CENTRE FOR WORKFORCE INTELLIGENCE

Improving workforce planning for the psychological therapies workforce

April 2013

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Table of contents

Executive summary

The Department of Health (DH) commissioned the CfWI to undertake a review of the workforce delivering adult psychological therapies to the NHS in England, with a specific focus on non-IAPT (Improving Access to Psychological Therapies[1]) services.

Psychological therapies are recognised as effective treatments for a wide range of mental health needs, with an increasing evidence base demonstrating the effectiveness and economic benefits of psychological interventions. The National Institute for Health and Clinical Excellence (NICE) recommends that psychological therapies be made available on the NHS as first-line interventions for a number of conditions.

> **"The psychological therapies workforce is a very important element in realising the Government's ambitions to improve outcomes for people with mental health problems as outlined in the Mental Health Strategy, 'No health without mental health'. This analysis, led by the Centre for Workforce Intelligence in partnership with a number of other key organisations, will be of great value in helping us all to understand better our current and future workforce planning requirements."**
>
> **Dr Hugh Griffiths, National Clinical Director for Mental Health, Department of Health (2012).**

This report summarises the CfWI's approach to this review, describes our engagement with stakeholders and partners and explains how these discussions informed developments. It establishes a consensus definition of what a psychological therapist is across all therapy modalities incorporating feedback from professional bodies, service users, therapists and employers. It highlights the limitations of the current information about the NHS psychological therapy workforce and provides data on what we currently know about this workforce, it highlights the reasons why better planning for this diverse workforce is crucial, and makes recommendations about how the situation can be improved.

What we have done

Working with the DH and the NHS Confederation Mental Health Network Workforce Reference Group, we convened a project advisory group[2] comprising high-level representation of those with subject matter expertise from a range of professional and regulatory bodies, employers and service providers. The project advisory group supported and guided the review, providing advice, feedback and, where appropriate, potential solutions on workforce issues and concerns.

Why we have done it

We have tried to make sense of existing workforce intelligence and developed a definition of a psychological therapist to help policymakers, commissioners and providers to better understand and shape the future direction of the workforce. Commissioners need to understand both the available workforce and the skills and knowledge required to meet local needs and national priorities to:

- identify workforce numbers
- plan effectively for the future workforce supply
- conduct workforce profiling
- ensure effective education and training commissioning
- identify the contributions psychological therapists make to improving patient outcomes.

Who it is for

The report is intended for policymakers and decision-makers across the changing landscape of the NHS:

- At a local level:
  - clinical commissioning groups
  - local education and training boards (LETBs)
  - health and wellbeing boards (HWBs)
  - local Healthwatch organisations.
- At a national level:
  - the Department of Health

[1] Further information about the IAPT Programme can be found at: http://www.iapt.nhs.uk/

[2] Members of the project advisory group are listed at Annex 1.

  - NHS England
  - Health Education England (HEE)
  - Public Health England (PHE).
- employers and service providers across the private, independent and voluntary sectors
- professional bodies and regulatory organisations
- service users and their supporters.

Key findings

- There is inconsistent and incomplete data about the psychological therapies workforce.
- There is currently no consistent single definition of what a psychological therapist is, although there is a clear desire to have a definition and to promote a shared understanding across all psychological therapy modalities.
- There is wide agreement and strong support for the definition proposed by the CfWI.
- There are potential practical benefits of using this definition in the workplace and elsewhere: feedback from testing the definition in practice (although limited in its scope) suggests it would be useful.
- There are circa 29,000 psychological therapists in England who would currently fit this definition with, potentially, a significant number of others who could meet the required standards.

Definition of a psychological therapist

After careful consideration of the feedback received from stakeholders, and discussion with the project advisory group, the CfWI proposes that to be defined as a psychological therapist, the following standards must be met.

Required standards for a psychological therapist:

1. To have completed one year of recognised full-time (or equivalent part-time) psychotherapy or counselling training leading to a qualification, certification or accreditation recognised by a relevant professional or regulatory body.

2. To have achieved a competency level that fulfils the requirements of the regulatory, accrediting or professional body.

3. To be a member of a relevant professional or regulatory body, and continue to fulfil any accreditation or membership criteria, including meeting requirements for:
   - continuing professional and personal development
   - regular supervision
   - codes of practice.

4. To have gained the supervised therapy experience required by the regulatory or professional body.

Recommendations

- The proposed definition of a psychological therapist is adopted and promoted across the system to ensure a consistent single definition of a psychological therapist.
- Any subsequent recommendations of the subgroup to the Workforce Information Review Group (WIRG) established to review the coding and classification of the psychological therapy workforce are adopted.
- All providers of NHS-commissioned psychological therapy services (across all sectors) are required to gather workforce intelligence and comply with WIRG subgroup future recommendations on classification and coding of the workforce.
- Further work to be done to raise the profile and secure the future supply of the psychological therapy workforce, building on the findings of this review to quantify the existing workforce (for example, with regard to geographical distribution and types of therapy modalities delivered).
- Discussions to take place between key partners in the sector (e.g. the DH, HEE, PHE and NHS England) to agree how this future work is commissioned and taken forward.
- Employers and service providers to undertake workforce capacity assessments to ensure they understand their own workforce delivering psychological therapies across different levels of intensity, and to help to ensure maximum utilisation of current capacity.

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1. Introduction

1.1 Background and context

Effective workforce planning across organisations delivering and commissioning psychological therapies will be crucial for the future development of the workforce as a whole and for professional training and practice.

In particular, it will be vital to meet the objectives of the Government's strategy paper for mental health, *No health without mental health: A Cross Government Mental Health Outcomes Strategy for People of All Ages* (DH, 2011a), and the aims of the Care and Support white paper (DH, 2012a) and the draft Care and Support Bill (DH, 2012b)[3].

The DH commissioned the CfWI to undertake a review of the workforce delivering adult psychological therapies[4] to the NHS in England, with a specific focus on non-IAPT (Improving Access to Psychological Therapies) services. The rationale for this decision was that good intelligence about the current IAPT workforce already exists; information on the IAPT workforce is currently gathered separately from mainstream workforce data. To explore the potential future workforce supply, there was a need to concentrate on elements of the psychological therapies workforce where intelligence is more limited, (see section 1.3 for further information on the review's scope).

Currently, there is no clear or consistent way of categorising and collating information on the psychological therapies workforce. Consequently, there is no robust way of planning strategically for future workforce and training needs.

The existence of a wide range of funding streams also makes this group of staff less visible to commissioners and providers. In particular, training for many in this workforce is often self-funded. Commissioners need to understand both the available workforce, and the skills and knowledge required to deliver national priorities.

> **"We can only be sure to improve what we can accurately measure."**
>
> **Lord Darzi, *High Quality Care for All* (2008).**

[3]The draft Care and Support Bill sets out a vision of a transformed and integrated social care system that is focused on prevention and built around the needs and goals of people.

[4] The term psychological therapies is used throughout this document to include counselling, psychotherapy and arts therapies.

1.2 Aims of the review

The aims of the psychological therapies workforce review are to:

- gain a clearer understanding of the difficulties in planning for the psychological therapies workforce
- gather information on current and potential sources of information on the psychological therapies workforce
- identify potential areas for improvement in planning the psychological therapies workforce of the future, including workforce supply and education and training provision.

1.3 Scope of the review

The scope of the review is limited to the provision of psychological therapies for adults, and concentrates on psychological therapies funded by the NHS in England.

This review focuses specifically on psychological therapists: those delivering therapy as independent practitioners and for whom it is their primary role, irrespective of their professional background.

Therefore the term includes high-intensity therapists in IAPT services, but not psychological wellbeing practitioners (PWPs), who provide low-intensity interventions. PWPs make a vital contribution to the wider psychological therapy workforce, but their training and experience would not equip them to be defined as independent psychological therapists in accordance with the definition proposed by this review.

Furthermore, the scope of the review does not include the wider workforce for whom the delivery of psychological interventions is only part of their broader role.

1.4 Building a community of interest

Our review of the psychological therapies workforce involved working collaboratively with stakeholders and ensuring their involvement from the outset. To this end, the CfWI, together with the DH and the NHS Confederation Mental Health Network Workforce Reference Group, convened a project advisory group with high-level representation and support from a range of professional and regulatory bodies, employers and service providers. The group also included those with subject matter expertise on NHS information systems, representatives from commissioners, and those representing local education and training boards (LETBs).

The overarching purpose of the project advisory group was to provide a forum to utilise this multi-professional knowledge, expertise and experience to support the planning and the future development of the psychological therapies workforce.

In addition to those represented on the project advisory group, the review draws upon the views of a wider group of stakeholders. We have actively engaged with service users, carers and supporters, psychological therapists and individuals with an interest in this area to inform the outcomes of the review and this report. We have shared our thoughts and findings with them by posting information on the CfWI website and providing regular updates to networks and umbrella groups such as the NHS Confederation Mental Health Network Workforce Reference Group, and we have actively encouraged comments and feedback from them on the definition of a psychological therapist.

2. The current picture

2.1 About psychological therapies

The term psychological therapy refers to a range of interventions to help people understand and make changes to their thinking, behaviour and relationships to relieve distress and to improve their functioning, well-being and quality of life. The most common psychological therapy modalities include cognitive behavioural therapy (CBT), psychodynamic psychotherapy, interpersonal therapy, arts therapies (including art, music and drama therapy), counselling, and family and couple therapy.

Psychological therapies are recognised as effective treatments for a wide range of mental health needs, with an increasing evidence base demonstrating the effectiveness and economic benefits of psychological interventions. The National Institute for Health and Clinical Excellence (NICE) recommends that psychological therapies be made available on the NHS as first-line interventions for a number of conditions.

2.2 Policy drivers

2.2.1 No health without mental health

No health without mental health (DH, 2011a), the Government's strategy paper for mental health, makes a commitment to 'parity of esteem between mental and physical health services', and pledges significant investment in psychological therapies.

In *Talking therapies: a four-year plan of action*, a supporting document to *No health without mental health*, the Government outlines in more detail its commitment to expanding access to psychological therapies, and to offer a choice of high-quality evidence and practice-based psychological therapy interventions. By 2015, the aim is to complete the nationwide roll-out of IAPT services for adults of all ages who have depression or anxiety disorders, and expand access to talking therapies services for people with severe mental illness. Psychological therapies are to be made more widely available to people with physical long-term conditions or medically unexplained symptoms, and to children and young people. Improved access, quality and choice are among the principles that underpin the approach outlined in the plan.

The mandate for NHS England, the 'contract with the NHS,' will specify that mental healthcare should be on a par with physical care and that it values mental and physical health equally. The psychological therapies workforce is critical to the Government's ambition to create this 'parity of esteem'

> **"We will be asking the NHS to demonstrate real and meaningful progress towards achieving true 'parity of esteem' between mental health and physical care by March 2015."**
>
> **Norman Lamb, Care and Support Minister (2012).**

The Government believes that NHS patients should wait no longer for mental health therapies than they do for treatments for their physical conditions.

2.2.2 Improving access, quality and choice

The Government is committed to increasing choice and personalisation in NHS services both in terms of choice of provider and choice of treatment. Reforming the way in which services are commissioned forms the cornerstone of the changes to the NHS. The NHS white paper *Equity and Excellence: Liberating the NHS* (DH, 2010) sets out the Government's long-term vision for the future of the NHS. It details proposals to 'put patients at the heart of everything the NHS does', and for GPs and health professionals to be given more autonomy to commission local services. It also outlines the Government's intention to move the NHS away from focusing on process targets to measuring health outcomes.

The NHS Outcomes Framework (DH, 2012c) reflects the vision set out in the white paper (*Equity and Excellence: Liberating the NHS*) and contains a number of indicators selected to provide a balanced coverage of NHS activity. The outcomes framework for 2013–14 has added a measure for psychological therapies. A new indicator will measure outcomes for depression and anxiety disorders through the delivery of the IAPT programme.

The mandate to NHS England says the Government will work with them to consider new access standards, including waiting times for mental health services. NHS England will be required to measure levels of access and waiting times for mental health services, and clinical commissioning groups (CCGs) will have to address unacceptable delays and make significant improvements in access to services.

> **"Mental health has been excluded from major health policies, such as waiting-times standards, and people have suffered as a consequence. I am determined to end this institutional bias that exists in the health service."**
>
> **Norman Lamb, Care and Support Minister (2012).**

2.2.3 Other policy initiatives

Other policy initiatives include a drive towards integrated care pathways and simplified patient journeys, with integration around the patient and not the system. The Government believes that there is an extremely strong case for investing in psychological therapies to save costs to acute care, social care and other public services. It realises the benefits that can be achieved through addressing emotional and psychological needs and the key role psychological therapists can play in supporting people living with long-term conditions and medically unexplained symptoms (*Talking therapies: A four-year plan of action,* DH, 2011b). This is particularly relevant as the number of people with multiple long-term conditions is set to rise from 1 million in 2008 to 2.9 million in 2018 (DH, 2010).

2.3 Economic and social drivers

Mental health issues exact an enormous personal, social and economic cost. In their 2010 report on the *Economic and social costs of mental health problems,* the Centre for Mental Health (CfMH, 2010a) estimated that in economic terms the cost to the economy is around £105 billion annually.

> **Mental ill health constitutes the largest source of burden of disease in the UK. No other health condition matches mental illness; it contributes almost 23 per cent of the overall burden of disease compared to about 16 per cent each for cancer and cardiovascular disease.**

The National Institute for Health and Clinical Excellence (NICE) recommends that psychological therapies be made available on the NHS as first-line interventions for a number of conditions. NICE guidance sets the standards for high-quality healthcare and encourages healthy living. NICE guidance can be used by the NHS, Local Authorities, employers, voluntary groups and anyone else involved in delivering care or promoting well-being (www.nice.org.uk).

> **"We live in a stressful society and the number of patients with mental health problems presenting to GPs is on an upward spiral. GPs face tremendous challenges in caring for patients with mental health problems in primary care and we welcome any development which will help us improve their care."**
>
> **"GPs must have access to a range of talking therapies, from counselling and cognitive behavioural therapy to longer term psychotherapies, for the wide range of conditions that we see in our consulting rooms."**
>
> **Professor Clare Gerada, Chair of the Royal College of General Practitioners - comments on the report *How Mental Illness Loses Out in the NHS* (2012).**

While the economic cost of supporting unaddressed mental health needs is high, there is also evidence to support the argument that investment in mental health services, and psychological therapies in particular, can lead to significant economic savings:

- *The depression report: a new deal for depression and anxiety disorders* (LSE, 2006) by the Centre for Economic Performance's Mental Health Policy Group made the argument that the effective treatment of anxiety and depression can save the NHS money.
- *We need to talk* (MIND, 2010a) a report sponsored by numerous mental health and other charities, pointed to £1 billion of economic benefits that could be achieved each year by extending NICE-recommended treatment to all those with depression and anxiety.
- *How mental illness loses out in the NHS* (LSE, 2012) from the Centre for Economic Performance's Mental Health Policy group suggests that treatment for the common mental disorders of anxiety and depression can be self-financing within the NHS. The report suggests that NHS trusts are failing to commission evidence-based psychological therapies such as cognitive behaviour therapy (CBT) and family therapy, despite their being recommended by NICE. The costs of psychological therapy are relatively low and recovery rates are high (at around 50 per cent), so the report argues investment in psychological therapies will almost certainly pay for itself through higher rates of employment among people with mental health problems, reduced disability benefits and extra tax receipts.

> **"If local NHS commissioners want to improve their budgets, they should all be expanding their provision of psychological therapy."**
>
> **"It will save them so much on their physical healthcare budgets that the net cost will be little or nothing."**
>
> **Professor Lord Layard (2012).**

2.3.1 Wider economic and social changes likely to affect demand

A number of economic and social factors may also result in increasing demand for psychological therapies:

- The current economic climate, including unemployment, personal debt, home repossessions, offending and family breakdown may lead to a rise in mental health need. A survey for the mental health charity Mind (2010b) *Workers turn to anti-depressants as recession takes its toll,* found that since the last recession, one in ten workers sought support from their doctors and 7 per cent started taking antidepressants for stress. Additionally, their mental health needs were directly caused by the effects of the recession on their workplace[5]. The findings, which launched Mind's campaign *Taking Care of Business*, coincided with Government statistics showing the biggest rise in antidepressant prescriptions ever, with a record 39.1 million issued in 2009, up from 35.9 million in 2008[6].
- Demographic changes – including the ageing population and the increasing longevity of those with long-term conditions and complex needs – may also increase demand for psychological therapies. According to the Office for National Statistics (ONS, 2010a), the population in England is estimated to increase from approximately 52.7 million in 2011 to 60.8 million in 2031, an increase of approximately 15 per cent. The ONS estimates that the number of people aged 65 and over is likely to increase from approximately 8.8 million in 2011 to 13.2 million in 2013, an increase of approximately 51 per cent. Traditionally, those aged 65 and over have been low users of psychological therapy services, despite evidence supporting their effectiveness. One of the objectives in *Talking therapies: a four-year plan of action* is to ensure appropriate access to psychological therapy for people over 65 to address the current significant under-representation of those in this age group in IAPT services.
- Changing public attitudes and behaviour towards mental health, supported by campaigns such as Time to Change, and a reduction in the stigma associated with mental health issues could lead to people becoming more willing to seek help and access the services they need.
- Access to work policies are increasingly being promoted. The aim is to improve social and economic participation by tackling unemployment, by encouraging and providing access to services, including psychological therapy, for those with mental health issues to assist them to gain employment or return to work.
- The potential of innovation and information technology to transform mental health services – for example through the increasing exploration of online solutions and e-therapy – may also increase demand for psychological therapies.

2.4 The psychological therapies workforce

Delivery of psychological therapies in the NHS may involve several different groups of staff, including clinical psychologists, nurse practitioners, psychotherapists and counsellors. In addition to staff directly employed by the NHS, psychological therapy may also be provided by therapists working for private, independent or voluntary sector organisations.

Staff may join the psychological therapies workforce from a range of different occupations and training routes. Some enter from specific training within the NHS, such as clinical psychology. Others may be trained in core professions such as nursing or psychiatry and then develop specific competencies in psychological therapy. Others may train directly in counselling or psychological therapies, often completely outside the NHS.

Members of the project advisory group reported that self-employed and sessional therapists are increasingly forming a significant but as yet, largely unrecognised sector of the workforce.

2.4.1 The private, independent and voluntary sectors

In line with the Government's policy to expand choice, and in an increasingly competitive marketplace, voluntary and private sector providers are competing to deliver psychological therapies. In particular, the voluntary sector has substantial experience in delivering specialist psychological therapies to groups that are traditionally under-represented in services, as well as to the wider population.

[5] Based on interviews of 2,050 adults in work aged 18+, in England and Wales, carried out by Populus (a member of the British Polling Council) in March 2010

[6] Data from the annual Prescription Cost Analysis - released April 2010

> **" We know already that there are some very good exemplars of services that are much more in tune with patient wishes, needs and expectations that are provided by the voluntary sector. The 'Any Willing Provider' policy opens the door to those opportunities to become much more widely taken up."**
>
> **Paul Burstow, Minister for Care Services (2011) on commissioning voluntary sector services.**

2.4.2 The IAPT workforce

The IAPT programme has resulted in changes to the composition of the psychological therapies workforce. PWPs deliver low-intensity interventions to a high volume of patients at step 2 of the NICE stepped-care model[7]; those requiring more intensive therapy are stepped up to high intensity therapists (HITs) at step 3 of the NICE model for anxiety and depression. The main focus in the first two years of the IAPT programme was to train PWPs and HITs based on the use of CBT. Additional evidence-based therapies for depression are now offered including: interpersonal therapy, couple therapy for depression, counselling for depression, and brief dynamic interpersonal therapy.

Between 2008 and 2011 the IAPT programme aimed to train and employ 3,600 new staff in new IAPT clinical services, with a further cohort of around 2,400 new staff developed between 2011 and 2014. The supply of PWPs has largely come from psychology graduates but there are real concerns about the sustainability and continuity of the future of this workforce resulting in efforts to attract trainees from a wider source.

The supply of HITs has tended to come from the existing professions such as nurses, clinical and counselling psychologists, occupational therapists and counsellors. There has been more difficulty in recruiting to HIT posts recently and one of the aims of our review has been to highlight the potential workforce that could help ensure the future supply of HIT therapists.

The IAPT education and training model has been one of recruiting people into post as trainees to undertake bespoke accredited training courses. Training curricula have been based on specifically-developed competence frameworks drawn from research trials included in NICE guidelines. Supervision is integral to the training and the ongoing continuing professional development of all staff in IAPT services. The multi-professional education and training (MPET) budget has been the route by which central training funds have been channelled for local education and training commissioning.

Providers of IAPT services are increasingly a mix of NHS organisations, the private sector and the voluntary sector.

2.5 Current access to psychological therapies

2.5.1 Progress to date on the IAPT programme

The *IAPT three –year report: The first million patients* (DH, 2012d), reports on the progress made by the IAPT programme since October 2008.

> **"At the end of the first three full financial years of operation (end of March 2012), more than 1 million people have used the new services, recovery rates are in excess of 45% and 45,000 people have moved off benefits."**
>
> **Norman Lamb, Care and Support Minister (2012).**

Some of the key successes of the programme in the first three years include:

- treating more than 1 million people in IAPT services
- more than 680,000 people completing a course of treatment
- recovery rates consistently in excess of 45 per cent and approaching those expected from the randomised controlled trials that generated the initial NICE recommendations
- training of a new, competent workforce of nearly 4,000 new practitioners, to deliver NICE-recommended treatments
- economic gains in terms of employment attainment and retention, with more than 45,000 people moving off sick pay and benefits.

[7] The NICE Stepped-care model for anxiety and depression can be found at Annex 3.

However, the Chief Executive of the NHS in England, Sir David Nicholson, also commented in this report that:

> **"more remains to be done to consolidate local services and realise the full benefits of the step change in investment and delivery of accessible, safe and effective psychological therapies in England".**
>
> **Sir David Nicholson, Chief Executive of the NHS (2012).**

2.5.2 Current issues

Despite the advances made by the IAPT programme, further improvements to psychological therapy provision are required if evidence-based interventions are to be available to all who need them. Reports such as the MIND survey in *Time to Talk* (2010a) and *The abandoned illnesss* report (Schizophrenia Commission, 2012) suggest that there is strong public demand for psychological therapies yet many people still find it difficult to access them, therapy is not yet available to all those who may benefit from it, and that waiting times from referral to treatment are too long and vary significantly across the country. According to the 2010 MIND survey, one in five people had been waiting over a year, and one in 10 had waited over two years to receive treatment. In addition service users reported they did not always receive sufficient sessions to make genuine progress, and there was not always a real choice of effective treatments available.

The MIND report also highlighted that, as IAPT services developed, there were reductions in funding for non-IAPT psychological therapy services in some areas.

The growing recognition of the importance of psychological therapies, coupled with concerns about access to services, led the Healthcare Quality Improvement Partnership (HQIP) to commission the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) to conduct a National Audit of Psychological Therapies (NAPT).The baseline audit (conducted in 2010–11) showed that while performance was good overall for most standards, there was considerable variation for some standards. One of the key findings was that a substantial number of psychological therapists were delivering some therapies in which they had not been adequately trained.

2.6 Regulation of psychological therapists

There is currently no statutory regulation of psychological therapists. Most accreditation of psychological therapists is undertaken by professional bodies, including those listed in the definition of a psychological therapist (see Box 1, section 3.14).

However, some professions are regulated by statute, such as doctors by the General Medical Council (GMC), nurses by the Nursing and Midwifery Council (NMC), and clinical psychologists, arts, music and drama therapists by the Health and Care Professions Council (HCPC). The Professional Standards Authority (hereafter, the Authority) was established in 2003 (previously known as the Council for Healthcare Regulatory Excellence) to oversee the UK's nine Health and Care Professional regulatory bodies, including the GMC, NMC and HCPC.

In 2012 the Authority's remit was extended to accredit voluntary registers of unregulated health and social care occupations, provided the register meets the Authority's required standards in governance, standard-setting, education and training, management, complaints handling and provision of information. One professional body referred to in Box 1(the BACP) is already accredited by the Authority. Others on this list are in the process of applying to become accredited by the Authority. A full list of organisations applying or planning to apply for accreditation with the Authority and more information about the Accredited Voluntary Registers scheme can be found on their website (www.professionalstandards.org.uk/voluntary-registers).

3. Towards a working definition of a psychological therapist

3.1 Defining a psychological therapist

A central aim of the review was to reach a shared understanding of what constitutes a psychological therapist, to provide clarity and to develop a definition which could be used to inform future workforce planning. Following consultation with stakeholders, service users, and psychological therapists themselves, it became clear that they also welcomed this, and there was a widely expressed view that having such a definition would benefit many in understanding more about this workforce.

> **"A clear definition of a 'psychological therapist' would be very welcome (in both my workplaces) – we often encounter queries from the public, placement providers and from potential trainees."**
>
> **A psychological therapist who responded to the consultation exercise**

In particular, our stakeholders agreed it was important to make a distinction between those who deliver a certain range of psychological interventions at a practitioner level, e.g. those who work at step 2 of the NICE stepped-care model (such as IAPT psychological well-being practitioners (PWPs)) and those whose depth and breadth of training and experience enable them to be classified as psychological therapists.

3.1.1 The consultation process

We developed an initial draft definition of a psychological therapist following information received from the professional bodies and in discussion with the project advisory group. The definition built on previous work undertaken on the National Occupational Standards for Psychological Therapies, the Improving Access to Psychological Therapies (IAPT) competency frameworks, and examples of good practice from across the UK. As counsellors and psychological therapists are not currently regulated professions, it was deemed important to identify quality standards in this definition.

We shared the draft definition with a number of organisations and professional bodies for further comment and made it available to other interested parties via the CfWI website.

Consultation on the definition prompted a fair amount of discussion among those working in the field, and the response to this exercise was very positive, both in terms of the numbers and the range of different interest groups that responded. The feedback received ranged from joint responses from clinical departments and professional bodies to individual responses from service users, directors of services, professional leads, clinicians and psychological therapists. Contributions were also received from providers of education and training and from independent and voluntary sector providers. Details of those who were consulted and those who responded to the consultation exercise can be found in Annex 2.

> **"I think a definition is a good idea. The benefits of using the definition are clear (i.e. a factor in minimum standards) – along with the requirement of making it available to the service user at the outset."**
>
> **A service user who responded to the consultation exercise**

3.1.2 Key objectives

The objectives of the consultation exercise were to:

- engage and consult with key stakeholders to seek their feedback and comments on the proposed definition of a psychological therapist, and to create a working partnership and mutual understanding with those consulted
- ensure that in shaping and reaching agreement on a definition, it was informed by a wide range of knowledge and experience, including those with subject matter expertise, clinicians, commissioners, service providers, service users and carers, leading to a more realistic and robust definition that reflected a wide range of views
- identify any issues around the definition, particularly at the developmental stage, which might have had implications for the sector or different interest groups.

> **"The definition clarifies competency requirements for both employers and clients. This will be helpful for employers from outside of mental health, such as acute general hospitals, who historically haven't employed psychological therapists but are increasingly doing so."**
>
> **A psychological therapist who responded to the consultation exercise**

3.1.3 Key areas of debate

From the outset it was recognised by the project advisory group that complete consistency on a definition would not be possible; our aim was to achieve a good enough degree of consensus to reach a broad agreement.

The main area of debate was in relation to the entry-level qualifications and the duration of training required. The areas where views differed most significantly were about:

- entry-level qualifications – some respondents suggested degree-level entry to training, whilst others felt this would potentially exclude therapists who had not had this opportunity
- the level of psychological therapy training received – some respondents suggested that this should be at postgraduate certificate or diploma level
- the duration of training required – some suggested a longer period of training or experience should be mandatory.

Another area of debate was whether or not to include only professional bodies that are accredited, or in the process of applying for accreditation by the Professional Standards Authority for Health and Social Care. Although the authority launched an Accredited Voluntary Registers (AVR) scheme in December 2012, there is no statutory requirement for regulation by the authority.

> **"This definition is very useful to advise commissioners of services as to the standards required to practice."**
>
> **A psychological therapist who responded to the consultation exercise**

3.1.4 Proposed definition of a psychological therapist

After careful consideration of all the comments and feedback received, and discussion with the project advisory group, the CfWI proposes that to be defined as a psychological therapist, the standards outlined in Box 1 must be met.

BOX 1: Psychological therapist - required standards:

1. To have completed one year of recognised full-time (or equivalent part-time) psychological therapy or counselling training leading to a qualification, certification or accreditation recognised by a relevant professional or regulatory body (listed below).

Professional bodies:

- Association for Cognitive Analytic Therapy
- British Association for Behavioural and Cognitive Psychotherapies
- British Association for Counselling and Psychotherapy
- British Psychoanalytical Council
- British Psychological Society
- British Society of Couple Psychotherapists and Counsellors
- Royal College of Psychiatrists
- United Kingdom Council for Psychotherapy[8].

Regulatory bodies:

- Health and Care Professions Council – which is responsible for regulating art, music and drama therapists, and clinical and counselling psychologists
- General Medical Council
- Nursing and Midwifery Council.

2. To have achieved a competency level that fulfils the requirements of the regulatory, accrediting or professional body.

3. To be a member of a relevant professional or regulatory body, and continue to fulfil any accreditation or membership criteria, including meeting requirements for:

    - continuing professional and personal development
    - regular supervision
    - codes of practice.

4. To have gained the supervised therapy experience required by the regulatory or professional body encompassing assessment, formulation, engagement, developing the therapeutic relationship, using relevant therapeutic interventions, working collaboratively with clients, and working to end therapy.

[8] The UKCP includes those professional bodies that are organisational members of UKCP and accredit psychological therapists to the required standard.

Good practice recommendations:

The required standards in Box 1 apply to all types of psychological therapy. During the consultation exercise, comments were made regarding additional standards that may not apply to all types of psychological therapy, but are recommended as good practice.

1. The ability to provide long- and short-term therapy as appropriate to the therapy modality and client needs.
2. Competence to work with clients of moderate severity, significant complexity and impaired functioning.
3. The collection of outcome data and client feedback, and the use of this in clinical supervision and in service audit and evaluation.
4. To be working at step 3 or above in NICE guidelines stepped care model or equivalent.

For some therapy modalities, experience of personal therapy is an additional requirement or recommendation.

Exclusions

This definition specifically excludes those working solely using short-term 'low intensity' interventions who would more correctly be defined as working at practitioner level rather than therapist level, and those who may have attended shorter courses in counselling or psychological therapies. Therapeutic interventions from appropriately supervised therapy practitioners with lower levels of experience and training can still be of great value, and indeed such practitioners provide the majority of psychotherapeutic interventions in the NHS.

3.2 Evaluating the impact of the definition in practice

Having consulted widely on the definition of a psychological therapist, we went on to explore the practical implications of implementing this definition in the workplace, and what the impact might be of adopting it across the system. We conducted a further exercise – albeit limited in scope – to evaluate the use of the definition. A short questionnaire was circulated to a small group of participants who agreed to look at the impact the definition could have in their organisation or area of interest.

The majority of those who responded confirmed that the definition was useful and would help them to better identify their psychological therapies workforce by providing clarity of definition.

- The potential benefits identified by participants of using this definition were that:
  - it provides greater clarity between those who could be categorised as psychological therapists, and those who have some psychological therapy training but who do not fulfil all the criteria
  - it would be useful in terms of governance arrangements, and ensuring quality of services provided to service users
- Stakeholders suggested that the definition would be most useful to:
  - all staff – practitioners, service managers, and clinical or professional leads, recruiting officers and human resources– for recruitment, CPD requirements and workforce planning
  - employers –to assist them to identify what level of employee they might need to deliver effective psychological therapy services
  - commissioners –to understand both the available workforce and the skills and knowledge required to meet local needs and national priorities, and to ensure quality standards
  - the independent sector – to encourage independent providers to ensure their staff meet the definition standards.

In response to questions about whether the definition would have an impact on existing workforce numbers, the responses varied. Some saw the definition as having limited impact on the numbers of psychological therapists recorded, as the definition was in line with existing governance arrangements for the psychological therapies workforce. One organisation believed that using the definition would result in a significant reduction in the headcount of its psychological therapies workforce, as it does not currently require psychological therapists to be accredited members of professional bodies (this related particularly to IAPT high-intensity therapists). There was strong support for categorising the psychological therapies workforce and using the definition to develop the appropriate codes for the Electronic Staff Records (ESR) system.

4. Towards better workforce intelligence

4.1 Current data sources

In addition to an understanding of the context and drivers, effective workforce planning has its roots in the thorough analysis of workforce data obtained from reliable and consistent information sources.

Data on the psychological therapy workforce is collected by a variety of organisations for a number of different reasons. For example:

- Data held and/or collated by the NHS. The major NHS source of data is the ESR system. Other sources of data include:
  - NHS Census
  - NHS vacancy surveys.
- Data held by regulatory and professional bodies, including:
  - the Health and Care Professions Council (HCPC)
  - a number of professional bodies and organisations (see Table 1).
- Audits or surveys, including:
  - National Audit of Psychological Therapies (NAPT) conducted by The Royal College of Psychiatrists Centre for Quality Improvement
  - IAPT Census.
- Data held by the independent sector. For example, Skills for Care works with employers and providers to gather information on the adult social care workforce across all sectors via the National Minimum Data Set for Social Care (NMDS-SC).

However, attempts to establish the number of professionals and range of therapies being delivered using these data sources is problematic. The data lacks the consistency and depth required to develop an accurate picture of the workforce. Anomalies and inconsistencies exist, for example it was reported by members of the project advisory group that the numbers recorded on the ESR system and the information recorded by the regulatory and professional registration bodies does not always align.

There is no single reliable or consistent source of data for the psychological therapies workforce. In a previous review, *Workforce Information Architecture: Improving awareness of available data, information and intelligence* (CfWI, 2012), commissioned by the DH, the CfWI suggests that a common core dataset is essential to support more effective workforce planning, education commissioning and decision making in the future.

4.2 The data challenges

Whilst having a wide mix of professional staff delivering psychological therapies increases service user choice and the availability of essential skills, it also contributes to the lack of reliable data across the diverse workforce delivering psychological therapies.

There is a range of different job titles and roles, which are not always the same for staff doing similar jobs, and job titles do not always accurately reflect how much therapy is provided, or which types of therapy are being offered. There are no agreed categories by which staff delivering psychological therapies are designated for the purpose of recording workforce data. For example, a nurse trained to the standard outlined in the proposed definition (see Box 1) and working fulltime as a psychological therapist could be recorded on the ESR as a member of nursing staff, with no reference to their role providing psychotherapy.

4.2.1 Understanding supply across the sectors

Difficulties in understanding the existing workforce are further compounded by the lack of a single system which collates workforce data across all employers and the different sectors – the public, private, independent and voluntary sectors.

The voluntary sector workforce in England has grown significantly over the last ten years. The UK Voluntary Sector Workforce Almanac reports that in 2010 there were 765,000 people employed in the UK voluntary sector, an increase of 40 per cent since 2001(NCVO, 2011). Analysis of the Labour Force Survey (LFS) estimates that in 2010, more than half (57 per cent) of the voluntary sector workforce were employed in 'health and social work', but we do not know how many of these are psychological therapists as there is no reliable data or information available to confirm this.

Outside the NHS, Skills for Care works with employers and providers to gather information on the adult social care workforce via the National Minimum Data Set for Social Care (NMDS-SC). However, within this data set there is no specific category for recording the workforce delivering psychological therapies.

Comparability is an essential aspect of data quality, and data can only truly be comparable when the values available are applied consistently across different organisations.

4.3 Implications for future workforce planning

Effective workforce planning across the wide range of organisations commissioning and delivering psychological therapies – and those responsible for training and development – is crucial for the future development of the psychological therapies workforce and the provision of effective psychological therapy services. The limitations of current information sources make this difficult to achieve, and thus it is important to improve the accuracy of information in the future.

4.4 Data capture exercise

Whilst the limitations in the available data sources for the psychological therapies workforce have been identified and acknowledged, professional bodies hold registers of their members, and these registers can be a very useful source of workforce information.

As part of our review, a questionnaire was circulated to the main professional bodies to gain specific information about their membership, including:

- the criteria for accreditation, including:
  - the level of training required
  - the requirement of therapy experience
  - the hours of supervision required
  - any other specific criteria required to become a fully accredited or certified member of that professional body
- the numbers of those registered or accredited with the professional body (who would be deemed to satisfy the requirements of the proposed definition of a psychological therapist outlined in Box 1).

The purpose of the data capture exercise was to gather further information and build intelligence about the existing accredited and trained psychological therapy professionals. In the absence of robust data on the current NHS, independent and voluntary sector workforces, this exercise provides a more informed picture of the potential trained psychological therapy workforce.

The numbers of those members accredited or certified by the different professional bodies are listed in Table 1. The figures only include those members who would be expected to meet the required standards for a psychological therapist outlined in Box 1.

Table 1: Details of membership of the professional bodies: (those who would meet the standards and criteria in the proposed definition of a psychological therapist).

Professional body / organisation	Senior accredited / professionally accredited /certified members
Association for Cognitive Analytic Therapy (ACAT)	446
British Association of Art Therapists (BAAT)[9]	1,500
British Association for Behavioural & Cognitive Psychotherapies (BABCP)	2,883
British Association for Counselling & Psychotherapy (BACP)	8,757
British Association of Dramatherapists (BAD)	466
British Association for Music Therapy (BAMT)	555
British Psychoanalytical Council (BPC)	1,368
British Psychological Society[10] (BPS)	5,650
British Society of Couples Psychotherapists & Counsellors (BSCPC)	133
Royal College of Psychiatrists[11] (RCPsych)	110
United Kingdom Council for Psychotherapy (UKCP)[12]	7,516
Sub-total	**29,384**

[9] The figure for BAAT includes details of membership for England and Wales.

[10] The figure for membership of BPS only includes members of specific divisions that are deemed relevant to the scope of this review, i.e. the four divisions covering clinical psychology, forensic psychology, counselling psychology and health psychology.

[11] The figure for RCPsych membership relates to the number of medical psychotherapists only.

[12] The figure for UKCP is UK wide, and comprises data for accredited members of over 75 organisations affiliated to UKCP.

According to this exercise, and taking into account the appropriate caveats, this would suggest that there are circa 29,000 psychological therapists meeting the standards in the agreed definition.

4.4.1 Limitations to the data available

As there is currently no statutory regulation of psychological therapy, there is no compulsion to belong to one of these professional bodies.

Membership is voluntary, so the figures in Table 1 do not necessarily represent the entire membership of those professions. For the purpose of this review we have focused only on those who could be categorised as a senior accredited, professionally accredited or certified member at a level that would meet the required standards and criteria described in the definition of a psychological therapist (see Box 1). The figures also exclude those who are no longer practising, are working abroad, or who are student or associate members of the respective professional body.

Information we have received from the BABCP and the BACP is that a significant number of their non-accredited members who have chosen not to go through the accreditation process are also likely to meet the criteria in Box 1, and would be eligible for accreditation if they applied. The total numbers of non-accredited members in those two organisations is 21,700. This is a very significant number for those who could potentially meet the required standards for accreditation.

We recognise that there is an element of double counting, as some individuals belong to more than one professional body. For example, we know that just over 1,700 of the accredited members of the BACP are also members of other professional bodies, that many BABCP members are also chartered clinical psychologists, and that a number of cognitive analytic therapists are also accredited with the UKCP. What we do not know is the extent of the overlap for those who hold accredited membership of more than one professional body.

While some organisations are able to identify members residing in England, others do not collect this information and their figures reflect UK-wide membership. A further caveat to be considered with regard to the information in Table 1 is that some organisations are able to identify those members working with adults only (the scope of this review) whilst others include those working with both adults and children.

5. Conclusions

5.1 Key findings

- There is inconsistent and incomplete data about the psychological therapies workforce.
- There is currently no consistent single definition of what a psychological therapist is – although there is a clear desire to have a definition and to promote a shared understanding across all psychological therapy modalities.
- There is wide agreement and strong support for the definition proposed by the CfWI.
- There are practical benefits of using this definition in the workplace and elsewhere – feedback from testing the definition in practice (although limited in its scope) suggests it would be useful.
- There are approximately 29,000 psychological therapists in England who would meet this definition, with potentially a significant number of others who could meet the required standards.

5.2 Next steps

5.2.1 Establishing a dedicated subgroup to look at workforce coding and classification

A significant outcome of the review is the agreement by the Workforce Information Review Group (WIRG)[13] to establish a subgroup to review the coding and classification of the psychological therapy workforce. The WIRG has responsibility for NHS workforce standards and therefore any changes to them need to be approved by the WIRG.

The subgroup will work with the Health and Social Care Information Centre (HSCIC), the DH, the CfWI and other stakeholders to ensure that key value sets, such as occupation codes, job roles and areas of work for psychological therapists meet requirements, and that guidance is available to those entering data to assist them in the selection and entry of the appropriate values. The definition of a psychological therapist outlined in this report will provide an important basis for the work to be undertaken by this group

[13]The WIRG is a specialist reference group for NHS workforce information; it comprises representatives from within the NHS, the DH and other interested bodies. The overall objective of the WIRG is to provide an expert forum which makes recommendations at a national level on the technical arrangements for the collection of workforce related data from health service organisations and by the Health and Social Care Information Centre (HSCIC).

5.2.2 Building on the workforce information architecture programme in the commissioning of services

Within the education and training reform programme, the workforce information architecture (WIA) workstream is working closely with Health Education England (HEE) to ensure that the workforce information required in the new NHS reform is available at all levels of the system and across all sectors.

A range of activities is underway, including an agreement that the NHS contract will require all providers (including those in the private and voluntary sectors) to complete data on the workforce. What is not clear as yet is the level and type of information that providers will be required to provide (see recommendation 3).

5.2.3 Recognising the importance and benefits of gathering local workforce intelligence

We recommend that provider organisations are encouraged to map the profile of their current psychological therapies workforce, where they are not already doing this, to improve workforce planning, commissioning and training.

5.3 Recommendations

Recommendation 1: Adopt the definition of a psychological therapist proposed by the review

We recommend that the definition of a psychological therapist outlined in Box 1 (Psychological therapist – required standards) is adopted.

The benefits of adopting a consistent single definition are that:

- it applies across all modalities or types of psychological therapy
- it is easy for service users, commissioners and employers, and psychological therapists to understand
- it helps to raise workforce professionalism by identifying the minimum quality standards and levels of training expected of a psychological therapist, encourages individual therapists to become accredited, and therefore helps to demonstrate the fitness for purpose of the workforce
- promoting it across the public, private and voluntary sectors will lead to better workforce intelligence on the psychological therapies workforce
- it forms the basis to take forward the work of the WIRG subgroup, to look at standardising the classification and coding of this workforce

- a consistent definition and associated guidance will help to ensure that the information and details required to make correct coding decisions on the NHS Electronic Staff Record (ESR) are provided to those responsible for entering the data, so that people entering data are able code this workforce correctly.

Recommendation 2: Adopt any subsequent recommendations of the WIRG subgroup looking at the psychological therapies workforce

To ensure improvements in the quality and accuracy of data on the psychological therapies workforce, we recommend that any future recommendations on the coding and classification of the workforce arising out of this work should be implemented across the system.

This will help to:

- develop and maintain a robust, resilient and secure system for workforce data collection
- work towards continually improving the quality of data and raising awareness of the impact of poor-quality data
- align efforts to improve information flow across the public, private and voluntary sectors and improve operability between data systems
- support national, local and neighbourhood commissioning bodies to use workforce data in determining priorities and preparing integrated workforce strategies
- promote the use of data to improve effective workforce commissioning, planning and training among employers, providers and local education and training boards (LETBs)
- undertake future workforce research and modelling underpinned by reliable and high-quality data
- promote the benefits of high-quality workforce data in improving services and outcomes for service users.

Recommendation 3: All providers of NHS commissioned psychological therapy services to gather workforce intelligence

We recommend that NHS commissioning bodies require providers from all sectors to gather information on the psychological therapies workforce, and that this should comply with any future recommendations of the WIRG subgroup on classification and coding of the workforce. This will ensure that information on the psychological therapies workforce is fit for purpose.

In line with this recommendation, to ensure improvements are brought about in the quality of data, we recommend that providers adopt the recommendations for improving data, information and intelligence in the 2012 CfWI report *Workforce Information Architecture: Improving awareness of available data, information and intelligence* commissioned by the DH.

Recommendation 4: Further work to be done to raise the profile and secure the future supply of the psychological therapies workforce

It will take some time for the WIRG to agree and implement any changes to current information systems, and then to gather and analyse this information to support better workforce planning for the future.

In the interim, to ensure the future supply of the workforce is secured, and to build capacity and capability, we recommend that further work is carried out to quantify the existing workforce, building on the findings of this report, and seeking information, for example, on the geographical distribution of the psychological therapies workforce and types of therapy modalities delivered.

This information should inform training and education provision at a local level, as there is currently no alignment between future service demand for access to psychological therapies and training for most forms of psychological therapies.

Support could be provided by producing guidance notes for LETBs, clinical commissioning groups (CCGs), and health and well-being boards (HWBs) to raise awareness of the importance of gathering local workforce intelligence on the psychological therapies workforce, and of the benefits of investing in this workforce.

We further recommend that discussions take place between key partners in the sector (e.g. the Department of Health (DH), Health Education England (HEE), Public Health England (PHE) and the NHS England) to agree how this future work is commissioned and taken forward.

The psychological therapies workforce needs to be addressed within HEE so there is clarity about leadership for the future supply of this workforce, with clear access routes to professional advice.

Recommendation 5: Employers and providers to undertake workforce capacity assessments for their psychological therapies workforce

We recommend that employers and providers undertake workforce capacity assessments to ensure that they understand their own workforce delivering psychological therapies across different levels of intensity, and to help ensure maximum utilisation of current capacity.

6. Annex 1: Project advisory group

Table 2: Project advisory group

	Name	Representing organisation/ group
1.	Nick Armitage	Health and Social Care Information Centre
2.	Martin Barkley	Mental Health Trust Chief Executive Officers and LETBs
3.	Marta Buszewicz	Primary care representative
4.	Jeremy Clarke	National Audit of Psychological Therapies Clinical Lead/ Association for Psychoanalytic Psychotherapy/Chair New Savoy Partnership
5.	Hugh Griffiths	Department of Health – Mental Health; National Clinical Director for Mental Health
6.	Roslyn Hope	NHS Confederation Network Workforce Reference Group/ Improving Access to Psychological Therapies (IAPT)
7.	Rhidian Hughes	CfWI Head of Social Care
8.	Rod Holland	British Association for Behavioural and Cognitive Psychotherapies (BABCP)
9.	Ruth Kinniburgh (Project Manager)	Centre for Workforce Intelligence
10.	Tony Lavender	British Psychological Society (BPS)
11.	Helen Matthews (Chair)	Centre for Workforce Intelligence
12.	Neil McLauchlan	National Education Commissioners – North West Strategic Health Authority (SHA)
13.	Ian McPherson	Mental Health Providers Forum (MHPF)
14.	Barbara Monk-Steel	United Kingdom Council for Psychotherapy (UKCP) Co-Chair Developing Occupational Practice Committee
15.	Kevin Mullins	Department of Health – National Improving Access to Psychological Therapies (IAPT) Programme Director
16.	Louise Robinson	British Association for Counselling and Psychotherapy (BACP)
17.	Jacqui Ruddock	Department of Health – Workforce, Education and Training Project Manager (IAPT)
18.	Peter Sharp	CfWI Chief Executive
19.	Josie Turner	NHS London – Workforce Planners Network

In addition to the regular membership of the project advisory group, who we thank for their time and commitment to this review, we would also like to acknowledge the contributions made by other occasional contributors to the project advisory group, including:

- Clare Baguley – IAPT North West Programme Field Lead
- Tim Cate – Associate Director Psychology and Psychological Therapies, Tees Esk and Wear Valleys NHS Foundation Trust / Visiting Fellow Teesside University
- Rebecca Grace – Register, Quality and Standards Manager BACP.

7. Annex 2: Other people we have consulted over the course of the project

The professional bodies, organisations and representative groups consulted

In addition to discussion with the project advisory group who helped to shape the definition of a psychological therapist and a session held at the New Savoy Partnership Conference, the draft definition was shared with the following groups and organisations either directly, or via the network of umbrella or consultation groups to which they and/or their members are affiliated.

The definition was also posted on the CfWI website and anyone with an interest in this area was invited to provide feedback and share their views and comments.

Table 3: Professional bodies and organisations with whom the definition was shared:

Professional bodies / groups consulted	
Professional bodies	▪ Association for Cognitive Analytic Therapy ▪ Association of Dance Movement Psychotherapy UK ▪ British Association of Art Therapists ▪ British Association for Behavioural and Cognitive Psychotherapies ▪ British Association for Counselling and Psychotherapy ▪ British Association of Dramatherapists ▪ British Association for Music Therapy ▪ British Psychoanalytical Council ▪ British Psychological Society ▪ British Society of Couple Psychotherapists and Counsellors ▪ Royal College of Psychiatrists ▪ United Kingdom Council for Psychotherapy
The NHS Confederation Mental Health	▪ British Association of Social Workers ▪ British Dietetic Association
Network Reference Group	▪ Empathy with Carers (carers organisation) ▪ Chartered Society of Physiotherapy ▪ CME in the Community ▪ College of Occupational Therapists ▪ Forum for Mental Health Nurse Directors and Leads ▪ Hackney Link (service users organisation) ▪ NHS Confederation Mental Health Network ▪ Royal College of Nursing ▪ Royal College of Speech and Language Therapists ▪ Skills for Care ▪ Skills for Health ▪ Social Perspectives Network ▪ UK Psychiatric Pharmacy Group ▪ Unison ▪ Values based practice
The New Savoy Partnership Consultation Group	▪ Big White Wall Ltd ▪ Carers ▪ Centre for Mental Health (CMH) ▪ Children and Young People IAPT Critical Friends Forum ▪ Improving Access to Psychological Therapies (IAPT) ▪ IAPT for Older People ▪ Mental Health Providers Forum ▪ MIND ▪ Psychologists Special Interest Group for the Elderly (PSIGE) ▪ Rethink ▪ Royal College of General Practitioners (RCGP) ▪ Tavistock and Portman ▪ Young Minds
NHS trusts and foundation trusts	▪ Avon and Wiltshire Mental Health Partnership NHS Trust ▪ Cheshire and Wirral Partnership

Professional bodies / groups consulted	
	NHS Foundation Trust ▪ Devon Partnership NHS Trust ▪ Lancashire Care NHS Foundation Trust ▪ Leeds Community Healthcare NHS Trust ▪ Norfolk and Norwich University Hospital ▪ North East London NHS Foundation Trust ▪ Pennine Care NHS Foundation Trust ▪ Rotherham, Doncaster and South Humber NHS Foundation Trust ▪ South Staffordshire and Shropshire Healthcare NHS Foundation Trust ▪ Tees Esk and Wear Valleys NHS Foundation Trust ▪ West London Mental Health Trust ▪ Worcestershire Health and Care NHS Trust
Department of Health	▪ IAPT regional leads
Workforce planning representatives in NHS national bodies	▪ NHS Northern Ireland ▪ NHS Scotland ▪ NHS Wales

The information in Table 4 provides details of those who responded to the consultation exercise. It should be noted that the majority of responses were received via email, but not all of those who responded provided details of their designation or employing organisation.

Table 4: Professional bodies, groups and individuals who provided feedback on the definition:

Professional bodies / groups /range of individuals who provided feedback	
Professional bodies	▪ Association for Cognitive Analytic Therapy ▪ British Association of Art Therapists ▪ British Association for Behavioural and Cognitive Psychotherapies ▪ British Association for Counselling and Psychotherapy ▪ British Association of Dramatherapists ▪ British Association for Music Therapy ▪ British Psychoanalytical Council ▪ British Psychological Society ▪ British Society of Couple Psychotherapists and Counsellors ▪ Council of Occupational Therapists ▪ Royal College of Nursing ▪ United Kingdom Council for Psychotherapy
NHS trusts and foundation trusts, and other service providers	▪ Avon and Wiltshire Mental Health Partnership NHS Trust ▪ Black Country Partnership Foundation Trust ▪ Cheshire and Wirral Partnership NHS Foundation Trust ▪ Devon Partnership NHS Trust ▪ Hertfordshire Partnership NHS Foundation Trust ▪ Lancashire Care NHS Foundation Trust ▪ Leeds Community Healthcare NHS Trust ▪ Norfolk and Norwich University Hospital ▪ North West London NHS Foundation Trust ▪ Pennine Care NHS Foundation Trust ▪ Psychological Partnership CIC ▪ Rotherham Doncaster and South Humber NHS Foundation Trust ▪ St Andrew's Healthcare ▪ St Helens and Knowsley NHS Trust ▪ Sheffield Teaching Hospitals

Professional bodies / groups /range of individuals who provided feedback	
	NHS Foundation Trust ▪ South Staffordshire and Shropshire Healthcare NHS Foundation Trust ▪ Surrey and Borders Partnership NHS Foundation Trust ▪ Tees Esk and Wear Valleys NHS Foundation Trust ▪ West London Mental Health Trust ▪ WPF Therapy ▪ Worcestershire Health and Care NHS Trust
Academic and training institutions	▪ Goldsmiths, University of London ▪ University of Chester - Centre for Psychological Therapies in Primary Care, ▪ University of Leeds ▪ York St John University
Workforce planning representatives	▪ Health and Social Care Information Centre (HSCIC)
Range of individuals who responded	▪ Service users – including: ▫ BPS Division of Clinical Psychology's Service User and Carer Liaison Committee ▫ Hackney link ▫ Limbpower ▪ Therapists and professional practitioners – including: ▫ cognitive behavioural therapists ▫ counselling psychologists ▫ consultant clinical psychologists ▫ director of psychological services ▫ head of profession – arts psychotherapies ▫ high-intensity therapist (IAPT) ▫ occupational therapists / lead occupational therapists ▫ professional lead – psychological services ▫ R & D specialist – in the arts

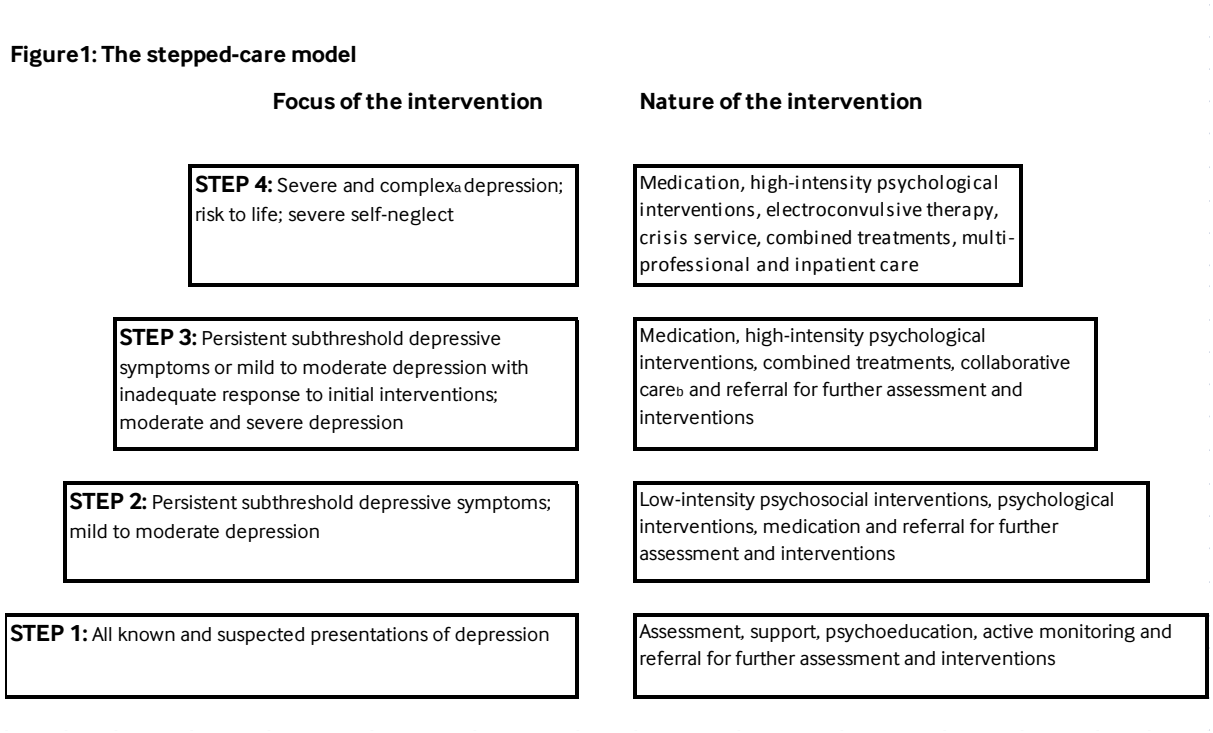
Professional bodies / groups /range of individuals who provided feedback	
	psychotherapies ▫ research and clinical audit lead ▫ senior lecturer ▫ service managers ▫ speech and language therapist ▫ specialist occupational therapist – in older people's mental health ▫ teaching fellow in counselling and psychotherapy

8. Annex 3: NICE Stepped-care model

Stepped Care

The stepped-care model provides a framework in which to organise the provision of services, and support patients, carers and practitioners in identifying and accessing the most effective interventions (see Figure 1). In stepped-care the least intrusive, most effective intervention is provided first; if a person does not benefit from the intervention initially offered, or declines an intervention, they should be offered an appropriate intervention from the next step.

Figure1: The stepped-care model



a Complex depression includes depression that shows an inadequate response to multiple treatments, is complicated by psychotic symptoms, and/or is associated with significant psychiatric co-morbidity or psychosocial factors.

b Only for depression where the person also has a chronic physical health problem and associated functional impairment (see 'Depression in adults with a chronic physical health problem: treatment and management' [NICE clinical guideline 91]).

Extract from NICE clinical guideline 90 – Depression

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10. Acronyms

ACAT Association for Analytic Therapy

BAAT British Association of Art Therapists

BABCP British Association for Behavioural and Cognitive Psychotherapies

BACP British Association for Counselling and Psychotherapy

BAD British Association of Dramatherapists

BAMT British Association for Music Therapists

BPC British Psychoanalytical Council

BPS British Psychological Society

BSCPC British Society of Couples Psychotherapists and Counsellors

CBT cognitive behaviour therapy

CCG clinical commissioning group

CQI Centre for Quality Improvement

CfMH Centre for Mental Health

CfWI Centre for Workforce Intelligence

DH Department of Health

ESR electronic staff record

GP general practitioner

HCPC Health and Care Professions Council

HCQIP Health Care Quality Improvement Partnership

HEE Health Education England

HSCIC Health and Social Care Information Centre

HWB health and wellbeing board

IAPT improving access to psychological therapies

LETB local education and training board

LFS labour force survey

LSE London School of Economics

NAPT national audit of psychological therapies

NCVO National Council for Voluntary Organisations

NHS National Health Service

NICE National Institute for Health and Clinical Excellence

NMD-SC national minimum data set – for social care

ONS Office for National Statistics

PHE Public Health England

PSA Professional Standards Authority for Health and Social Care

PWP psychological wellbeing practitioner

RCPsych Royal College of Psychiatrists

WIA workforce information architecture

WIRG Workforce Information Review Group

UKCP United Kingdom Council for Psychotherapy

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CENTRE FOR WORKFORCE INTELLIGENCE

Centre for Workforce Intelligence
209-215 Blackfriars Road
London SE1 8NL United Kingdom

T +44 (0)20 7803 2707
E enquiries@cfwi.org.uk

www.cfwi.org.uk