The new NHS therapy workforce: who can do what for whom?
Getting the skills mix right
Roslyn Hope
Director, NIMHE Workforce Programme
Core objectives

- Refining the core IAPT service
- Developing provision for a wider range of NICE approved therapies
- Ensuring sustainability and spread
Professional backgrounds of the existing HI qualified workforce; the national picture
How many HI staff are Counsellors by professional background?
A regional view

<table>
<thead>
<tr>
<th>Region</th>
<th>No of Counsellors</th>
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<tr>
<td>N East</td>
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<tr>
<td>N West</td>
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<tr>
<td>S Central</td>
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<td>SE Coast</td>
<td>2</td>
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<td>S West</td>
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<tr>
<td>Yorks &amp; Humber</td>
<td>40</td>
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<tr>
<td>W Mids</td>
<td>36</td>
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<tr>
<td>E of England</td>
<td>29</td>
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### Backgrounds of the HI trainees

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<tr>
<th>SHA</th>
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<th>Nurses</th>
<th>OTs</th>
<th>Couns</th>
<th>GMHW</th>
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The IAPT workforce strategy – where we have come from

Graham Turpin
Aims

• To overview the contribution of the National IAPT team to workforce development
• To share the thinking that has underpinned these developments
• Future challenges for the IAPT workforce
Workforce planning - the beginning

To inform the Business Case and estimate workforce numbers required:

- Need and morbidity
- Access, presentation rates and expected flows into services
- Types of service model and care pathways
- Skill mix and competences of staff to deliver care pathways
Workforce planning - ongoing

Scoping and creating a capable workforce:

– Capacity of existing staff - NHS, voluntary and independent sectors?
– Capacity to train and supervise new roles and staff?
– Developing and specifying appropriate competences
– Developing curricula and educational and training to deliver competent staff
– Quality assurance: accreditation and regulation
Work informed by the NIMHE New Ways of Working programme:

- Ensuring that the skills of **ALL** staff are being used to meet the **needs of service users & carers** in a more efficient and effective way.
- Developing **new roles**, to bring **new people** into the mental health workforce.
- Developing the **roles of existing staff**, to enable them to take on more or different tasks.
- Using **senior staff** to supervise and develop others

**Ongoing work through NWW for Psychological Therapists**

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**Improving Access to Psychological Therapies**
Principles into practice

• Identifying competences and National Occupational Standards
• Developing job roles - low and high intensity therapists
• Specifying job descriptions, person specifications and advice on AfC Bandings
• Linking to training and accreditation
• Embedding in a transparent career framework
Importance of competency

Skills and competencies: Existing service delivery

New competency framework

Evidence-based, competent practitioners

Competent Workforce: Levels & Modalities

Context: Users, 10 ESCs, Teams

Professional Regulation?

Existing education and training

Professional accreditation, NOS and QAA

NICE guidance and the evidence base
Competency frameworks

CBT

Psychoanalytic/dynamic

http://www.ucl.ac.uk/clinicalpsychology/CORE/psychodynamic_framewok.htm

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IAPT Skills Mix

Low Intensity:
- 1 day per week on course
- Depression, anxiety disorders & related conditions
- Focus on guided self-help, computerized CBT, problem-solving, behavioural activation, brief CBT, medication compliance, sign-posting, assessment. Includes telephone delivery.

High Intensity:
- Modelled on existing post-graduate diplomas in CBT
- 2 days per week
- Focus on evidenced based CBT programme for each disorder relevant to anxiety and depression

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Providing resources to support local delivery:

- National training curricula
- Job descriptions, person specs, bandings etc.
- Advice on who are the existing qualified staff.
- Selection of PCTs and training providers.
- Selection of trainees for both high and low intensity courses
- Supervision principles and standards
Future developments of the IAPT workforce

Refinement of the core CBT model

- Learning from the lessons of wave 1 implementation
- Ensuring that SHAs select new implementer sites which have sufficient & appropriately qualified staff
- Career development and retention of existing staff
- Providing CPD to up-skill and develop existing staff in CBT
- Strengthening supervision
- Course accreditation and quality assurance
Future developments of the IAPT workforce

Personalization and choice

• Emphasis on broadening the range and choice of NICE recommended evidence based therapies.

• Utilising the skills of practitioners in other modalities

• Scoping priorities for non-CBT therapies and training through New Ways of Working for Psychological Therapists

• Emphasis on ongoing CPD in order to skill up the existing workforce in other therapies
Future developments of the the IAPT workforce

Sustainability and spread of services

- Commissioning for the whole community
- Linkage with Department of Work and Pensions
- Liaison with Primary Care, SHAs and commissioners
- Effective partnerships with professional bodies and HEIs
- Career frameworks
- Robust systems of accreditation and regulation
Commissioning the New IAPT Services

Jane Wood
Strategic Development Manager NHS
Leeds
Commissioning IAPT Utilising the Strengths of the Existing Primary Care Workforce

- Leeds is one of the largest PCTs in the country
- Need to commission a service that can meet the needs of 21,000 people per year
- Provider landscape includes PCT provided Primary Care Mental Health Service, Secondary Foundation Trust provider, a strong and capable MH voluntary sector
• Requirement for 1/3 of workforce to be in place/available
• Leeds primary care mental health service – made up of low intensity workers and mental health practitioners
• Current service receiving around 11,000 referrals per year as primary care element of stepped care pathway
• Some 3rd sector counselling provision
• Very high intensity (step 4) service provided by psychological therapy service in FT
Commissioning IAPT to Meet the Diverse Needs of the Population

• Yr 1 (08/09) consolidation of generic common mental health pathway covering adult and older adult population
• Yr 2 (09/10) tender for services that will specifically focus on particular settings or needs – prisons, people with BSL as first language, younger adults (18 – 21), African Caribbean and south east Asian populations
• Yr 3 (10/11) consolidation and review
Workforce Opportunities and Challenges

- Skill mix of low intensity workers, experienced MH practitioners and high intensity workers
- Opportunities for part time staff
- 3rd sector providers with track record of working with diverse needs
- Opportunity to ensure IAPT workforce is representative
- Capacity building role understated?
- Existing service anchors new service/s

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Improving Access to Psychological Therapies

NHS
Are all evidence based therapists created equal? Some complexities.

Peter Fonagy
The logic of evidence in the making of an effective therapist

- **Design** a treatment that works
- **Test** it is effective in hands other than yours
- **Extract** what the therapist has to do in order to practice the treatment
- **Create** a training programme around those competencies
Psychotherapy research and the psychotherapist

• Emphasis on the intervention over the interventionist

• Is there a ‘supershrink’ out there somewhere?
  – A 1991 meta-analysis of 27 studies by Crits-Christoph and Mintz: therapist effects ranged from 0% to 50%, with a mean of 8.6%
But how important is the therapist?

- Same RCT data set (NIMH study) 17 therapist 4-11 pts each
  - Elkin et al. (2006): no significant therapist effects
  - Kim et al. (2006): 5%–10% of outcomes variance is therapists

- Okiishi, Lambert, Nielsen, and Ogles (2003, 2006)
  Naturalistic study of 91 therapists over 1,841 patients (replicated)
  - Best therapists’ change rate 10 times greater than mean

- Effect is more on rate (17%) than degree (8%) of change (Lutz et al. (2007))
So what are the conclusions?

• *Preponderance of the evidence suggests that such variability is there*—even when therapist fidelity is carefully monitored.

• Therapists contribute **around 6–9%** of the outcome variance (Wampold and Brown, 2005)
Research on Specific Therapist Contributions: Overview

• **Few** therapist characteristics found to make substantial contributions to outcome

• Results are typically **inconsistent** and most effect sizes are **small**

• **So there is therapist variability in outcome but we do not know what accounts for this**

• Why is research not more helpful?
Research on Specific Therapist Contributions: A Summary

- Competent, creative, and compassionate therapists *transcend* their age, gender, or skin color
- *Discipline & training* might affect user satisfaction
- *Experience* is likely more important in treating more difficult clients and complex and long-standing problems
Research on Specific Therapist Contributions: A Summary

• Therapist Belief in a Treatment (Allegiance)
  – Insufficient therapist buy-in will likely jeopardize therapy outcomes (Davis & Piercy, 2007b; Sprenkle & Blow, 2004a; Wampold, 2001).
  – But too much buy-in will provide the therapist with the proverbial hammer to turn every client into a nail.
Research on Specific Therapist Contributions to Good Outcome

- *Therapeutic style characterised by therapist positivity, low hostility, sufficient directiveness and adjusting to client’s state*
- **Therapist well-being**
- **High levels of respect for minority cultures**
- **Characteristics of the therapist in the therapeutic relationship** (Cahill, Barkham, Hardy, Gilbody, Richards, Bower, Audin and Connell, 2008) HTA review

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*Improving Access to Psychological Therapies*
The alliance mystery

- Naturalistic studies sometimes find **no alliance effects** on outcome when initial symptom distress controlled (Puschner et al., 2008)
- Therapeutic alliance is not robust **explanation for therapist differences** (e.g. Dinger et al., 2008)
- Patients have **better alliances with more effective therapists** but for same therapists good or bad alliance has similar outcome (Baldwin et al., 2007)
Best guess at common effective teachable components of being an effective therapist

- The therapist should be taught to be highly active in engaging patients and preparing them for change.
- The therapist should work to create a strong fit between him- or herself and the clients (matching).
- The therapist should be able to negotiate with clients, be flexible, responsive, creative, and committed.
- Competence in other relevant evidence related to the human experience (development, culture, gender, aging, communication, family studies, relationships).
Some solutions – learning from experience

Ben Wright
Lead Clinician Newham IAPT
Key Themes

• Qualified experienced multi-professional staff allowed rapid creation of therapy team who delivered timely results
• Administrative staff are important
• Provision of Low Intensity care requires a cohesive, well defined team
• Multiple changes are difficult for a service to absorb
• Clinical / Management interface issues
Where next for IAPT?
Louise Lyons
Trust Clinical Director
Tavistock and Portman NHS Foundation Trust
In conclusion

Roslyn Hope
Questions to take back with you:

- Knowing and understanding your service model?
- Knowing that you have sufficient staff and that they have the appropriate competences to deliver the service model – capacity and capability?
- Knowing that they have access to quality training, support and supervision?
- Knowing that they are delivering the best outcomes for clients – linking staff competence and abilities, plus supervision with clinical outcomes?
Thank You