

**Improving Access to Psychological Therapies**

**Case Study Report with particular reference to  
Workforce Issues**

## ***Introduction***

Many Primary Care Trusts across the United Kingdom have been developing services which provide access to psychological interventions. Care Service Improvement Partnership (CSIP) were asked to identify some of these sites so that their experiences could be utilised in the further development of the national Improving Access to Psychological Therapies (IAPT) programme. This document draws upon these experiences to provide information to others who are developing similar services. This will be of particular use to the Pathfinder Sites which are to be established during 2007. Reference is made to the issues which need to be considered in relation to workforce.

In developing services it is helpful to have a whole systems approach and an attempt to make some of these linkages is addressed.

One important link to make at the beginning of this report is the published work by the Primary Care Development Team – Improving Primary Care Mental Health Services a practical guide (DH 2006) which covers key skills for key staff in the broader view of Primary Care Services and is available from <http://www.csip.org.uk/resources/publications/primary-care.html?keywords=primary%20care>

The National Institute for Clinical Excellence (NICE) guidelines set out a stepped care approach for depression and anxiety. The complexities of having an appropriate workforce to implement these guidelines is the essence of what is contained in this report. (<http://www.nice.org.uk/pdf/CG023NICEguideline.pdf> &<http://www.nice.org.uk/guidance/CG22>)

There are some key messages for those undertaking the development of Primary Care Psychological Therapy services

### **Key Messages:**

- **Care Services Improvement Partnership (CSIP) Regional Development Centres are a useful source for gaining local information**
- **Workforce data, definition of skills, level of capability, training and education needs are currently being developed**
- **Data on measures and outcomes are being refined**
- **Work is underway with Skills for Health regarding competencies required at different levels of the career framework**
- **New sites linked to the National IAPT programme will be identified in 2007**

## **Psychological Therapy services in Primary Care**

It appears that there is no one, clear model of how these services should be delivered or indeed the exact makeup of the workforce to do so. Much of what has been achieved has had to reflect local need and circumstance. It must also be in line with the overall governmental directions to promote health and well-being, develop safer communities and enable people to remain in work.

## **Purpose of Psychological Services in Primary Care**

Services providing structured psychological interventions in primary care appear to have common aims, which include

- Helping people to develop fulfilled lives in all areas of their life including occupation, family, work, education, social and mental functioning (also reflected in the social inclusion work programme- (CSIP 2006) [www.socialinclusion.org.uk](http://www.socialinclusion.org.uk))
- Provision of multi levelled, high quality psychological therapies
- Fast access to services
- Reduction of referrals to secondary care
- Working seamlessly across other services (Whole systems - see Integrated Care Network <http://www.icn.csip.org.uk/> )
- Weaving research findings and adaptations to NICE Guidelines e.g. as happened in 2006 with the updated guidance on computerised CBT.

## **Services involved in this Study**

The Improving Access to Psychological Therapy CSIP regional leads were asked to identify sites who had already commenced work in developing their psychological therapy services in Primary Care. It was from those suggested that this work is based. It is acknowledged that there are many other sites across the country which have also developed services, however it is likely that similar issues would emerge.

## Interventions

The services studied offer a range of interventions, which are based around steps 1 - 3 within the stepped model of care. These varied between services as shown in the table below

**Table 1 Interventions offered by Sites**

	Langbaurgh	Swindon	Cambridge & Peterborough	Chester	Manchester	Ashton Leigh & Wigan	Ealing London	Oxfordshire
Watchful waiting				x	x	x	x	
Signpost /triage	x	x	x	x	x	x	x	x
cCBT		x				x	x	x
Promote self help	x	x	x	x	x	x	x	x
Increase social inclusion	x	x	x	x			x	
Facilitate use of other services	x			x			x	
Books on prescription	x	x		x		x	x	
Counselling	x		x	x	x	x	x	x
CBT – up to 6 sessions which may include group work		x	x	x	x	x	x	x
Exercise		x		x	x		x	
Psycho-education		x		x			x	
Supportive listening				x				
Medication monitoring				x	x		x	
Lifestyle change					x	x	x	
Employment linked services	x	x	x		x		x	

Different sites identified the need for a differing variety of interventions. For some, the importance of screening or signposting was identified to ensure that service users and carers were directed to the correct interventions as well as

detecting if referrals were inappropriate. An example of an inappropriate referral was when the case was more severe and should be referred directly to secondary services. The person who carries out this role may also undertake other duties, for example in Cambridgeshire and Peterborough the same person also provided brief therapy. The table above indicates how some interventions were more popular than others. The most popular interventions included signpost / triage, promoting self help, counselling and CBT. The CBT interventions might take the form of facilitated self help over a period of 6 sessions as in Langbaugh or behavioural activation as in Swindon, it is expected that these sessions would be supervised if not carried out by a trained therapist. In Ealing the Graduate mental health workers received specific training to carry out the role of supporting CBT based self help. Sites were not asked about the numbers of interventions or how long a person could receive help however it is known that in one site (Cambridgeshire and Peterborough) these treatments were limited to a maximum of 6 sessions. The range of services available will depend on the network of local provision, such as Early Intervention, Crisis and Home Treatment Teams and the range of voluntary, private and community provision.

## **The Workforce**

Just as the range of interventions varied by site, so too did the makeup of the workforce. Most sites appeared to continue to call their workforce by their traditional role e.g. nurse, social worker etc however this is not the case in all areas. Swindon have moved to call their workers Assistant Primary Care Mental Health Workers (who are banded 4 or 5 on Agenda for Change banding) and Primary Care Mental Health Practitioners who could include counsellors, clinical psychologists, social workers, nurses or occupational therapists (with a banding of 5 – 8).

Moving from the traditional roles to one where competencies are utilised to determine roles and pay is a current challenge. The National Occupational Standards for psychological therapists being developed by Skills for Health should provide some help in making these changes ([www.skillsforhealth.org.uk](http://www.skillsforhealth.org.uk) )

The use of the “new roles” in mental health also appeared common including Primary Care Mental Health Workers, Support Time and Recovery workers (STaR) and Gateway Workers. The latter were often given the role of signposting and ensuring that access to services was promoted both within the primary care mental health services and other local community services. Some services implied that the gateway role required the skills of an experienced practitioner (often a person who had previously been a CPN) which fits with the recommendations in the Review of Mental Health Nursing – From Values to Action: The Chief Nursing Officer’s review of Mental Health Nursing (DH 2006) (<http://www.dh.gov.uk/assetRoot/04/13/38/40/04133840.pdf>)

None of the sites had the full compliment of roles but those most often employed were counsellors, Primary Care Mental Health workers and practitioners and clinical psychologists.

A breakdown of the workforce by site is shown in Table 2 below

**Table 2 Workforce by Site**

Workforce	Site							
	Langbaugh	Swindon	Cambridge & Peterborough	Chester	Manchester	Ashton Leigh and Wigan	Ealing London	Oxfordshire
Gateway worker	X		X	X			X	
Primary Care Mental Health Worker	X			X	X	X	X	
Counsellor	X		X	X		X	X	X
Counselling Psychologist	X			X			X	X
Clinical Psychologist	X		X	X			X	X
Psychology Assistant			X					X
Admin staff	X	X		X			X	
Assistant Primary Care Mental Health workers (bands 4&5)		X						
Primary Care Mental Health Practitioners		X		X	X	X		
Psychotherapist				X			X	

As well as the variations in the workforce there was also a range as to who carried out the specific interventions. An example of one discrepancy is in carrying out individual and group treatments. In Cambridge and Peterborough there was a tendency to use Clinical Psychologists and their Assistants whereas in Swindon any of the Primary Care Mental Health practitioners carried out this function.

Where counsellors were employed either within the service or as a separate entity there was a need to ensure that services worked closely together. In Langbaugh counselling is an integral part of the service whereas in Cambridgeshire and Peterborough it is a separate service. In the latter, links were quickly established and training was given to the counsellors so that they became cognisant with CBT techniques, thus resulting in the two services complimenting each other. This is an example of how new services needed to integrate with previous service provision to make best use of all the resources. In Swindon there has been a move away from counselling as a separate

entity; the primary care mental health practitioners now deliver the whole service. However registered counsellors working within this service (who are now named as primary care mental health practitioners) remain registered with the British Association of Counsellors and Psychotherapists (<http://www.bacp.co.uk/>). The Chester service is currently considering the best solution for them regarding counselling.

Chester also includes services at Step 4 thus requiring the skills of a consultant psychologist, counselling psychologist or psychotherapist. To solve a recruitment and retention issue this member of staff has been employed within secondary services but providing interventions in Primary Care.

A breakdown of interventions by staff is provided in Table 3

**Table 3 Interventions Carried out by Different Members of the Workforce**

	GP	Gateway Worker	PCMHW	Counsellor	Counselling Psychologist	Clinical Psychologist	Psychology Assistant	Assistnat Primary Care Mental Health Workers (bands 4 &5)	Primary Care Mental Health Practitioners	Volunteers
Watchful waiting	x									
Signpost /triage	x	x	x	x	x	x				
cCBT			x							
Promote self help	x	x	x		x	x				
Increase social inclusion		x								
Facilitate use of other services		x								
books on prescription	x		x							
Counselling			x	x						
CBT			x		x	x	x	x	x	x
Exercise										
Psycho-education					x	x	x			
Medication monitoring	x								x	
Lifestyle change	x		x							
Employment linked services	x	x	x	x	x	x	x		x	

## **Training Education and Development**

The sites utilised many different routes to develop their staff and no clear principles emerged. There was a wide range of learning and development opportunities, as well as more formal education and training programmes to which workers have had access. These include;

- Higher Education Certificate and Diploma Programmes
- CPD Short Courses
- In-House Training and Development Programme
- Action learning and networking events
- A range of leadership and team-working opportunities
- Primary Care Mental Health CD Rom training (CCAWI Uni. of Lincoln )

The introduction of the Primary Care Graduate Mental Health Workers has led to a number of programmes linked to Universities which has in some areas been built upon to meet specific local needs.

There has also been a National Primary Care Trailblazer programme for mental health, which has helped to develop multi disciplinary working and promote the treatment options in this sector. These developments have been supported by events to support the leaders and spread ideas quickly throughout the Primary Care Networks.

Despite the variety of these various programmes they all appear to be promoting the need to look towards competency based multi disciplinary training, which can be undertaken by a range of staff. The recently published learning and development toolkit for the whole of the mental health workforce across both health and social care (DH 2007) should further help in this work.

## **Impact of the Service**

All of the services were able to report on a positive outcome regarding the impact that they had made on secondary care.

The services had in the most part meant that service users could be seen very quickly in primary care although there was still a few months wait for psychological assessment and treatment in Cambridgeshire and

Peterborough. As well as this the waiting times in secondary care had significantly reduced e.g. in Cambridgeshire and Peterborough the waiting list for CBT in secondary care had reduced from 20 months to 7 months in 2 ½ years, and they were able to close a secondary care assessment clinic. Early indications also showed a decrease in the use of antidepressants.

All but one of the services indicated that they utilised the Clinical Outcomes in Routine Evaluation Outcome Measure (CORE) to evaluate their effectiveness. Four of the services were able to provide data for this which showed that between 47- 50 % of service users showed significant changes, 17- 22% showed reliable change and 29- 36 % showed no reliable change or deterioration. Some service also used other outcome measurements including the Beck Depression and Anxiety Inventories and service user and GP satisfaction questionnaires all of which indicated a positive impact.

### **Links to other Services**

All of the services indicated that there was a need for effective links to other services. This included not only health services e.g. secondary care but also other community groups and support (Whole Systems work). Ealing have established good partnership working with their local counselling service and protocols are in place so that cases can be easily referred from one service to the other. There was some indication of links to employment issues this did not appear to be of primary interest and is an area which needs further development.

### **Staff Involvement in other activities**

Those in more senior roles were involved in a variety of activities which were essential to the smooth running of the service. The Swindon service articulated that those at Band 7 and upwards were involved in service development and training activities both within and beyond the immediate service whilst those at Band 6 and upwards were involved in supervision which could also be external to their own service. It was deemed that these roles are important not only at the commencement of services but also as they progress so that continual changes can be implemented. This will ensure

service development is an ongoing process. The percentage of time not spent in face-to-face work with patients was not easily identifiable.

Some staff were involved in supervision both within and outside the direct service. This is an important aspect of service delivery and there needs to be scope for flexible arrangements which will meet local need.

Training of other staff was also a necessary component of the work. This included training primary care nurse in self-help techniques, and training Counsellors in strategies and techniques relating to CBT.

Apart from direct patient contact, evaluation and audit of the service was deemed to be important, particularly when service change was taking place. Sharing information and data via the IAPT wider programme looks very positive.

### **Lessons to learn**

Starting a new service is not straightforward and one of the very important issues identified was the need for good governance arrangements. This included good supervision, training attendance at meetings and clear lines of accountability. Where staff are part time or in lower grades these issues can be especially challenging and need to be carefully addressed.

Administration support for services was clearly important as they provide an important support role in ensuring the workers are freed up to see patients. More work needs to be completed on quantifying ratios of how many of these administration staff are required.

Local issues need to be taken into account when setting up new services.

This should include how to manage the interface between existing services new services, and the whole network within that community.

Counselling services are one example, which has been dealt with in different ways. In Swindon the pre-existing counselling services have now been incorporated into the service whilst in Cambridgeshire and Peterborough recommendations are to increase this service still ensuring both provisions work smoothly together.

### **Risks and Strategies for the Future**

There were several areas highlighted which may mean that services are difficult to sustain. Firstly it was noted that although a mix of level of skill can

deliver a service, there is an essential requirement for some staff at a senior level i.e. Bands 6 and upwards. These staff will be involved in service development and providing support to other services which could be by providing supervision and training. To maintain a whole system these elements are important so that these specialist skills are available for developing both the service and the workforce. Those with these skills need to be able to work across organisations. No definite ratio for levels of staff has been determined but consideration should be made in the light of local circumstances. Recruitment and retention of this more highly skilled group of staff is vital.

The issue of promotion opportunities for those at lower grades may also be an issue and as a result, retention of staff may become difficult. The introduction of the Primary Care Graduate Mental Health Worker initially increased the workforce but many of the recruits left within two years of recruitment. To overcome this, strategies need to be introduced to address these difficulties. The principles within New Ways of Working for Everyone (DH 2007) should help to address some of these difficulties alongside the developing career framework being led by Skills for Health. As more services emerge in the private and independent sector the issues of recruitment and retention may become more complex.

### ***Summary***

The sites have illustrated different ways to implement and sustain primary care mental health services. Although different skill mixes of staff are utilised in different services there is an acknowledgement that there could potentially be a number of staff that could carry out certain roles if they are competent and skilled to do so through adequate training and development.

Local circumstances must be considered in setting up new services to make best use of current service provision. Sharing the stories of local development and building on collaborative work will be vital for ongoing improvements.

The implementation of primary care services shows high service user and GP satisfaction and has a positive impact on waiting times both in primary and secondary care.

## ***Acknowledgements***

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*Langbaugh Primary Care Psychology and Counselling Service*

*Swindon. Part of Avon and Wiltshire Mental Health Partnership Trust*

*Cambridgeshire and Peterborough Mental Health Partnership*

*Chester Primary Care Mental Health Service*

*Central Manchester Primary Mental Health Service*

*Ashton Leigh and Wigan Primary Care Mental Health Service*

*Oxfordshire Primary Care Counselling and Psychology Service*

*Ealing CBT Service part of West London Mental Health Trust*

## References

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<http://www.nice.org.uk/pdf/CG023NICEguideline.pdf>

National Institute for Clinical Excellence (2007) Clinical Guidance for Anxiety (amended) NICE publication  
<http://www.nice.org.uk/guidance/CG22>

## Useful resources/websites

<http://www.nimhe.csip.org.uk/publications-and-other-resources/publications/primary-care-.html>

<http://www.improvementfoundation.org/View.aspx?page=/default.html>

<http://www.lincoln.ac.uk/ccawi/>

[www.socialinclusion.org.uk](http://www.socialinclusion.org.uk)

<http://www.dh.gov.uk/assetRoot/04/13/38/40/04133840.pdf>

<http://www.csip.org.uk/resources/publications/primary-care.html?keywords=primary%20care>

[www.dh.gov.uk/publications](http://www.dh.gov.uk/publications)

<http://www.newwaysofworking.org.uk/>