GIG CYMRU NHS WALES

Llywodraeth Cymru
Welsh Government

www.cymru.gov.uk

Psychological Therapies in Wales

Policy Implementation Guidance

March 2012

WG15211
Digital ISBN 978 0 7504 7315 0
© Crown copyright 2012

CONTENTS

1. VISION AND PURPOSE OF THE GUIDANCE 2
2. INTRODUCTION 3
3. RECOMMENDED IMPLEMENTATION STEPS..... 4
4. POLICY AND LEGISLATIVE CONTEXT 5
5. DELIVERING PSYCHOLOGICAL THERAPIES 7
6. SERVICE PHILOSOPHY.....7
7. SERVICE MODEL 10
8. QUALITY STANDARDS 16
9. IMPLEMENTATION STEPS 18
REFERENCES AND FURTHER READING..... 19
APPENDIX 1.....21
APPENDIX 2.....24

1. VISION AND PURPOSE OF THE GUIDANCE

Vision: to help improve the nation's health and wellbeing by offering the people of Wales appropriate access to services that are both psychologically minded and psychologically therapeutic.

Psychologically minded services are those in which - at all stages of assessment and intervention - the psychological needs of service users are considered and addressed through the use of evidence-based interventions. Furthermore, a psychologically minded service focuses upon the quality of relationships between practitioners and service users in the delivery of all treatment and interventions. These relationships provide the foundation for effective service delivery.

1.1 The purpose of this policy guidance is to help services:

- improve the availability of psychological interventions in Wales
- integrate a psychologically informed approach within the delivery of mainstream care.

1.2 This psychologically informed approach serves to increase the efficacy of services and improve clinical and social outcomes. Importantly, it recognises that it is not simply what we do (the intervention), but the way we do it (the use of relationships) that derives the best outcomes for service users and increases the effectiveness and efficiency of services.

1.3 The document therefore seeks to spread the use of evidence-based psychological interventions and to reinforce within organisations the importance of therapeutic approaches that promote recovery and resilience in people who use their services.

1.4 Improving clinical outcomes and service user satisfaction through the delivery of person-centred therapeutic interventions therefore serves to improve the quality, safety and efficiency of health and social care services. In order to achieve these outcomes, local services will need to address the training needs of their workforce together with any organisational development changes needed to enable staff to use these skills most effectively.

1.5 The document has been produced with a specific focus on improving outcomes in mental health. However, implementing this guidance has potential to also improve outcomes and efficiency in physical healthcare. This is because mental health problems are more prevalent among people who are physically ill; in particular, those who have long-term conditions. If left untreated, mental health problems can have an adverse affect on long-term conditions. For example, patients with cardiac problems are three times more likely to die if they also have depression. Untreated mental health problems can also have an impact on the cost of treating long term conditions. For example, for patients with co-morbid depression and diabetes, the cost of their diabetes care can be 50-75% greater than in patients with diabetes alone.

2. INTRODUCTION

2.1 Psychological treatment approaches are a core component of mental and physical health interventions. All NICE guidance[1] produced on the treatment of mental disorders and some on physical illness recommend the use of at least one type of psychological therapy.

2.2 The necessity to deliver improved outcomes requires the development of efficient and effective mental health services which liaise with physical healthcare. Delivering improved health outcomes has the potential to empower service users to live more independent and fulfilling lives and reduce their dependence upon services.

The delivery of evidence based psychological interventions is a core component of such an approach and one which requires psychological services - together with medical, nursing, occupational therapy, primary care and social work staff in statutory and third sector services - to deliver a range of psychological therapies in partnership.

2.3 Improved access to these therapies does not only improve the quality of care, it can also lead to significant economic benefits. There is growing evidence that psychological therapies can improve the efficiency and effectiveness of both mental healthcare and physical healthcare, deriving potential savings for reinvestment. The Improving Access to Psychological Therapies (IAPT) programme in England has demonstrated effectiveness in treating depression and anxiety. Offering effective psychological interventions can also lead to a reduction in unnecessary admissions where people experience anxiety and depression co morbid to a physical health problem, particularly a long term condition. Psychological therapies can also provide improved outcomes in the management of people with medically unexplained symptoms, reducing costs and sometimes unwarranted invasive interventions.

2.4 This document seeks to assist Local Health Boards (LHBs) and local authorities to increase the availability of, and access to, psychological therapies in the treatment of mental disorder and common mental health problems. It seeks to assist the development of a psychologically minded mental health system across primary care, specialist health and social care services and the third sector.

2.5 The guidance is intended for use by service planners, operational managers and practitioners in both the statutory and third sectors. It is also intended to inform service users and carers of the approach being developed by the Welsh Government to incrementally increase access to psychological therapies in Wales. It sets out the service philosophy and establishes a set of quality standards for psychological interventions in Wales. Importantly it provides guidance on the specific implementation steps each LHB needs to take to improve access to psychological therapies. The guidance will therefore

[1] See http://guidance.nice.org.uk/Topic/MentalHealthBehavioural.

assist LHBs and local authorities to meet the new statutory duties emanating from the Mental Health (Wales) Measure 2010.

2.6 A specific risk has been identified in Wales concerning the recruitment and retention of psychological therapy staff and counsellors. The risk arises from competition for staff from other UK administrations which have already focused on improving access to psychological therapies. In England, some 3,700 staff have been recruited into their IAPT programme, this is set to rise to 6,000 by 2014. It is known that staff trained in Wales have been recruited to work in England and future increases in the English programme are likely to continue to attract practitioners from Wales to staff these services. Furthermore, Wales does not have a strategic programme to meet the training and development needs of staff working in Wales.

3. RECOMMENDED IMPLEMENTATION STEPS

3.1 In order to develop psychological therapies in Wales, as a minimum, the following implementation steps should be taken:

Implementation step 1

Each LHB Psychological Therapy Management Committee (PTMC) shall take responsibility for the delivery of the implementation steps set out within this guidance, in line with its quality standards

Implementation step 2

Each LHB should, as part of their *Health and Wellbeing Strategy*, measure local demand for, and capacity to deliver a locally appropriate range of psychological therapies and ensure they train and develop a workforce capable of delivering the range of interventions within a formal supervision structure.

Implementation step 3

Each LHB should establish a clinical outcome data collection system which is compatible with other LHBs across all tiers of service.

Implementation step 4

Arrangements should be in place at a LHB and a national level to performance manage the delivery of improvements in the availability of psychological services. These arrangements will be driven locally by the PTMC which will convene nationally to benchmark local performance and feed local and national data to Welsh Government.

4. POLICY AND LEGISLATIVE CONTEXT

Policy Requirements

4.1 The importance of access to a range of evidence-based psychological interventions is set out in Welsh mental health policy. Reference is also made to psychological therapies in a number of physical health policy documents.

4.2 The adult mental health strategy for Wales *Equity, Empowerment, Effectiveness, Efficiency* (2001) identified that success would depend on six key developments. One of these was to ensure the availability of psychotherapy services in all areas within primary and secondary care. Every Community Mental Health Team (CMHT) should be providing psychological treatment. The Strategy stipulated that "there is also a need for a more specialised service to provide the more formal psychotherapies and act as a centre for advice and training about psychological treatments for all staff".

4.3 Key action 26 of *Raising the Standard: The Revised Adult Mental Health National Service Framework for Wales* (2005) sought to improve access to psychological therapy within Wales. The *National Service Framework Older People in Wales (2006)* identifies the need for psychological interventions in the treatment of depression and psychosis, they are also identified as beneficial in the treatment of dementia, including early onset dementia and are beneficial in providing support to carers.

4.4 The following key principles have been identified as underpinning these policies

- Services should offer a comprehensive range of formal high quality psychological therapies.
- psychological therapies should be co-ordinated, accessible and delivery should be through multidisciplinary staff groups.
- Specialised staff should be involved in training, but all mental health professionals should be confident to apply some of the key techniques in their everyday work and to receive supervision in their use.

4.5 In 2006/2007 two annual operating framework (AOF) targets were set in an attempt to reduce waiting times to psychological interventions in primary and secondary care settings.

4.6 More recently the Intelligent Targets for depression and dementia and *Talk to Me: The National Action Plan to Reduce Suicide and Self Harm in Wales* (2009), require the delivery of psychological interventions in a variety of settings.

4.7 The *Programme for Government 2011-2015* made mental health commitments for delivery within the current Assembly term which include a commitment to review access to the range of 'talking treatments' across Wales.

4.8 In terms of wider service change, the Welsh Government's *Chronic Conditions Management (CCM) strategy* (2007) and strategic framework for the

shift of services to primary and community care *Setting the Direction* (2009), both envisage improvements and co-ordinated care for physical and mental health.

Legislative Requirements

4.9 In order to improve mental health services in Wales, including strengthening the delivery of this policy intent, Welsh legislative developments have include requirements to ensure improvement in the delivery of psychological interventions.

4.10 The *Mental Health Act 1983 Code of Practice for Wales* (2008) identified nine areas to be addressed in developing a care plan for individuals falling within the scope of the Act, one of which is a requirement to include other forms of treatment, including psychological therapies within a care plan. This will be superseded by provisions within the Mental Health (Wales) Measure 2010.

4.11 These new provisions place requirements on LHBs and local authorities in respect of care and treatment planning for all persons receiving secondary mental health services. Section 18 (1) of the Measure sets out: "*that a relevant patient's care coordinator must work with the relevant patient and the patient's mental health service providers, with a view to agreeing the outcomes which the provision of mental health services for the patient are designed to achieve, including…medical and other forms of treatment including psychological interventions".*.

4.12 The Measure also makes provision in respect of local primary mental health support services. These services will include *"the provision for an individual, following a primary mental health assessment, of the local primary mental health treatment identified by the assessment as being treatment which might improve or prevent a deterioration in the individual's mental health; "* Such treatments will frequently require the delivery of psychological interventions. The National Service Model for Local Primary Care Services (NSM) has been developed to support implementation of the Measure. The NSM identifies that in order to meet its objectives there is a requirement to provide wider access to psychological therapies.

4.13 Welsh mental health policy and statutory duties therefore require LHBs and their partners to ensure that a range of psychological therapies are available within primary and specialist care settings.

4.14 The reconfigured health service in Wales provides a unique opportunity for LHBs to review the provision of psychological therapies spanning primary and specialist health and social care services in line with the Welsh Government's commitment to review access to the range of talking treatments across Wales.

4.15 Despite these policy and legislative drivers the Wales Audit Office in its *Adult Mental Health Services Follow up Report* 2011) found that whilst psychology therapy services have improved since 2005 and that there has been some progress in moving towards a stepped model of care, waiting times can still be very long. The follow up review found that services in specialist

services and primary care did not meet the requirements of Welsh Government policy.

5. DELIVERING PSYCHOLOGICAL THERAPIES

5.1 Psychological therapies encompass a broad range of treatment approaches aimed at improving understanding of and alleviating a person's distress. There are many different theoretical models which can be delivered in different forms – individual, couples, group or family.

5.2 In order to provide the necessary range of psychological therapies across the various tiers of service and at appropriate levels of intervention. LHBs and local authorities - together with third sector organisations - require a multidisciplinary workforce with the necessary skills to deliver these interventions efficiently and effectively.

5.3 Staff will be required to deliver interventions at the following three levels:

"Level A - Mental health worker. Using engagement and the relationship, informed by counselling and psychotherapeutic skills, to promote change and recovery. Generic skills, requiring appropriate values and attitudes which can be taught and enhanced by reflective practice and supervision;

Level B - Practitioner able to deliver formulation-based or manualised evidence-based interventions for specific problems, through regular structured sessions for an agreed time. Requires training in the particular interventions appropriate to the particular diagnosed problems, and the theory underpinning them, and requires the practitioner to work under close consultative supervision;

Level C - Expert psychological therapist. Able to work with complex cases for whom level B interventions are not considered appropriate, or for whom they have failed to achieve necessary outcomes. Able to work autonomously, through formulation and using a particular model at high level, or through integration of different models or approaches. Able to apply models across different conditions and different contexts."

5.4 A brief description of psychological therapies available in the NHS can be found in *Treatment Choice in Psychological Therapies and Counselling* (2001) (an excerpt of which is reproduced at Appendix 1).

6. SERVICE PHILOSOPHY

6.1 Service design needs to be underpinned and quality assured by an evidence base, an example of which is NICE guidance. However, delivery of evidence-based practice on its own is not sufficient. It needs to be set within services that are based on a psychologically informed policy framework. A key intent of the Care Programme Approach (CPA) and the Measure is to provide a framework that ensures a person's medical, social, psychological and spiritual needs are addressed through the intervention of a multidisciplinary team

capable of meeting all of these facets of care and treatment in a manner consistent with a recovery approach.

6.2 Such a framework can be developed on the basis of identifying universal psychological needs alongside physical and social needs.

6.3 Fundamental psychological needs include:

- to have secure, stable, enduring attachments to at least one significant other person
- to have attempts to communicate recognised empathically
- to belong to a family or other social group or system and to have a recognised respected and valued identity and status within it
- to have secure, clear and consistent social boundaries
- to have a sense of hope, belief, value, meaning and purposeful occupation
- to develop an understanding and realistic sense of influence over our selves and our environment.

6.4 A psychologically informed generic policy framework should recognise that effective treatments rely on effective care relationships. Service design needs to reflect and foster this. Services should therefore offer evidence-based treatments within a service designed to ensure a focus upon the nature and quality of relationships with service users and between colleagues. It is not just what we do, but the way in which we do it, that makes the difference in achieving more effective outcomes from mental healthcare and treatment interventions.

6.5 A paper detailing the background to the proposed service philosophy is available here. While this philosophy is drafted specifically for psychological therapies, it is imperative that the 'business' of psychological therapies does not become seen solely as the domain of specialist practitioners or departments but is adopted within the generic mental health policy framework.

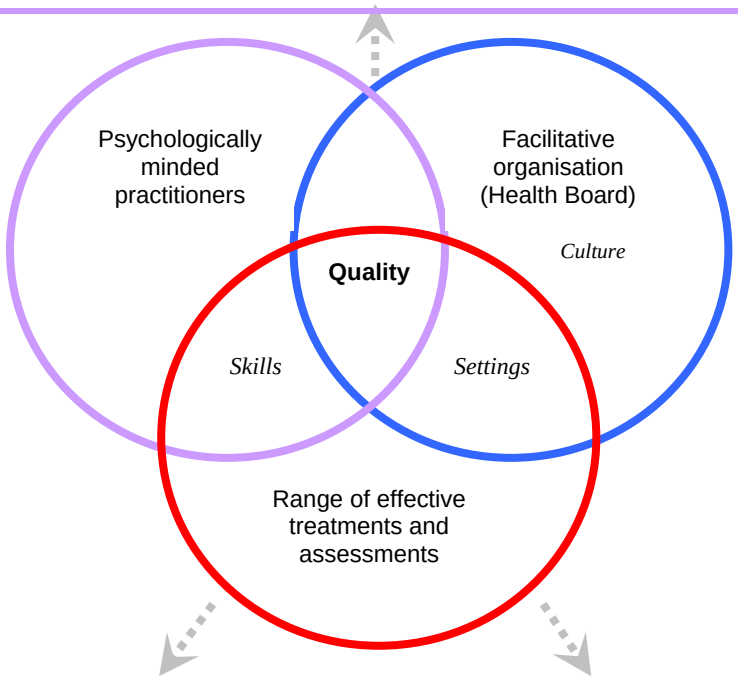
6.6 Each LHB should develop a plan to embed this philosophy within their organisation in order to provide effective treatments through a psychologically minded staff. Some of the practical outcomes of adopting this approach are outlined in Fig 1 below.

Fig 1: Improving Service user and organisational outcomes

Relationship Outcomes
(service user, practitioner and managerial)

The organisation can expect to improve:

- Co-ordination and promote workforce planning through its Psychological Therapies Management Committee, PTMC).
- Staff welfare consideration (conducts staff morale survey)
- Learning from service user experience (e.g. develops service user consultancy)
- Processes and systems to enable staff to form emotionally reliable and consistent contact, reviewing caseload numbers, conducting an attachment audit which reviews for example the working environment, admission and discharge processes etc.
- Training by establishing a training programme from a psychological needs perspective considering mandatory training.



Training and staff skills outcomes

- Develop sensitivity to service user experience through training in the use of outcomes and alliance measures
- Develop a culture which promotes supervision which is enshrined within policy
- Deliver training in core psychological mindedness skills including effective communication, understanding of workplace and teams, self-awareness and reflective skills, understanding connections between present distress and past experience (see KUF programme Inst of MH, Nottingham)
- Deliver psychological risk assessment training for example training on personal/professional boundaries

Service Provision Outcomes

- Development of a tiered system deploying evidence based practice drawing upon service user based feedback (practice based evidence)
- Conserve and enhance therapeutic skills across diagnostically framed networks
- Review specialist team provision (gap analysis)
- Deploy auditable quality standards reviewed by PTMC in relation to clinical outcomes, appropriateness, acceptability and accessibility of service options

7. SERVICE MODEL

7.1 In order to make efficient and coordinated use of limited resources yet maximise choice for service users, a tiered care system (sometimes referred to as 'stepped care') needs to be in place. A tiered care system is one that allocates appropriate resources to ensure that expertise and treatment interventions match the complexity of need, whilst minimising service user burden by avoiding multiple assessments. It also ensures provision of accessible, appropriate, acceptable treatments with measurable outcomes.

7.2 Service users who are receiving therapy that does not benefit them - and yet remain in the system failing to improve - need to be identified early on by clinical staff and their managers. This requires a clinical outcome and supervision system that can sensitively oversee the recovery process and inform clinical practice and decision making at the practitioner/service user level.

7.3 Various forms of tiered care exist across the UK. The breadth of LHB provision in Wales provides an opportunity for a whole system approach for the delivery of psychological therapies across the clinical spectrum – from health promotion and education at the population level, through to specialist psychological therapy services for complex needs.

7.4 The National Service Model (NSM) for local primary care services description of a mental health whole system is outlined in Fig 2 below. Psychological therapies are required in each of its tiers at an appropriate level of intensity as outlined in section 5 above.

7.5 In general, as the pyramid is ascended the number of service users accessing the tier of service reduces, but the treatment intensity increases. Further detail of service options are given in Table 1 below.

7.6 The effective delivery of this service model should be overseen at a LHB level by its Psychological Therapy Management Committee (PTMC). Each LHB currently has a PTMC but the role and function of these varies across Wales. In order to improve consistency and ensure that PTMCs address the critical issue of workforce an exemplar set of terms of reference is at Appendix 2.

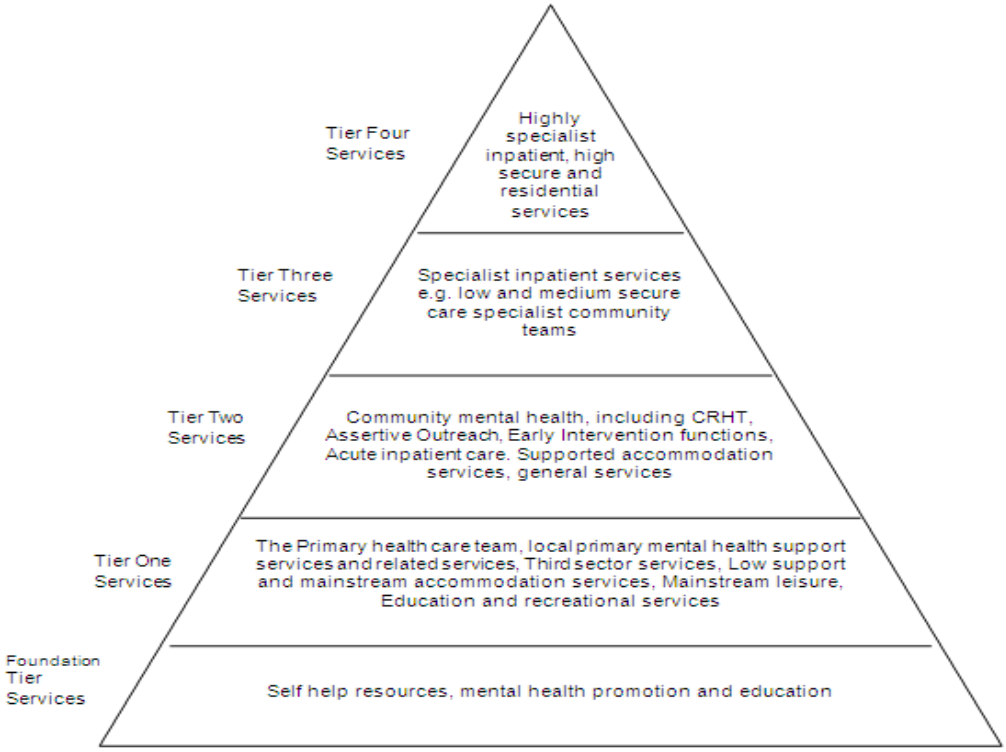
7.7 Foundation tier services and Tier 1 options are delivered in community and primary care settings and shall be undertaken in line with the NSM for local primary care services under part 1 of the Measure. There should be a single point of entry at primary care level for assessment and, where appropriate, referral to tiers 2 to 4. Staff delivering psychological therapies at the various tiers of service should have the appropriate skill set as set out in section 5 above and be competent in their delivery. This would include as a minimum, behavioural activation; overcoming avoidant behaviour; thought records and sleep hygiene

7.8 NICE guidance suggests that treatment outcomes are better where self help approaches are guided by trained staff

7.9 National Occupational Standards and competence frameworks for the delivery of different psychological therapies, the statutory regulation of applied psychologists and the standards set out by professional bodies apply across the UK.[2] As a result of these initiatives specific skills sets for the major psychological therapy models and their clinical supervision and curricula have been devised for higher education institutions to enable them to set up accredited training for these skills sets.

7.10 In order to avoid duplication of effort Psychological Therapy Management Committees, PTMCs should map third sector provision and coordinate it with statutory service provision.

Fig 2: The National Service Model Mental Health Whole system



7.11 Tier 1, Primary mental health Care, Tier 2 secondary care teams and acute in-patient care and Tier 3 specialist psychological therapy services, need clear step up and step out criteria and should offer a portfolio of evidence based treatment options appropriate to clinical need. The recommended treatment within a stepped care model should be at the lowest level of treatment intensity which is likely to provide significant health gain. It is important that decisions about the use of minimal interventions as a first line treatment are made on the basis of good research evidence and risk assessment. There will be cases in which early intensive treatment is actually more clinically and cost effective than a minimal intervention. The outcome of treatments should be monitored systematically and stepped up if current treatments are not achieving significant health gain. Monitoring progress in treatment is a fundamental component of stepped care models and a fundamental responsibility of therapists and the system of care in which they

[2] See http://www.skillsforhealth.org.uk/.

work. Tier 3 staff should have responsibility for providing training, supervision and consultation possibly through their involvement in clinical networks.

7.12 Tiers 1 to 4 should be audited using the same or a compatible service user directed outcome focused audit system in order to track case complexity and progress through the system.

7.13 Therapeutic networks which focus upon particular diagnoses, for example eating disorders or personality disorder, should be further developed.

7.14 These networks can help conserve expertise, develop critical mass and by extending the availability of more specialist therapeutic interventions over larger geographical areas provide greater economies of scale. Networks can also play a significant role in ensuring effective clinical governance.

7.15 The networks should consist of a leadership group for given geographical areas possibly; although not necessarily the whole of a LHB, for a given diagnostic range. They should offer supervision and consultation meetings for example within CMHTs. Other key tasks may include the identification of audit priorities, the fostering of treatment protocol adherence and evaluation of local implications of NICE guidance and emerging professional knowledge. They may also be involved in delivering training events and brokering out of area referrals and resettlement. They should also create cross organisational links relevant to their diagnostic field (e.g. with third sector organisations).

7.16 On occasions, specialist psychological therapies may not be available locally to meet the needs of people with very complex clinical needs. In these circumstances LHBs should have arrangements in place to organise and review the continuing need for out of area placements. This should ideally be within Wales but sometimes may require placements elsewhere in the UK.

7.17 The service model for psychological therapy should be developed in line with the quality standards set out below.

Table 1: Example of Tiered Care Functions

TIER	WHAT'S PROVIDED	WHO PROVIDES	WHERE IT'S PROVIDED	HOW IT'S PROVIDED
0	The promotion of health and wellbeing using leaflets, local media, mental health first aid etc. Self-help resources – internet sites, self assessment, self help literature, computer based CBT Stress control courses Bibliotherapy (Book Prescription Wales)	Mental health promotion network Third sector services Occupational health staff Staff from higher tiers to perform particular tasks as appropriate	Media Internet Community sites e.g. libraries mental health voluntary sector drop ins Schools Colleges Work places Primary care settings	Campaign events Educational opportunities (teacher training, receptionists, etc) Local brochure of available options Internet sites Via NHS Direct
1	Advice line First line assessment appointments The promotion of health and wellbeing using leaflets, local media, mental health first aid etc. Self-help resources – internet sites, self assessment, self help	Psychological services staff e.g. primary care mental health workers, Occupational Health. or HR Staff with I.T. and information management skills 3rd Sector services Professionally qualified staff to supervise/ lead	Drop-in centres Community sites Workplace Primary care practices	Managed by psychological services staff. Produce, oversee and 'market' tier 1 options Formal assessment and screening

TIER	WHAT'S PROVIDED	WHO PROVIDES	WHERE IT'S PROVIDED	HOW IT'S PROVIDED
	literature, computer based CBT Stress control courses Bibliotherapy (Book Prescription Wales) Signposting, Referral to appropriate step up services	Professionally led staff e.g. (Wellbeing Through Work programme) Professionally led psychological therapists trained to practitioner level or above. First Access Teams GPs		
2	A range of psychological interventions including single model therapies and integrative/multi modal treatment approaches Psycho-education, family interventions	Clinical and counselling psychologists and psychotherapists Psychological therapists with training equivalent to at least practitioner level enabling accreditation and registration with a nationally recognised accrediting body	Secondary care e.g. CMHT, Specialist community mental health services e.g. Crisis Resolution Home Treatment, Assertive Outreach & First Episode Psychosis (services Secondary mental health staff)	Care co-ordination e.g. CPA care and treatment plan.
3	Specialist assessment and treatment for complex and enduring presentations within LHBs	Clinical and counselling psychologists and psychotherapists Psychological therapists with training equivalent to at least	Specialist secondary care services/teams Day services In-patient	Therapeutic networks Training of tier 1-2 staff

TIER	WHAT'S PROVIDED	WHO PROVIDES	WHERE IT'S PROVIDED	HOW IT'S PROVIDED
		practitioner level enabling regulation under HPC and/or registration with a professional body such as BACP, BABCP		
4	Highly complex care (frequently continuing care cases)	Tertiary care	All Wales regional service provision or by other UK provider	By referral from tier 3 staff when lower tier options not optimal

8. QUALITY STANDARDS

8.1 Measurable quality standards which provide service delivery assurance should be used throughout Wales. They need to be compatible with pre-determined national audit standards established at an England and Wales level through the National Audit of Psychological Therapies[3] and should be relevant to specified tiers of service.

8.2 Quality standards have been defined in relation to *accessibility, appropriateness, acceptability* and *outcome.* Assessing compliance with outcome quality standards is dependent upon the establishment of an appropriate benchmarking system.

8.3 The access quality standards relevant to the foundation tier are:

- Group interventions are provided at locations and occur at times which facilitate access for groups of people who would otherwise be unable to attend

- Groups audited to ensure uptake reflects the socio-demographic profile of the local community

- Resources are made available and participation in groups occurs without formal referral to LHB and local authority services or acquiring a record on the medical record of referral to a mental health service.

8.4 Access quality standards for services at tier 1 and above are:

- The number of people referred for and starting treatment at tier 1 is in accordance with expected primary care figures for the LHB area based upon local epidemiological analysis

- Referrals are representative of the locality population in terms of the protected characteristics set out in the Equality Act 2010

The tier 1 and above quality standards can be operationally defined in terms of rates of anxiety and depression as these are proxy diagnostic indicators of core clinical business (although it is not anticipated that all patients accessing tier 1 or above will be suffering from anxiety and depression).

- The number of people stepped up from tier 1 to specialist care should be benchmarked against national norms

- Expected waiting times for referral to assessment and assessment to treatment for psychological therapy should be in line with the recommended times for treatment in physical health domains.

[3] http://www.rcpsych.ac.uk/pdf/Revised%20Standards%20FINAL%204%20May%202010.pdf

8.5 Outcome quality standards for tier 1 provision and above are:

- The service and clinical outcomes are comparable to those achieved by benchmarks, clinical trials and effectiveness studies and to those in other services where available

- The rate of attrition between referral to assessment and assessment to commencement of treatment is comparable to other services.

8.6 The **appropriateness** of the intervention can be assessed for all tiers in relation to the following quality standards

- Where relevant NICE guidance exists therapy should conform to the recommendations set out in these national guidelines (e.g. services should offer the range of therapies recommended by NICE for depression)

- Where NICE guidance does not exist (e.g. for complex issues and life events such as loss, bereavement, relationship problems and sexual abuse) then other forms of published evidence can be used, such as Randomised Control Trials, systematic scoping reviews and reports of practice based evidence

- Practice based evidence should also be gathered by the service to ensure the effectiveness and appropriateness of therapeutic interventions

- Clinicians must receive adequate training and continue to receive adequate supervision to deliver the therapy provided.

8.7 The **acceptability** of service user experience can be determined by whether

- Service users report receiving adequate information about and involvement in the choice of therapy and therapist, language of therapy and therapeutic materials

- Service users report a positive therapeutic relationship comparable to other services

- Service users report comparable service user satisfaction levels across different services

9. IMPLEMENTATION STEPS

Implementation step 1

Each LHB Psychological Therapy Management Committee (PTMC) shall take responsibility for the delivery of the implementation steps set out within this guidance, in line with its quality standards

Implementation step 2

Each LHB should, as part of their *Health and Wellbeing Strategy*, measure local demand for, and capacity to deliver a locally appropriate range of psychological therapies and ensure they train and develop a workforce capable of delivering the range of interventions within a formal supervision structure.

Implementation step 3

Each LHB should establish a clinical outcome data collection system which is compatible with other LHBs across all tiers of service.

The outcome data collection system should:

- Achieve agreed data completion rates: a minimum of 75% data collection is the figure identified by other IAPT programmes required for meaningful comparison between services.
- Support transfer protocols
- Identify waiting times
- Provide the percentage of people accepted for treatment
- Provide rates of
    - recovery and improvement
    - unplanned endings/DNA rates
    - completed risk assessments.

Other activity data such as discharge rates/length of interventions, number of sessions and types of therapy provided

Implementation step 4

Arrangements should be in place at a LHB and at national level to performance manage the delivery of improvements in the availability of psychological services. These arrangements will be driven locally by the PTMC which will convene nationally to benchmark local performance and feed local and national data to Welsh Government.

REFERENCES AND FURTHER READING

Department for Health (2001) *Treatment Choice in Psychological Therapies and Counselling: Evidence-Based Clinical Practice Guideline.* London: Stationery Office

National Assembly for Wales (2010) *Mental Health (Wales) Measure 2010,* available at: http://www.assemblywales.org/bus-home/bus-legislation/bus-leg-measures/business-legislation-measures-mhs-2.htm

Wales Audit Office (2011) *Adult Mental Health Services Follow up Report*

Welsh Government (2001) *Equity, Empowerment, Effectiveness, Efficiency: Adult Mental Health Services in Wales Strategy Document*

Welsh Government (2005) *Raising the Standard: The Revised Adult Mental Health National Service Framework for Wales*

Welsh Government (2006) *National Service Framework Older People in Wales*

Welsh Government (2007) *Designed to Improve Health and the Management of Chronic Conditions in Wales: An Integrated Model and Framework*

Welsh Government (2008) *Mental Health Act 1983 Code of Practice for Wales*

Welsh Government (2009) *Setting the Direction: Primary & Community Services Strategic Delivery Programme*

Welsh Government (2009) *Talk to Me: The National Action Plan to Reduce Suicide and Self Harm in Wales*

Further Reading

Bird, A. (2006) We Need to Talk: The Case for Psychological Therapy on the NHS. London: Mental Health Foundation

Bower, P. and Gilbody, S. (2005) *Stepped Care in Psychological Therapies: Access, Effectiveness and Efficiency. A Narrative Literature Review.* British Journal of Psychiatry 186:11-17

Cardiff Chronic Conditions Management Demonstrator Team/NHS Wales (2011) *Report on the Coordination of Care for Patients with both Dementia and Chronic Conditions,* available at: http://www.nliah.com/portal/microsites/Uploads/Resources/YXLEZTRpQ.pdf

Chronic Conditions Management Demonstrator/NHS Wales (2011) *Final (Year 3) Report from the Chronic Conditions Management (CCM) Demonstrators: Learning to Support Integrated Primary and Community Care across Wales,* available at: http://www.nliah.com/portal/microsites/Uploads/Resources/O4hVtyoTw.pdf

Glover, G., Webb, M. and Everson, F. (2010) *Improving Access to Psychological Therapies: A review of the Progress made by Sites in the First roll out year.* North East Public Health Observatory

Layard, R. *et al* (2006) *The Depression Report: A New Deal for Depression and Anxiety Disorders*, The Centre for Economic Performance's Mental Health Policy Group

Moulding, R. *et al* (2009) *Integrating Psychologists into the Canadian Health Care System: The Example of Australia*, Canadian Journal of Public health 2009. March-April 100(2):145-7

Scottish Executive Health Department (SEHD) (2006) *Delivering for Mental Health.* Edinburgh: SEHD

Scottish Intercollegiate Guidelines Network (2010) *Non-pharmaceutical* Management *of* Depression *in Adults: A* National Clinical *Guideline* (Guideline 114). Edinburgh: SIGN

APPENDIX 1

Psychotherapies commonly practised in the NHS

Cognitive behaviour therapy (CBT)

This refers to the pragmatic combination of concepts and techniques from cognitive and behaviour therapies, common in clinical practice. *Behaviour therapy* is a structured therapy originally derived from learning theory, which seeks to solve problems and relieve symptoms by changing behaviour and the environmental factors which control behaviour. Graded exposure to feared situations is one of the commonest behavioural treatment methods and is used in a range of anxiety disorders. *Cognitive therapy* is a structured treatment approach derived from cognitive theories. Cognitive techniques (such as challenging negative automatic thoughts) and behavioural techniques (such as activity scheduling and behavioural experiments) are used with the main aim of relieving symptoms by changing maladaptive thoughts and beliefs.

Psychoanalytic therapies

A number of different therapies draw on psychoanalytic theories, although they differ in terms of technique. *Focal psychodynamic therapy* identifies a central conflict arising from early experience that is being re-enacted in adult life producing mental health problems. It aims to resolve this through the vehicle of the relationship with the therapist giving new opportunities for emotional assimilation and insight. This form of therapy is often time-limited, with anxiety aroused by the ending of therapy being used to illustrate how re-awakened feelings about earlier losses, separations and disappointments may be experienced differently. *Psychoanalytic psychotherapy* is a longer-term process (usually a year or more) of allowing unconscious conflicts opportunity to be re-enacted in the relationship with the therapist and, through interpretation, worked through in a developmental process.

Systemic therapy

Systemic and family therapists understand individual problems by considering the relevance of family relationships and the impact of the wider social and economic context on people's lives, their wellbeing and their mental health. Therapeutic work is undertaken with individuals, couples, or families and may include consultation to wider networks such as other professionals working with the individual or the family. Therapy aims to identify and explore patterns of belief and behaviour in roles and relationships and therapists actively intervene to enable people to decide where change would be desirable and to facilitate the process of establishing new, more fulfilling and useful patterns. Therapists may work in teams using live consultation or as sole practitioners using retrospective consultation. Therapy is often relatively short term.

Eclectic therapies

Many NHS therapists formulate the patient's difficulties using more than one theoretical framework and choose a mix of techniques from more than one therapy approach. The resulting therapy is pragmatic, tailored to the individual. These generic therapies often emphasise important non-specific factors (such as building the therapeutic alliance and engendering hope). By their nature, they are more idiosyncratic and difficult to standardise for the purposes of randomised controlled trials research.

Integrative therapy

An integrative therapy differs from eclectic approaches, as it is a formal theoretical and methodological integration of, for example, behavioural, cognitive, humanistic or psychodynamic approaches. These therapies are therefore amenable to research. One such approach is cognitive analytic therapy.

Other psychotherapies

The above list is by no means comprehensive. Other types of therapy practised in the NHS include existential, humanistic, process-experiential (client-centred), feminist, personal construct, art therapy, drama therapy, transactional analysis and group analysis. Further information about psychotherapy types can be obtained from the UK Council for Psychotherapy.

Counselling in the NHS

Counselling is a systematic process which gives individuals an opportunity to explore, discover and clarify ways of living more resourcefully, with a greater sense of well being. Counselling may be concerned with addressing and resolving specific problems, making decisions, coping with crises, working through conflict, or improving relationships with others.

Counsellors may practice within any of the therapeutic approaches listed above, using psychodynamic counselling, cognitive behavioural counselling, systemic counselling and so on. However, most are influenced by humanistic, process-experiential and psychodynamic principles.

The work of most counsellors is generalist (analogous to general practice) and is not necessarily linked to diagnostic categories. Many counsellors work in primary care, but they are increasingly found in secondary care settings. A broad distinction can be made between generic and specific counselling. The latter may be specific to a therapeutic model (for example, psychodynamic counselling) or a life crisis (for example, bereavement counselling).

In relation to specific life crisis issues, there are many voluntary sector counselling agencies (Relate, bereavement agencies, sexual abuse survivor groups etc) to whom GPs commonly refer patients with mental health problems.

For example, one such service, Cruse Bereavement Care, currently receives more than one third of its referrals from GPs.

Other therapies in research review

A number of forms of psychological therapy have been mentioned in the research review (Chapter 2), although they are not necessarily widely practised within the NHS:

Applied relaxation therapy
Autogenic training
Cognitive analytic therapy (CAT)
Dialectical behaviour therapy (DBT)
Eye movement desensitisation & reprocessing (EMDR)
Hypnotherapy
Interpersonal therapy (IPT)
Problem-solving therapy
Psychoanalytically informed day hospital treatment
Psychodynamic-interpersonal therapy
Rational emotive therapy
Schema-focused cognitive therapy
Social skills training
Stress inoculation therapy
Supportive psychotherapy
Therapeutic community

From: *Treatment Choice in Psychological Therapies and Counselling: Evidence Based Clinical Practice Guideline* (Department of Health, 2001).

APPENDIX 2

Exemplar Set of Terms of Reference: Guidance Terms of Reference for Psychological Therapies Management Committees for Welsh Health Boards

Preamble

These guidance notes are to help establish Psychological Therapy Management Committees (PTMCs) for delivering psychological therapy for adults and older adults in Welsh Health Boards. Traditionally services have been divided into primary and secondary divisions. In contrast, tiered care (sometimes called stepped care) requires whole system oversight of patients from so-called low intensity work (at primary care level) through to high intensity/complex care work (at secondary/tertiary levels).

The key principles that a Health Board PTMC needs to establish are:

1) Clear accountability to the Board. This is best accomplished if the PTMC is chaired by an Executive Board member or somebody who is directly accountable to them.

2) The Committee should be multi-professional in membership and title.

3) The roles of the contributory psychological therapy staff need to be clearly defined and demarcated consonant with New Ways of Working for Psychological Therapists

4) The Committee should have budgetary transparency in reporting

Terms of Reference

- To give managerial/strategic oversight for the development of a tiered care system , related clinical networks and for adults of working age and older adults – to focus on core quality indicators relating to service delivery (access, appropriateness, acceptability and clinical outcomes)

- Workforce planning

- To relate to an agenda set by stakeholders (see below)

Membership

- Chair (see above)

- Core professional representation (psychology, nursing, psychological therapists, occupational therapy, psychiatry)

- Key management leads (e.g. older persons services, CMHT managers, tiered care service lead)

- GP

- Clinical network leads (e.g. personality disorder, eating disorders, psychosis, etc)

- Training and research lead

- The committee should aim to have 10-12 people in it. Individuals may have multiple roles.

- Third sector representative

- Service user/carers reps

Agenda

- Meetings should be held monthly

- Meetings should receive service reports organised around key service quality indicators, i.e.

a) Access issues (waiting list times, choice)

b) Delivery of appropriate treatments by appropriately trained staff issues (review the provision of empirically supported treatments, workforce training)

c) Oversight of clinical outcomes (feedback from practice based evidence audit system)

d) Acceptability issues (feedback from stakeholders and information from the systematic collection of service user feedback)

- Complex care issues (CMHT reports, clinical network reports)

- Workforce planning

- Research links

- Liaison issues

Stakeholder involvement

It is crucial that views from relevant stakeholders are actively brought into the PTMC. This could be done through direct membership or through the convening of a parallel stakeholder group which would delegate one member to sit within the PTMC with a PTMC member on the stakeholder group. Stakeholders include service users and carers, third sector representatives and other leads, e.g. from important accreditation bodies and primary care.