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The new NHS therapy workforce: who can do what for whom? Getting the skills mix right

Roslyn Hope
Director, NIMHE Workforce Programme

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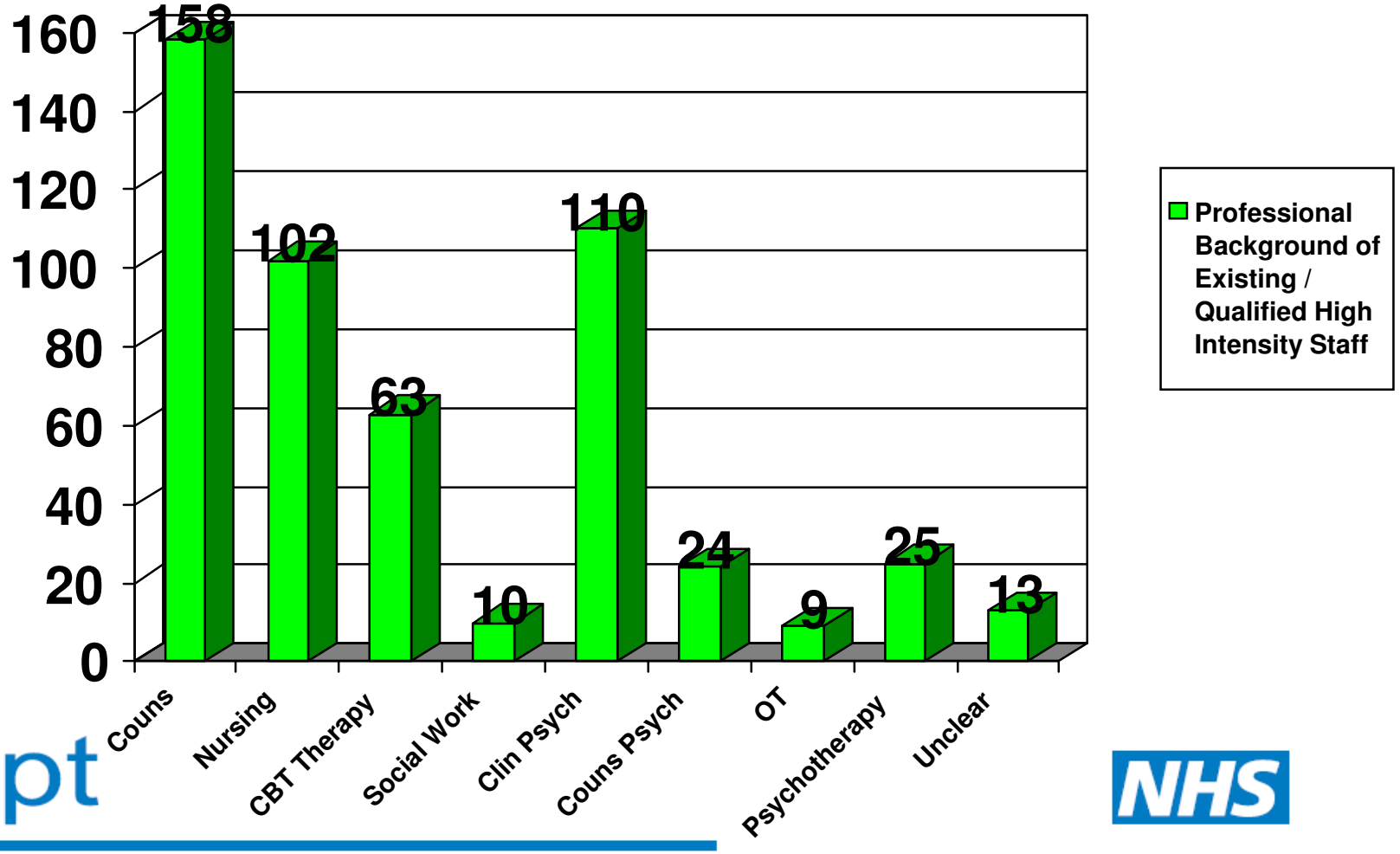
Core objectives

- 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



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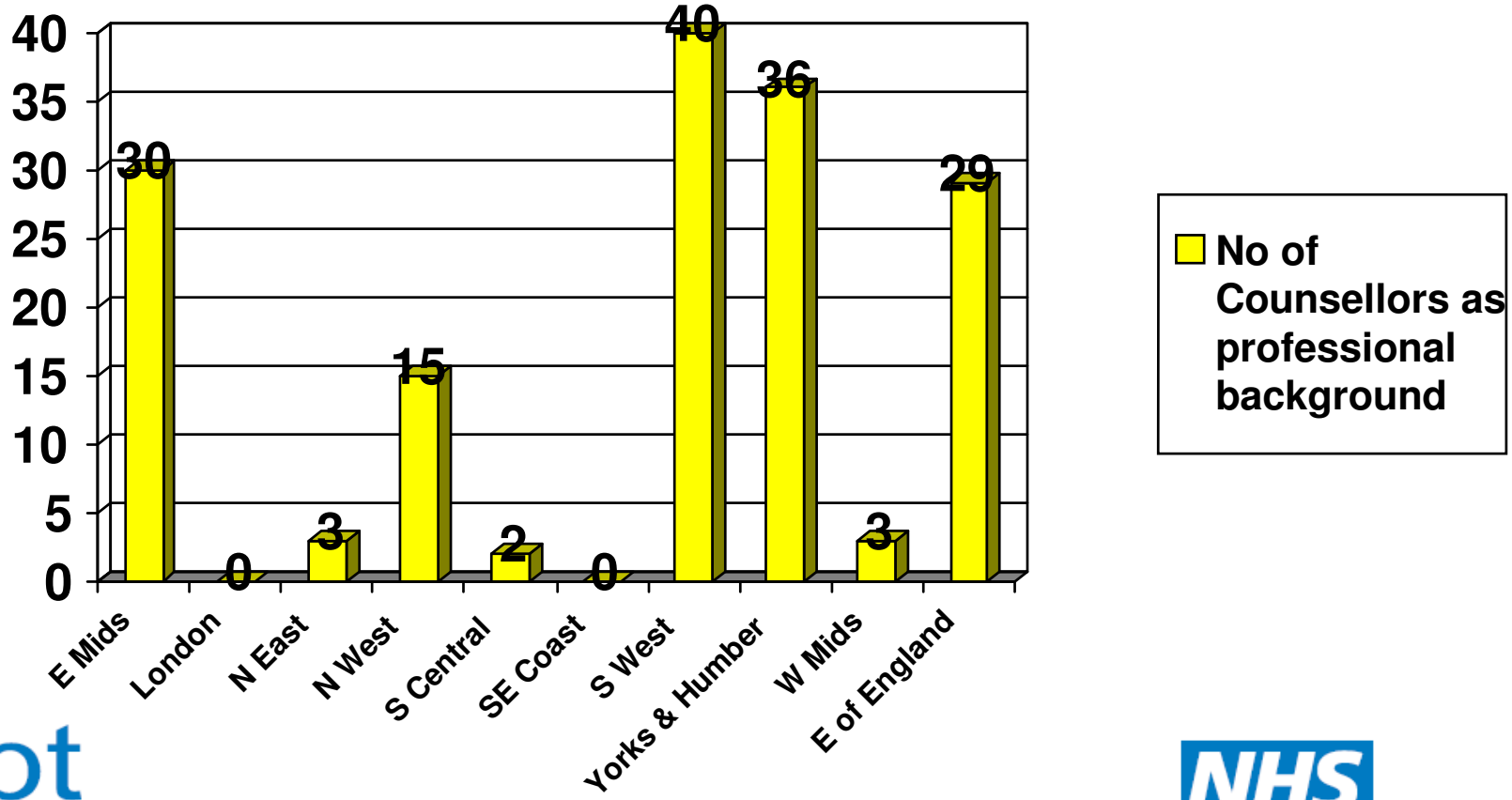
How many HI staff are Counsellors by professional background? A regional view



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Backgrounds of the HI trainees

SHA	Psych	Nurses	OTs	Couns	GMHW
North West	2	17	3	9	10
East Mid	4	24	2	2	5
West Mid	0	10	3	6	0
Eastern	0	6	1	1	0
London	35	13	4	2	14
SEC	1	15	3	2	5
SC	2	0	1	1	2
Yorks	0	16	1	1	3
South West	2	4	2	1	1

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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

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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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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

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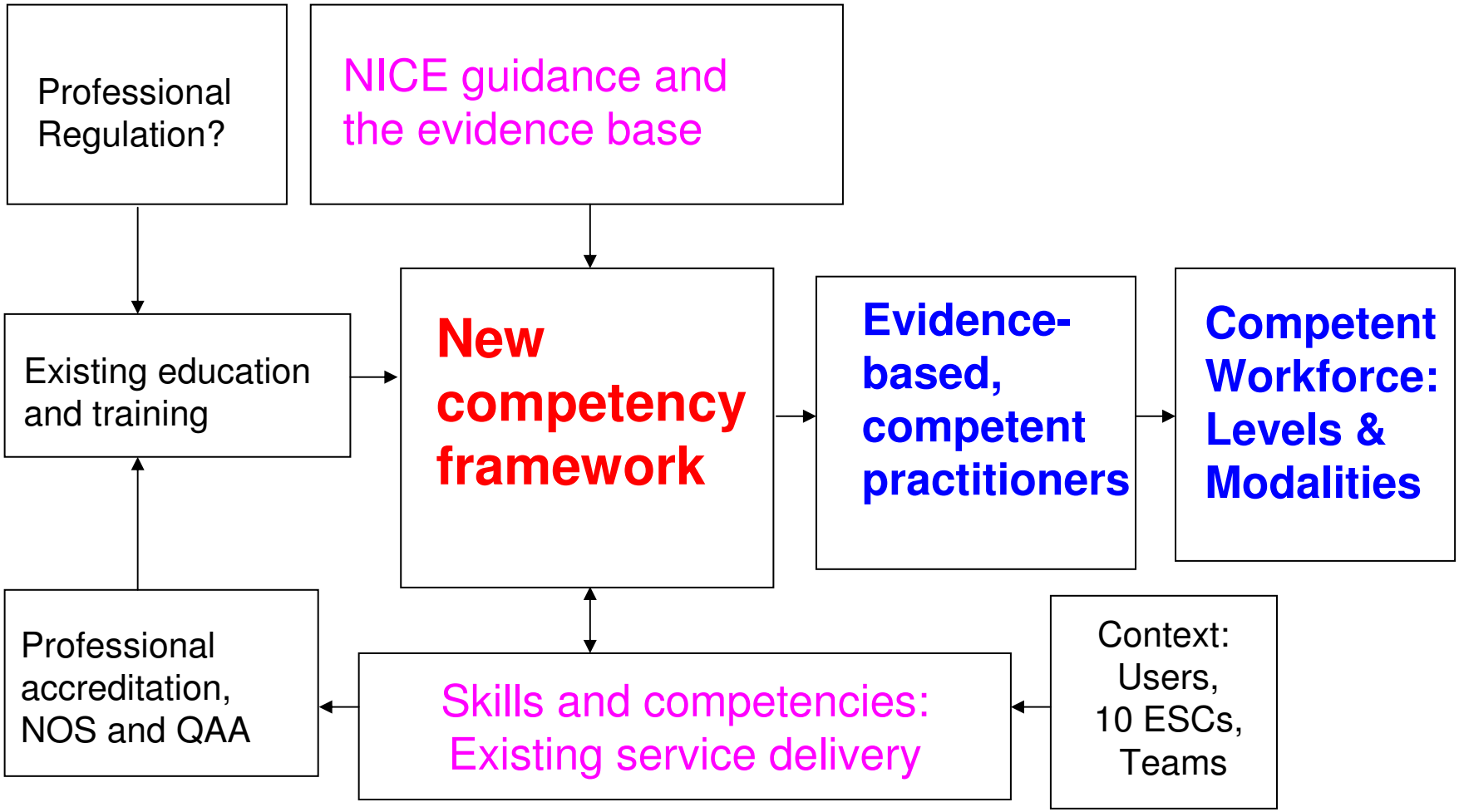
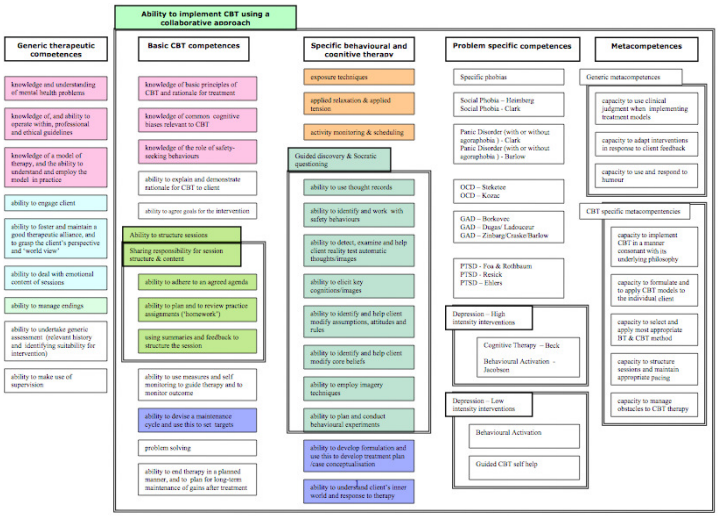
Importance of competency

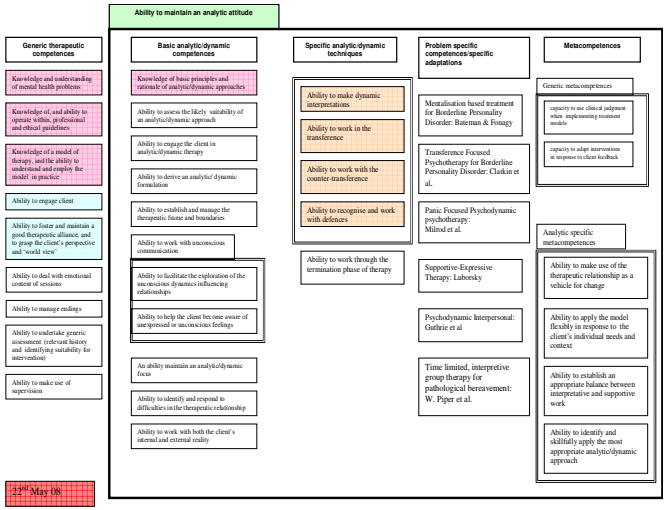


Competency frameworks

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

BUT

- 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

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Future developments of the 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

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Future developments of the 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

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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

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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

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- 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

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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

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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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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

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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)

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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)

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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?*

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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*

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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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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)

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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)

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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

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Where next for IAPT?

Louise Lyons
Trust Clinical Director
Tavistock and Portman NHS
Foundation Trust

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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?

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Thank You