the few services providing group analytic treatment for people with a learning disability.
The aim: to elicit clients’ views and identify positive and negative aspects of the experience to inform future planning. The text box below summarises what services users said.

Service user views

Psychotherapy for people with learning disabilities

What I liked

• I liked everything about the group
• I felt valued
• I liked the people
• I liked being listened to and understood
• I liked the therapist
• I liked meeting people with similar issues
• I liked coming into the hospital
• I liked humour in the group

What I didn’t like

• Talking can be distressing
• I didn’t like the feeling I was expected to speak
• Fear of loss of confidentiality
• Seeing others’ distress
• I was disappointed there was no dramatic change in my problems

3.10 Some services now use video-conferencing facilities to assess, treat and supervise patients and workers from a distance. This is an effective way of exporting specialist expertise (e.g. in psychotherapy of Learning Disability) to geographically distant places. Internet and web-based assessment and treatment programmes are readily available and are proving increasingly popular with some users. Those with language or learning difficulties will also value non-traditional ways to receive information about their care, especially pictorial and audio information. Further information about psychological therapies and issues for people with learning disabilities is available from the Institute of Psychotherapy and Disability.
Accessible Services

In this section, issues relating to access are described in terms of the location of services, waiting times, co-ordination of services and mode of delivery. Recommendations are made to improve information, access and choice.

3.11 Accessible services are those that the public can use easily, and different service users have different needs. Accessibility needs to be defined at the very least in relation to:

- **Location** - for example in locally available GP surgeries, community centres and/or in clinics with good road and rail links, with escorts provided where necessary.

- **Timing** - availability outside office hours; whether available promptly or only after a long wait.

- **Co-ordination** - partnership between different elements of the service system

- **Mode of delivery** - for example, face to face, through interpreters, via the internet, over the telephone or by computer in order to promote choice and maximise access.

Recommendation

Consider the range of different means to deliver information to service users and carers about psychological therapies, including in a form that will have meaning for different user groups. Pictorial and audio information is particularly useful for people with learning disabilities and/or literacy difficulties. Essential information might include web-based as well as written material, information about what to expect from treatment and how to complain.

Location

3.12 Psychological therapy services are provided by a wide range of NHS, social care, independent, charitable and voluntary agencies. However, information about their location is very limited. In 1994, all NHS trusts providing mental health and community services were asked to supply
information about provision as part of the Review led by Glenys Parry for the Department of Health.

3.13 Fifty one organisations responded. The results showed that in large District trusts all three types of psychotherapy (A, B and C) were typically provided. In smaller, non-teaching districts provision was typically less diverse or less well developed. Of all the formal therapies (type C) Cognitive Behavioural Therapy and Behaviour Therapy were most commonly available. Group psychotherapies and psychological therapies for children were less available, and for older adults, people with learning disabilities, substance misuse and forensic patients, were generally not available.

3.14 Apart from survey information such as this, little information is captured routinely about the location and employment arrangements for practitioners of the psychological therapies. For example, only employment data on consultant medical psychotherapists, child psychotherapists and clinical psychologists (formerly listed under the Whitley Council) is collected centrally. Information about nurses whose remit specifically includes a role in psychological therapy service delivery and information about counsellors is not collected.

Recommendation
Local services could begin to map psychological therapy services in terms of their location and type, and whether there are restrictions on access and choice for particular client groups. This would help them understand the main gaps and could be used to assist planning and commissioning.

3.15 The mental health mapping project at the University of Durham is beginning to remedy (www.dur.ac.uk/service.mapping/amh2002/queries) the shortfall in information. Although there are still some problems with the reliability of the data, a picture is emerging of where services are located, and some of the gaps.

Recommendation
Look at the mental health mapping database. Make contact with your local LIT and ensure that the data captured about psychological therapy services in your area is accurate and up to date.
Timing

3.16 For the most part, issues of accessibility relating to the timing of psychological therapy services concern waiting lists and waiting times. Service users and carers are particularly concerned about this. The London Regional Advisory Committee in Clinical Psychology has explored the issue in relation to the proposal that waiting times for psychological therapy should be included in the list of Trust performance indicators for 04/05.

3.17 The Committee points to some important differences between psychological therapy services in the way they manage waits; for example:

- Some services have separate assessment and treatment waiting lists, such that patients are first assessed and then, if considered suitable for treatment, are put on a waiting list for the relevant treatment. The different treatments to which a patient may be allocated (e.g. group treatment versus individual therapy) may then have separate waiting lists. In other services, there is just one waiting list, with patients proceeding to treatment immediately after assessment.

- Some services use an “opt-in” procedure, where patients are invited to contact the service to make an appointment at a time convenient to them and, if the patient does not make contact, no appointment is made. In other services, patients are sent an appointment time.

- Some services use an initial “opt in” procedure which asks patients to complete a self-report form. The patient is not offered an appointment until they have returned the questionnaire. This sometimes requires a further follow-up if no initial response is made.

- Some services offer “holding sessions” to people on treatment waiting lists or offer “extended consultations” before referring on.

Recommendation

Long waiting lists are very common for psychological therapy. In some services, clients are allocated to one of three bands: short-term therapy (up to 12 sessions), medium term (12 to 30 sessions), long-term (more than 30 sessions). This permits a managed approach to the waiting list and could help to provide better information for clients.

3.17 The Committee points to some important differences between psychological therapy services in the way they manage waits; for example:
3.18 The best and most accessible services appear to have managed waiting lists of some kind, and where service users are fully informed and involved. At this stage, however, the evidence is lacking that one method as against another has any special advantage. Responsibility for deciding whether waiting times should be included in the list of Trust Performance Indicators now lies with the Commission for Health Audit and Inspection (in future, the Healthcare Commission). However, local services should consider the advantages for themselves of developing a system to manage waits more effectively.

Recommendation for Local Services developing Performance Indicators (Pis)

(London Regional Advisory Committee on Clinical Psychology)

• The PI should focus on type B and/or C psychological therapies
• The PI should be focused in secondary care settings (i.e. excluding in GP practices and primary care) in the first instance, but extending to primary care where the data can be collected reliably
• PIs should only be developed for services provided by a department, service or team comprising more than a single individual, with an allocation procedure/waiting list that is common across staff in the service (i.e. excluding where the "service" is essentially of different single practitioners each having a separate waiting list in the separate specific teams in which they work)
• PIs should be developed for adults (over 18 and including older adults) with mental health problems
• PIs should be developed for adults referred by primary care teams or from within mental health services

Co-ordination and work in partnership

3.19 Psychological therapies are provided by practitioners working across agencies, professional groups, and statutory and non-statutory boundaries; this presents a number of difficulties. Different professional groups may see one another as competitors when resources are limited. Different agencies have different and possibly contradicting values. Managers may find it hard to understand the subtleties of different theoretical approaches and viewpoints; thus, they may allocate psychological therapies a relatively low priority more out of frustration and incomprehension than ill will.
3.20 Whilst the NHS provides the backbone of psychological services, especially for those with severe and complex disorders, the voluntary, charity, and private sectors offer useful and appropriate support for many people. Community services such as victim support and rape counselling are often delivered to a high standard by voluntary agencies. Ethnic minority support services and refugee groups also provide user-friendly psychological support.

3.21 Good co-ordination with NHS mainstream services is essential to ensuring that patients are offered a choice of available help and that those with complex conditions and higher levels of need are helped appropriately. Accessible services are those that have clear referral procedures and clear cross referral agreements between the different 'points of entry' into the psychological therapy service.

3.22 This requires NHS psychotherapies to be co-ordinated across a service user area with formal structures of common assessment and treatment protocols throughout the system. Co-ordinating and organising these services is a significant challenge.

Recommendation

The 1996 NHS Review suggested each Trust should establish a Psychological Therapies Committee (PTC) with representatives from all the relevant practitioners and psychotherapy services. As a minimum, this should include any staff appointed from the professions of clinical psychology, adult psychotherapy, Consultant (medical) Psychotherapy, clinical nurse specialist, child psychotherapy and counselling. Senior Management input into this committee is essential, and ideally there should be a representative of Psychological Therapies on the Trust Executive Board. The PTC could, as an early task, examine current practice against the recommendations of this report and to devise an implementation programme.
3.23 The principles identified by the HAS for the NIMH(E) Eastern Development Centre specifically concerned with partnerships include the importance of jointly agreed local pathways (maps) covering the routes for common conditions between primary care and specialised mental health services.

**Recommendation**

Consider integrating all primary care psychological therapy provision so that all GP practices can access these services equitably. This has advantages for service users and carers. It has advantages for staff who can then have fair access to equal terms and conditions, equal pay, supervision, CPD and ongoing support.

3.24 The NIMH(E) Eastern Development Centre guidance also suggests that services should be organised to allow a ‘stepped-care’ approach. Several accounts of how to deliver a ‘stepped approach’ to care have now been published\(^{23, 24}\). Based upon an assessment of patients’ needs and combined with a good understanding of staff competence and training, this approach involves the delivery of a low intensity, low cost treatments, including supported self-help, as a first option prior to referral to higher intensity, high cost care. It can help to reduce the chance of wasting resources and promote means to organise services around patients’ needs rather than service interests.

3.25 Some localities lack psychological therapy services specifically designated for components of their system of care, and/or important groups are excluded. Issues for black and minority ethnic mental health communities, people with learning disabilities and older adults have already been mentioned. Other important groups include those in prison, or those in acute inpatient care who can also benefit from psychological therapies.
Haringey Psychological Therapies Service

This multi-disciplinary service employs doctors, psychologists, nurses, occupational therapists, generic psychotherapists and counsellors. It provides psychological treatments to the London Borough of Haringey (population 280,000). The service is organised on three levels: primary, secondary and tertiary. At the primary care level, brief structured psychotherapeutic interventions are available including brief dynamic therapy, cognitive behaviour therapy, cognitive analytic therapy and supportive therapy (Types B and C). At secondary care level, psychological treatments are integrated with the psychiatric care of the patient (Type A) within the community mental health team and treatments include brief and long term interventions. At the tertiary level (at Halliwick on the hospital site) treatments are offered by specialist practitioners and there is a dedicated service for personality disorder offering day hospital treatment and an intensive outpatient programme (Types A and C). Specialist level therapies include long term individual and group psychoanalytic psychotherapy, family and couple therapy for psychosis and other disorders, cognitive analytic therapy, cognitive behaviour therapy, and long term supportive psychotherapy.

There is one point of entry for referrals, regardless of source. Following an assessment by a senior member of the team, patients are allocated to treatment at the appropriate level without further assessment. Training and supervision for mental health professionals, and consultation to teams are provided, and there is an active programme of research and audit.

Winterbourne House

The psychological therapies department ‘in-reaches’ to the psychiatric hospital inpatient service offering joint assessment, group psychotherapy, and consultation and supervision for staff. By this means, people are able to form a sound therapeutic alliance and engage with treatment, where appropriate, before they leave hospital.

(Contact: Amanda Stafford, Consultant Psychotherapist/Service Manager, at amanda.stafford@berkshire.nhs.uk)
Mode of delivery

3.26 In the past, psychological therapy departments were often committed to a single theoretical stance. This meant some patients did not receive the treatment indicated for their problems and choice was severely restricted. When units offer a variety of psychological therapies, and/or when therapists of different persuasions find ways to work more closely together, there is an increased likelihood that patients will access the most appropriate treatment quickly and easily. For example, much more could be done to strengthen access to psychological therapies for couples and for families.

3.27 The most common means to deliver a psychological therapy is via weekly face to face office-based hour-long meetings between the client and the therapist lasting for between 8 and 20 weeks, although longer treatments are available in some cases, for example, for people with personality disorder or long term depression. Some commissioners have only been prepared to fund very brief treatments (e.g., six sessions). However, the ‘Treatment Choice’ guideline makes the point clearly that treatments of fewer than eight sessions are unlikely to be effective for other than specific phobias and uncomplicated panic disorder. Sixteen sessions or more are generally considered necessary for symptomatic relief in more severe cases.

3.28 The use of less therapist-intensive methods of delivering help for people with relatively straightforward anxiety and depression – so-called ‘common mental disorders’ have also been explored. For example, telephone support is a simple intervention that can improve the care and outcome from depression.
3.29 Computerised treatments may also be a means to improve access and choice. Preliminary evidence suggests that some service users might actively choose this method of delivery over other means. The National Institute for Clinical Excellence has issued guidance on the use of computerised cognitive behavioural therapy for anxiety and depression. Although NICE concluded they could not recommend unquestioning use of the general range of products currently on the market, it is clear that some are better researched. Randomised controlled trials have been undertaken for Beating the Blues, Fearfighter and Stresspac and there is promising data suggesting they have potential.

Example

PsychologyOnline is a Nationwide private practice which provides information, consultations and psychological treatment via the Internet. Although this service says it is not suitable for people with a history of mental illness where the continuation of existing professional relationships is important, or for people who have had serious thoughts about suicide, it could be a useful adjunct to self help. The service may be contacted at www.PsychologyOnline.co.uk or by telephone on 01296 623193
In this section, unacceptable inequalities in access to psychological therapy services are discussed, and recommendations are made concerning how to reduce inequalities.

Social, cultural and economic inequalities

4.1 The gap in health outcomes between those at the top and those at the bottom of economic, cultural, and social hierarchies is large and growing. For example, in the early 1970s deaths amongst men of working age were almost twice as high for unskilled groups as for professional groups, and by the 1990s they were almost three times higher\(^3\). Inequities such as this are likely to also be true for outcomes from psychological therapy.

4.2 A recent longitudinal study by the Office for National Statistics\(^3\) of treatment for common mental disorders showed that, although need predicted overall service delivery, men (especially young men) were less likely to receive help. After adjusting for sex, age and problem severity, people who classed themselves as White, widowed and divorced, those living alone and lone parents with children, had greater chance of receiving mental health treatment or services (including psychological therapy) compared with other groups.

The Marlborough Day Hospital

This service offers psychotherapy and family work for children and families with severe mental health difficulties. Finding that there were many referrals from the Chinese community in central London, the Hospital approached the local workforce development confederation for help to establish a training programme in for Chinese speaking workers from the local community. Two such workers were offered a two-year training programme and now provide a vital liaison and therapy role with the Chinese community. They in turn have identified local community leaders who help channel families and children with difficulties to the appropriate services.
4.3 We already know that members of black and minority ethnic (BME) communities are less likely to be referred for psychological therapies and are less likely to be registered with a GP. The ONS survey showed that despite nearly 6.4 million people identified as belonging to BME community, only 10% (compared to 24% of their White counterparts) received treatment. Only 11% of the sample as a whole reported receiving a psychological therapy by way of treatment.

4.4 Work with translators and members of local communities who can help people access services, and/or shape their delivery in innovative ways show promise. People with severe mental ill health, a learning disability, or personality disorder are also commonly thought unsuitable for psychological therapies despite evidence that they would benefit.

Inequities in supply

4.5 The relationship between need and supply is complicated. Treatment delivery clearly depends on a number of factors. These include staffing; clients’ willingness to seek help; professionals’ ability to assess problems, understand the evidence base and their capability to deliver effective treatments. It also depends on clients’ preparedness to accept any treatment offered.
4.6 Treatment supply is also affected crucially by the availability of trained staff and this varies widely across different parts of the country. Thus, there are national as well as local geographical inequities in access to treatment. A well-organised psychological therapy service should offer behavioural, cognitive behavioural, psychodynamic and family interventions for the most common conditions, as well as counselling for adjustment disorders presenting in primary care.

4.7 It would also offer treatments for those with severe conditions where the evidence base was sound (as in the case for family and cognitive interventions for schizophrenia). Other therapies with a solid evidence-base such as Interpersonal Therapy or Dialectical Behaviour therapy may be considered, as well as brief therapies with particular applications, such as Cognitive Analytic Therapy.

4.8 In addition to shortages in the availability of trained staff, psychological therapists report difficulties gaining access to further training and continuing professional development (CPD). Further discussion of this issue and recommendations for local services to consider are discussed in section 7. As far as the national picture is concerned, it is difficult to obtain an accurate picture of the distribution of psychological therapy services.

4.9 Table 2 below is taken from the Mental health service mapping database at the University of Durham and it shows summary information for the main approaches. Although there are issues relating to the quality of this data, and it is likely that several services have not reported information yet, it appears that cognitive and behavioural treatments are still the most widely available. This information can be accessed in terms of the availability by Strategic Health Authority and by PCT. In future, as data quality improves, the database has the potential to provide good quality information concerning the main gaps in provision.

<table>
<thead>
<tr>
<th>Total services</th>
<th>Behavioural</th>
<th>CBT</th>
<th>Psychodynamic</th>
<th>Counselling</th>
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</thead>
<tbody>
<tr>
<td>396</td>
<td>163</td>
<td>102</td>
<td>113</td>
<td>190</td>
</tr>
</tbody>
</table>
Recommendation

Discuss local population demography with your local consultant in Public Health. What implications do local population statistics have for the way your psychological therapies service is organised and located? Ask whether the location or organisation of your services discriminates against particular groups directly or indirectly.
In this section we consider factors associated with value in psychological therapy service delivery. Recommendations are made concerning how to target the most effective treatments where they are most needed, reduce wastage and reduce the risks associated with failure to train and retain staff or deliver services safely.

**Efficacy and effectiveness**

5.1 The evidence for the effectiveness of psychological therapies is substantial across diagnostic groups and settings. Attempts have been made to establish “empirically validated” treatments, but the current state of knowledge is often not well enough developed to differentiate between different approaches and treatments; there are substantial gaps in the knowledge base. In general “brand names” rarely predict outcomes and in direct comparisons most studies show a broad equivalence between therapies.

5.2 Overall, the evidence base is most extensive for cognitive behavioural therapies, but there is growing evidence about psychodynamic, interpersonal, and systemic therapies and counselling. More work is needed to tease out findings from studies of efficacy (carefully designed studies of particular techniques used with restricted populations) and studies of effectiveness (undertaken in real life clinical settings with service users who commonly have multiple problems).

**Evidence based practice**

5.3 There are several current sources of evidence-based guidance that can be used to inform routine clinical practice. In addition to the ‘Treatment choice’ guideline already discussed, guidelines for referrals from primary to secondary care based on an analysis of systematic reviews of psychotherapy across diagnostic groups are available.
5.4 National guidance on the treatment and management of specific conditions including psychological treatments is also available from the National Institute of Clinical Excellence (NICE). NICE guidelines for the management of schizophrenia have been published, and guidelines on depression and eating disorders are on the way. These go a considerable way towards providing a rational structure for delivering psychological therapies, but there are still significant gaps, particularly for people with more than one condition.

**Recommendation**

Read the 'treatment choice' guideline carefully. Ask whether the service in your locality offers the treatment best supported by the evidence for the main presenting conditions: anxiety and depression; PTSD; adjustment problems; eating disorders; somatic complaints and personality disorder. Check whether the service is supplying in-effective or contra-indicated treatment and whether patients have any choice.

**Practice based evidence**

5.5 To complement the evidence-based guidance described above, there is also a framework for using local evidence to support practice. This is commonly known as “practice based evidence” (Barkham, M, 2003). Whilst evidence based practice can be seen as the process of disseminating the best information on "what should be done" in a service, practice based evidence including audit asks "has the right thing been done?" and "has it been done right?" There are three main components to consider: service audit and quality improvement; service monitoring and “benchmarking;” and routine outcomes monitoring.
Service audit
There is a well-established structure for service audit, designed to monitor actual service activity against accepted service standards and make recommendations for service change where there is a shortfall. The audit cycle is completed with monitoring to ensure that the desired changes have indeed occurred. Quality improvement strategies may include audit but extend beyond this to the use of additional processes such as “quality circles”.

Service monitoring and “benchmarking”
In addition to the above, it is important to monitor service accessibility, equity, diversity, and efficiency. Many services “benchmark” their performance on such measures against comparable services. Practice research networks (PRNs) are particularly effective ways of supporting such an approach to quality improvement.

Routine outcomes measurement
Systems in general use within mental health services, such as HoNOS, are not generally very useful as a way to measure outcome from psychological therapies. However, most psychological therapy services are moving towards routine measurement of outcome. Measures are typically used before and after treatment, but service researchers are developing methods to “track change” during treatments to improve effectiveness. These
systems (sometimes referred to as “report cards”) can improve awareness of those clients who are failing to respond or even deteriorating during therapy.

University of Leeds and Partners

How can a service decide which treatment is the most cost-effective option? Several centres have collaborated in a Practice Research Network (PRN) in the north of England with the Psychological Therapies Research Centre in the University of Leeds. Fifteen services have links and share data on mutually agreed projects. This allows staff to share research and data-handling tasks and make systematic comparisons to guide treatment length decisions and link research to practice and vice versa. Examples of work to date include a study of the value of HoNOS in psychological therapy services; and the development of a standardised assessment and outcome measurement system (CORE). PRNs are an effective way of sharing enthusiasm for research and quality improvement initiatives across disparate services.

Recommendation

Incorporate measures of outcome into your psychological therapies service as a matter of routine.

Cost-effectiveness

5.6 Cost effectiveness as a term is generally used to refer to economic valuations of one treatment versus another; whether treatment is better than no treatment; or of ‘offset costs’ – the cost to the health and social security system of not providing treatment. However, in the psychological therapy field these questions are not yet possible to answer. Firstly, there are very few true economic evaluations of treatment; second, it is difficult to place a financial value on some aspects of outcome (quality of life, or reduced need for social care, for example); and third, outcomes are not measured routinely.

5.7 Despite this, the evidence suggests that taking account of reduced costs (fewer prescriptions, less time spent in hospital and out-patients, greater likelihood of become employed) that psychological therapies can be ‘self-financing.’
5.8 There are also factors that have the potential to impair the cost effectiveness of an otherwise effective treatment – for example, treatment may be extended beyond the point that maximum improvement has been achieved – it goes on beyond the point when it should have ended. Alternatively, an effective treatment can be too short to deliver an effective ‘dose’ and this can happen when arbitrary restrictions are placed on treatment length. It is also possible to see how the effectiveness of treatment can be impaired if the therapist is not properly trained and supported to maintain high standards, or if failures in quality or ethical standards are not addressed within structured systems of corporate and clinical governance.

5.9 The ‘Treatment choice’ guideline (2001) argued that: ‘Cost effective intervention should be at the least complex, costly, and intrusive level consistent with effective treatment.’ The ‘stepped care’ approach described in section 5.16 would imply that, in addition to any necessary physical intervention, first presentations of depression or anxiety might be helped in primary care using low cost interventions such as computerised CBT, guided self-help or counselling prior to referral, if necessary to more specialised services.

**Primary Care CBT in North Devon**

In this large, rural setting, a psychological therapy service is provided in primary care. All surgeries have equal access to evidence based interventions (maximum eight sessions), with clear referral criteria for common mental disorders. Each surgery has an indicative number of referrals and there is monthly communication concerning capacity and waiting list status. A local target of six weeks to treatment has been agreed. All referrals are assessed pre and post treatment using CORE and HAD. A client satisfaction questionnaire is administered after treatment.

Close integration with Primary Care Health Teams ensures that staff develop knowledge and expertise. Therapists are employed by the PCT but a Service Level Agreement with the clinical psychology department ensures clinical leadership, support and supervision are provided.

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5.10 People with more severe or long-term problems can also be helped within primary care if GPs have access to an in-reach secondary service providing assessment for patients and supervision for their psychological therapy staff (e.g. graduate primary care mental health workers, practice counsellors) as well as treatment for selected cases.

5.11 Complex and severe problems will always require specialist assessment, formulation and treatment and such cases are generally best referred to and treated in secondary care where the additional support provided by specialised teams and services is more easily obtained. The assessment and treatment of complex cases is increasingly seen as a core task for specialist psychological therapy departments.

**Clinical governance**

5.12 Clinical governance is the framework through which NHS organisations are accountable for improving the quality of their services; for safeguarding standards; and for creating an environment in which excellence in clinical care will flourish.

5.13 Creating plans to address deficiencies in a service or service gaps are as much a part of clinical governance as establishing outcomes measurement, or systems to ensure equity of access and systems to manage waiting lists effectively. Safety is an essential component of clinical governance. Like any effective treatment, psychological therapy has the capacity to do harm if it is provided inappropriately or inadequately, or if it is delivered in an unethical fashion.
MANCHESTER MENTAL HEALTH AND SOCIAL CARE TRUST

Manchester Mental Health and Social Care Trust has followed the example set by its Medicines Management Committee. Frank Margison has established a committee to explore quality standards for psychological therapies. The committee is concerned with:

- Quality standards
- Providing evidence based treatments
- Considering new evidence
- Providing effective information to promote informed choice for service users
- Developing guidance

The committee has representation from service users and carers, involvement of staff from all leading treatment modalities, and settings. The committee has responsibility for advising the trust on all quality and governance issues relevant to psychological therapy.

Safe practice

5.14 Damage may be done to individual clients, and the dangerous consequences of bad therapy may impact on Trusts and other mental Health organisations as a whole, either by repute, through litigation, or both. Psychological therapies can become unsafe if delivered by untrained practitioners, without adequate supervision, in unskilful ways to the wrong clients with the wrong diagnoses. Unethical practices may include financial and sexual exploitation of clients, or at a less severe level, collusive protracted psychotherapeutic relationships that are wasteful of professional resources.
5.15 The tradition of reflective practice in psychological treatments makes a valuable contribution to maintaining safe practice. The regular clinical supervision will encourage reflective practice and needs to be available to all staff. Regular clinical discussion of the team's work is central to reflective practice and also helps to monitor the overall safety of the clinical work.

Well trained and supported staff

5.16 The importance of staff training and support cannot be underestimated. Local services therefore need a clear training strategy for the different modalities of treatment to ensure their quality. This will include defining the standards of training required for basic and advanced level practitioners. The strategy will need to include training pathways within the service, so practitioners can progress as they gain experience.

5.17 An effective program of continuing professional development (CPD) is also needed to help staff with their professional development and support the quality and safety of their clinical work. This will ideally be integrated with routine staff appraisal and clinical supervision to ensure a high quality of practice and also to ensure that any problems that arise in the interaction with patients are understood and monitored. Because so many components of psychological therapy provision are organisationally separate, this can be a difficult task for local commissioners and employers to support.

**Recommendation**

Some of the dangers of unsafe practice can be guarded against by:

- Ensuring that only well-established treatment modalities based on sound clinical and research evidence are deployed.
- Ensuring that practitioners have had accredited training, recognised by professional bodies with appropriate standards.
- Ensure full integration with the Care Programme approach, where appropriate to ensure close collaboration with other staff and services for people with severe mental illness.
- Ensuring that psychotherapy practitioners have in place a system of regular supervision of their clinical work.
5.18 Counsellors working in primary care who commonly have a different employer than secondary, more specialised psychological therapy staff, face a particular challenge. Many are employed on variable terms and conditions, from different budgets; some are self-employed; and not all have indemnity insurance. Helpful guidance is provided by the National Primary Care Research and Development Centre\textsuperscript{47} on the different models for organising and supporting such services. Helpful guidance on best practice employing counsellors and psychotherapists has also been published by the British Association for Counselling and Psychotherapy\textsuperscript{48}.

Complaints

5.19 An effective system of dealing with patients’ complaints\textsuperscript{49} and enquiries needs to be in place in each service. This enables the service to monitor areas where the safety and quality of the service may be falling short of best practice. Regular discussion and review of complaints can be undertaken in team meetings. This will also enable the staff team to discover areas in which both individual and generic practice are problematic. Individuals who are outside the service but have good links with it may provide a valuable perspective, e.g. PALS Officer or Trust Complaints Manager, when they engage in a review of a complaint.

Leadership and management

5.20 Preliminary evidence gathered by the Division of Clinical Psychology for the British Psychological Society shows vacancy rates rising to as high as 22%, despite significant growth in the overall number of posts. There is also evidence that posts in psychiatry are being lost due to early retirement, and there are difficulties recruiting into nursing and other mental health specialisms.

5.21 Good leadership and effective management of services are essential for the preservation of effective psychological therapy services. There is some evidence in some parts of the country that NHS re-organisation has impacted in an unhelpful way. It is alleged that financial shortfalls in some Trusts have led to cuts in services that have come to be regarded as ‘non-essential’, or services that are not specifically mentioned in the Planning and Priorities Framework. In some places, the process of re-deploying staff (to PCTs from secondary services or vice versa), following
plans to ‘level up’ provision across a geographical area, has led to a failure to retain staff.

Recommendation

It can be helpful to establish a local Psychological Therapies Management Team (PTMT) with senior management input to explore issues relating to the management and organisation of the service.

5.22 Nationally, it is important to maintain a clear focus on the importance of psychological therapies as an essential component of effective treatment and care. The recently published outcome of the ‘Choice’ consultation (www.dh.gov.uk/ChoiceConsultation) supports their importance to service users and carers. At local level, it is important that there is effective leadership and effective management of service planning for the provision of effective, evidence-based psychological treatments across the whole health economy; to develop recruitment, training of staff and to support their retention. This is very important at a time when psychological therapies are in such high demand, and when there is clear policy support for improving access.

5.23 It can be helpful to ensure there is a representative of psychological therapies at Trust Board or Executive level to guide this process. A Trust-wide body with responsibility to oversee the implementation of good psychotherapy practice and any Department of Health principles is strongly recommended. Representation at this level can also help to identify and remove inequalities in service provision within a trust, and engage in an informed discussion with PCT’s and other commissioning bodies.

5.24 As has been argued in other parts of this report, the coordination of locality based psychological therapy services is an essential first step towards improving quality, choice and equity. The aim is not just to ensure that service users can access the different approaches more easily, though this is very important, but also to ensure that practitioners themselves are able to deliver services to the highest standard and obtain the support they need.
5.25 Regular business and clinical meetings of therapists from different agencies and approaches can be helpful as a means to clarify roles, share referral protocols and ensure that patients can access the best available treatments for their problems. Communication between teams can also be facilitated by this means, with agreement on responsibility for issues such as onward referral, confidentiality, CPA, prescribing and crisis management.

5.26 A coordinated service has a system for ensuring that patients can access the best treatment for their problems as quickly as possible. This may mean a single point of entry for a screening assessment and clear transfer protocols if a patient is not suitable for the therapy offered by the service.

5.27 The service will also need to ensure that senior and advanced practitioners are able to retain a substantial clinical practice, while being in a leadership role within the service, so that the clinical work is not primarily done by the most junior, least experienced practitioners.
Psychological therapies have an important place amongst the range of treatments available as part of comprehensive, user-centred mental health services. As the evidence base for the effectiveness of psychological therapies has grown, so has their popularity; they should no longer be regarded as ‘optional’ components of mental health care.

This report is aimed at helping local commissioners and providers to develop effective services, and organise and manage them well. Its recommendations are based on a range of well-established scientific evidence, but also on professional consensus and the views of service users. A summary of the key recommendations for those with different levels of responsibility in the system of care is provided in the next section. A Framework for developing quality standards in psychological therapies services (Frank Margison) is provided at Annex C. This may be helpful for those directly involved in auditing services and/or with responsibility for clinical governance.
7 Recommended Action Points

1 Service users and carers
   a) User groups are entitled to involvement in planning, delivery and evaluation of psychological therapy services.
   b) Consider how best to achieve this locally.
   c) Service users can contact the NIMH(E) expert patient programme to share experience from a personal perspective.
   d) Service users in contact with or seeking to use psychological therapy services, can look at the ‘Choosing Talking Therapies’ booklet to help them understand the issues and the questions to ask.

2 Psychological therapy practitioners
   a) Establish a local Psychological Therapies Management Team (PTMT) with senior management input to explore issues relating to the management, organisation and delivery of a comprehensive service.
   b) Implement a ‘stepped care’ approach to delivering psychological therapies.
   c) Ensure that service delivery is not restricted by extraneous factors such as ethnicity, age, gender, and diagnosis and pay special attention to marginalised groups such as people with learning disabilities, older people and people from black and minority ethnic communities.
   d) Explore means to measure outcomes routinely, including quality of life and service user satisfaction.
e) Disseminate information to service users and carers, other practitioners and service commissioners and managers so that psychological therapies are longer seen as a luxury, but rather as part of the mainstream of mental health services.

3 Primary Care Trusts

a) An assessment of local population needs can be used to inform levels of service provision.

b) It would be helpful to prioritise the development of primary care based psychological therapies for people with common disorders, including computerised CBT, and co-ordinate provision so that access is equitable.

c) Ensure appropriate input from secondary care for the assessment of complex cases and for supervision.

d) Listen to the views of service users seeking better access to a wider range of psychological therapies and involve them in service design, delivery and evaluation.

4 Specialised mental health trusts

a) Secure direct representation on the Trust Executive Board of psychological therapy service provision.

b) Develop a psychological therapies clinical governance strategy, comparable to the Drugs and Therapeutics Committee, to monitor the quantity and quality of psychological therapies within the Trust. As for primary care trusts (above) service users and carers should be involved.

c) Arrangements should be improved to support staff who have undertaken training to practice their new skills once they return to work.

d) Contribute to the debate about the most suitable performance indicators for psychological therapies, of which waiting times for psychology and psychotherapy assessment is currently the most promising. Early planning for this eventuality is recommended.
Recommended action points

5 Strategic Health Authorities

a) The need for a ‘psychotherapeutically literate’ workforce should be recognised and become part of a strategic objective for service development – especially in relation to the functioning of new teams and services.

b) The provision of training and supervision in interpersonal, relationship and psychological matters could be developed as benchmarks for the measurement of trust performance.

6 Workforce Development Confederations

a) An inventory of local training courses in psychological therapy together with the most commonly used out-of-area training courses would be helpful to develop.

b) A training needs assessment exercise should be undertaken in order to prepare a psychological therapy training strategy, with short, medium and long-term aims.

c) Clarity for Workforce Development Confederations as to the scope and purpose of the main providers of psychological therapy will be important as a basis for planning training and commissioning workforce numbers.

7 Higher Education Institutions

a) Consider establishing training programmes in psychological therapies – including ‘short courses’, and also at Diploma and Masters levels.

b) Liaise with WDCs about gaps in psychological therapy provision and what would be the most suitable courses to mount.

c) Find ways to include research in psychological therapies as part of the University Research programme.
8 Mental Health Act Commissioners

a) When investigating Mental Health Trusts consider ways in which quality – i.e. effectiveness – of care could be improved if good psychological therapies were available.

b) Communicate this to Trust management via both local and national reports.

9 Professional Bodies

a) In planning pre-registration training programmes in Medicine and Psychiatry, Nursing, Clinical Psychology, Occupational Therapy, etc., consider psychological therapy training needs explicitly.

b) Interview skills, rapport building, simple cognitive behavioural interventions, and understanding of individual and group dynamics should be integrated into the training of all mental health professionals.

c) Consider establishing interdisciplinary training modules where psychological therapies can be accessed by people from different professional backgrounds.
Thanks are due to all those who contributed to meetings, discussion and to drafts of this document during 2003.

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Professor David Mears, Associate Dean, Education, University of Strathclyde.
Annex B  References


14 Department of Health (Dec 01) ‘Choosing Talking Therapies’ Free from DH publications, PO Box 777, London SE1 6XH or from the web site: www.doh.gov.uk/mentalhealth


16 More information about the NIM H (E) expert patient programme can be found on the NIM H (E) website at www.nimhe.org.uk. Jan Wollcroft leads and can be contacted on 0789 0819373.


19 The Institute for Psychotherapy and Disability, 1, Northcliff Road, Kirton Lindsey, Gainsborough, DN21 4NJ.

20 see reference (1) above.

21 www.chi.nhs.uk
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25 See reference (2) above.


30 Department of Health (July 03) ‘Tackling health inequalities.’ 32366 www.doh.gov.uk/healthinequalities/programmeforaction order by email doh@prolog.uk.com or write to PO Box 777, London SE1 6XH


41 see Audin et al (2000) above.


Wilson, K (2002) ‘Improving patient access to a wider range of psychological interventions: Recommendations for the commissioning of education and training for the health professional workforce in West Yorkshire.’ West Yorkshire Workforce Development Confederation. Kath.hinchliff@westyorks.nhs.uk


Department of Health ( )
www.doh.gov.uk/complaints/makingthingsright
## Framework for markers of best practice in psychological therapies services

<table>
<thead>
<tr>
<th>Desirable features of a psychological therapy service</th>
<th>Level 1: Not present at all</th>
<th>Level 2: Minimal evidence of the feature</th>
<th>Level 3: Making significant progress</th>
<th>Level 4: Present to a notable degree</th>
<th>Level 5: Present to an extent that warrants “beacon status”</th>
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<tr>
<td>Targeting those with greatest need</td>
<td>Accept any referrals with no protocols in place, no prioritisation for either assessment or for offering therapy</td>
<td>Some priority given for “urgent cases” as defined by the referrer</td>
<td>Clear processes in place to “triage” referrals to ensure priority is given to those with greatest need</td>
<td>As Level 3, but also a sophisticated awareness of the “trade off” between meeting greatest need and providing the most efficacious treatments</td>
<td>As Level 4, but also built into protocols which are regularly updated to optimise the overall effectiveness of the service</td>
</tr>
<tr>
<td>They are multi-disciplinary and multi-professional, i.e.; they do not confine themselves to a single psychotherapeutic modality or to a single grouping.</td>
<td>Operates to a single model for which clients have to “apply”. No advice given if client “not suitable”, no links to other professional groups or “case sharing”</td>
<td>Advice given to the referrer about alternative sources of help, but the service itself operates to a single model!</td>
<td>The service concentrates on one modality but is skilled in providing advice about a range of therapies and can expedite cross referrals because of good inter-agency and interservice relationships</td>
<td>The service is noted for giving accurate advice across a wide range of possible modalities, and can act as “brokers” to ensure that the client ends up with appropriate help. Some therapies available “in-house” but usually means a new internal referral</td>
<td>The service not only acts as an effective “broker”, but the staff have a wide range of skills and can offer a wide range of therapies with minimal “re-assessment” in-house</td>
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<tr>
<td>There is a clear training strategy, aiming to skill the workforce to meet the clinical needs of the population served.</td>
<td>The service has no training function, and takes on already trained staff who are responsible for their own professional development</td>
<td>The service does not have a training role but provides a structure for CPD and reviews the individual’s PDP with a view to service development needs</td>
<td>The service manages its own staff optimally by providing on-going education and support for CPD in a way which is clearly linked to identified therapy needs in the local population</td>
<td>The service operates at Level 3 for its own staff but provides some training and development for other staff</td>
<td>The service operates at Level 3 for its own staff and is part of an integrated training and development programme for the local workforce to increase psychological awareness and to train in psychological therapies</td>
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<td>They tend to have a single point of entry to emphasise the importance of assessment, and the use of referral protocols and procedures</td>
<td>The service takes referrals on an “ad hoc” basis from any referrer for any problem, irrespective of other services available locally, or the skills of the staff in the service. There are no agreed referral protocols.</td>
<td>The service takes referrals from a defined set of sources, but does not aid referrers in their decisions by making explicit advice about treatment suitability. There are no protocols.</td>
<td>There are clear protocols defining who is suitable for the service, but there is no advice about alternative sources of help.</td>
<td>There are protocols in place to aid referrers and those referred to understand the range of options available. The protocols are well supported by evidence, and are readable and widely available.</td>
<td>As in Level 4 but supported in addition by a readily available source of advice and support to aid the referral process from the outset</td>
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<td>They find ways to involve service users and carers.</td>
<td>Service users are not involved other than as recipients of treatment which has been arranged for them</td>
<td>Service users have involvement in choices about their own treatment within parameters set by the professional</td>
<td>Service users are involved collaboratively in choices about services, and are also represented to some extent in advising the service about future directions</td>
<td>Service users are involved as at Level 3, but also are represented in a transparent way in the overall management of the service</td>
<td>Service users are involved at every level of the service, and can influence a broad range of issues such as training priorities, treatment choices, improving access, and are involved in monitoring the service’s performance</td>
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<td>They have a clear understanding of the need for a ‘tiered’ psychological therapy network and for transfer protocols indicating which sorts of disorders are best managed by whom.</td>
<td>There is no distinction made in terms of referrals between those who need specialist services and those who can be effectively treated at a local level within non-specialist services.</td>
<td>There is a distinction between services at primary care and specialist care, but there are no protocols to aid decision making, and no shared systems.</td>
<td>Primary care and secondary care have clear arrangements about which disorders and problems can be best dealt with at each level, and there are arrangements in place and monitored to ensure that referrals are routed correctly</td>
<td>Primary care and the independent sector have access to “Tier 2” services which can deal with “intermediate” levels of difficulty, but where necessary can refer on to specialist services</td>
<td>There are clear arrangements between independent, primary, Tier 2 and specialist care with supporting protocols, an agreed joint training strategy, and common documentation including agreed outcome measures</td>
</tr>
<tr>
<td>Manages waiting lists effectively.</td>
<td>Waiting lists are not managed. Referrals are seen erratically and there is no system of prioritisation</td>
<td>Referrals are monitored so that the waiting time to the next appointment can be estimated</td>
<td>Referrals and waits for specialist forms of therapy are jointly managed so that estimated waits for all forms of therapy are readily available</td>
<td>Waiting lists are as in Level 3 but are also actively managed so that targets are set and if they are likely to be exceeded, action is taken to pre-empt this</td>
<td>Waiting lists are actively managed and resources are deployed proactively to prevent excessive waits, or there is a system which is managed so that waits are minimal</td>
</tr>
<tr>
<td>Undertakes regular routine audit and research.</td>
<td>No audit or research is undertaken, and there is no self-reflective capacity in the service</td>
<td>No audit or research is undertaken, or audits are undertaken which are not constructed in a way which allows useful conclusions, but there are opportunities to reflect on practice</td>
<td>Audits are undertaken which complete a cycle and can be demonstrated to improve practice. No research or research is “ad hoc” and unrelated to the service.</td>
<td>There is a good range of audit and research, (including externally funded), and results are fed back to the service</td>
<td>As in Level 4, but in addition there is service user involvement and opportunities to reflect on services in the light of research and audit</td>
</tr>
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### Framework for markers of best practice in psychological therapies services (Continued)

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<td>Has a clear and defined leadership structure.</td>
<td>Individuals and teams relate only in casual ways, with no shared accountability</td>
<td>There are professional leads but no other co-ordination of the service</td>
<td>There is a clearly defined leadership structure which deals with professional accountability</td>
<td>There is a clearly defined leadership structure which deals with professional accountability but also allows a shared sense of direction, and capacity to monitor against agreed goals</td>
<td>The leadership structure is effective and accountable, but also provides a shared vision with effective monitoring of short and long term goals which have been discussed and agreed with service users.</td>
</tr>
<tr>
<td>Is well integrated into the mental health services as a whole [i.e. supports the delivery of a service that is 'psychologically minded'].</td>
<td>The service stands alone and does not relate to other services clinically or managerially</td>
<td>There are organisational links to allow shared “business planning”, but no clinical or training links</td>
<td>As Level 2, but also some cross-referral, and joint training in place</td>
<td>The service has a clear place in the overall health economy, and there are clear and transparent arrangements for staff of other services to work jointly and to receive training and support</td>
<td>The service is as Level 4, but also carries a leadership role across services for improving psychological awareness</td>
</tr>
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