CR151

**Psychological therapies
in psychiatry and primary care**

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COLLEGE REPORT

Psychological therapies in psychiatry and primary care

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The Scoping Group
on Psychological Therapies
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Dame Fiona Caldicott	Chairman, Principal of Somerville College, University of Oxford
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Dr Roger Banks	Royal College of Psychiatrists
Dr Alan Cohen	Royal College of General Practitioners
Dr David Crossley	Royal College of Psychiatrists
Dr Rowena Daw	Royal College of Psychiatrists
Dr Gillian Fairfield	Mental Health Network
Dr Moira Fraser	Mental Health Foundation
Dr Jane Garner	Royal College of Psychiatrists
Ms Jane Harris	Rethink
Dr Michele Hampson	Royal College of Psychiatrists
Prof. Sheila Hollins	Royal College of Psychiatrists
Dr Peter Kennedy	Royal College of Psychiatrists
Prof. Graham Turpin	British Psychological Society

CONSULTEES

Dr Val Anness	Royal College of Psychiatrists
Dr Les Ashton	Royal College of General Practitioners
Dr Tom Brown	Royal College of Psychiatrists
Jayne Brown OBE	Doncaster Primary Care Trust
Dr Richard Byng	University of Plymouth

Jeremy Clarke	Association for Psychoanalytic Psychotherapy in the National Health Service
Dr Chess Denman	Royal College of Psychiatrists
Prof. Christopher Dowrick	University of Liverpool
Prof. Steve Field	Royal College of General Practitioners
Prof. Linda Gask	University of Manchester
Dr Carolyn Chew Graham	Royal College of General Practitioners
Dr Frank Margison	Manchester Mental Health and Social Care Trust
Dr Chris Manning	Primary Care Mental Health and Education
Dr Matthew Patrick	Tavistock and Portman NHS Trust
Steve Shrubb	NHS Confederation
Dr Dave Tomson	Royal College of General Practitioners

EDITORS

Dr Irene Cormac   Nottinghamshire Healthcare NHS Trust
Dr Chris Mace   Coventry and Warwickshire Partnership NHS Trust

ACKNOWLEDGEMENT

Foreword

It gives me enormous pleasure to introduce this report to the members of the two colleges that have produced it, and to all those who wish to learn more about psychological therapies in 2008.

Its timeliness will be evident to everyone concerned about the psychological well-being of individuals coming to clinicians for help, whether in the general practitioner's surgery, the hospital consulting room or in the community.

The provision of psychological therapies has been transformed in my professional lifetime, and this has had a profound influence on clinical practice of all kinds, far beyond the confines of the services offering these specific treatments. Many of us believe that this hugely benefits the society as well as the individuals who present to us.

Further work is needed to provide training for those additional therapists required to be able to offer psychological therapies at each of the steps of care, across the range of therapies of proven effectiveness, and in all appropriate settings.

We hope that this report will be of assistance to trainees, practitioners and commissioners alike, and therefore to all those who express the need for psychological therapy.

Dame Fiona Caldicott MA FRCP FRCPsych FRCGP
Principal of Somerville College
University of Oxford

Executive summary

The aim of this report is to improve the provision of psychological therapies to people with mental and physical disorders, in both primary and secondary care settings. It provides information and guidance about psychological therapies that should be useful to psychiatrists, general practitioners, employers and commissioners of services.

The report identifies key themes and principles, alongside ways to develop and maintain psychological services that meet satisfactory standards. It also sets out a number of benchmarks, with assessments of how well-recommended aims and standards are being accomplished. It provides advice for commissioners of the service.

In all settings, psychological therapies should be delivered by a workforce that is psychologically minded and trained in an appropriate range of psychological therapies. Key implications are set out for future medical training. The report may also assist those contemplating careers in general practice, or in psychiatry (which used to be known as 'psychological medicine') in weighing up the opportunities available for the holistic care of people with physical short- and long-term conditions as well as mental illness.

The principal recommendations set out in the report may be summarised in the following twelve sections.

Meeting the need

A significant and lasting improvement in mental health in the population will depend upon attention to its social well-being, and upon enhancing the psychological awareness and therapeutic skills of the existing healthcare workforce, in addition to providing dedicated psychological therapy services.

Equitable provision

The national initiative to improve access to therapies for anxiety and depression must be supplemented by strategic planning to ensure that secondary care attendees, including the elderly, people with severe and enduring mental illnesses, those with dual diagnoses, learning disabilities or in custody, and members of Black and minority ethnic communities can gain timely access to effective treatments.

Development of stepped care

The development of 'stepped care' models of provision between the National Health Service (NHS) and the voluntary sector should involve full

participation of clinical leaders from primary care and mental health services, to ensure efficient coordination of future provision across both sectors.

Delivery standards

These standards must ensure patients' safety as well as a high quality of care. There should be adequate facilities for psychological therapy, clearly designated staff roles, supervision of clinical practice and active involvement of clinicians in the audit of activity and outcomes.

Commissioning

Implementation of Improving Access to Psychological Therapies (IAPT) should be complemented by additional commissioning initiatives. Clinical advice from primary care and psychiatric services should be actively sought to improve coordination between primary care, acute care and mental health services, and to ensure that appropriate standards for supervision and staff training are met. Future commissioning of services must take into account the views of service users to ensure that services for vulnerable groups are protected.

Organisational support

Organisations providing psychological therapies should promote the development of psychological mindedness and therapeutic skills among all staff. A champion at a high level within the organisation may be required. Where staff teams are struggling to function effectively, organisations should make help available to address underlying difficulties.

Workforce

All front-line clinicians in primary and secondary care should have opportunities to develop personal skills in psychological therapies. All clinicians providing formal psychological treatments should be psychologically-minded, well trained and supported in their continuing professional development. This is helped by interdisciplinary training. A wide professional mix of staff increases patient choice and the availability of essential skills. These include awareness of the interdependence of psychological and physical health and greater expertise in the combination of physical and psychological treatments.

Research

Greater support for research into frequently used and promising psychological interventions is required. Variations in the evidence base for psychological treatments should reflect their relative effectiveness, rather than disparities in the amount and quality of research undertaken. Future

research is also needed into ways of helping practitioners optimise their skills in routine consultations and to compare the benefits of different models of service delivery.

FUTURE SERVICE AND PRACTICE GUIDELINES

A plethora of reports have been issued by different national bodies on future provision of psychotherapies in the UK. To simplify future documentation, the Scoping Group recommends that a single plan be derived, with the active involvement of interested parties.

GENERAL PRACTICE

All general practitioners (GPs) should have planned training experiences in treating mental disorders, including training in delivering effective therapeutic and supportive interventions. Revisions to training curricula should maximise opportunities for shared training with trainee psychiatrists. Because psychological therapies can now be more easily accessed, GPs should help primary care teams to become better aware of them, while primary care trusts should have a named lead for psychological therapies.

PSYCHIATRY

Consultant psychiatrists in all specialties should actively monitor the availability of psychological therapies on behalf of service users, drawing attention to gaps in provision. They must be able to give well-informed advice on these therapies, to be able to assess their impact, and to supervise colleagues providing supportive interventions. Training in psychotherapeutic understanding and skills, appropriate to their specialty, should be available throughout the postgraduate training of all psychiatrists.

CONSULTANT PSYCHIATRISTS IN PSYCHOTHERAPY

Consultant psychiatrists in psychotherapy have a pivotal role in ensuring new training expectations are met; in undertaking assessments and delivering treatment for individuals with very complex health needs; in integrating medical and psychological assessments and interventions; and in helping mental health providers to support staff teams and designated therapists through supervision and consultation. They can assist colleagues to move to new ways of working. Mental health providers and commissioners should review their services, resources and strategic plans to ensure that the number of consultant psychotherapists employed is adequate to meet these needs and that consultant psychotherapists are deployed to work with individuals with more complex needs.

Psychological therapies in psychiatry and primary care

Introduction

The National Institute of Health and Clinical Excellence (NICE) has recognised the contribution that psychotherapeutic treatments can make to the care of people with a wide range of debilitating mental and physical illnesses and the importance of initiatives such as the Improving Access to Psychological Therapies (IAPT) programme (CSIP, 2007). There has been an unprecedented growth of knowledge about how psychological therapies work, including biological changes associated with their use. Many people prefer treatments in which their relationship with their therapist is paramount and through which they can learn how to stay well once they recover.

It is not always easy to appreciate the kind of contribution psychological therapies can make, or to know what medical staff working in mental health and primary care settings, together with their host organisations and commissioners, can do to ensure service users benefit fully from what they have to offer. This report and its recommendations address this need.

Box 1 Examples of psychological therapies

- Cognitive–behavioural therapy – a structured problem-focused, goal-orientated approach aimed at modifying thoughts, assumptions, beliefs and behaviours in order to influence disturbing emotions and habits.
- Psychodynamic therapy – a relatively intensive therapeutic approach aimed at reducing inner tensions and relational conflicts through the exploration of unconscious meanings and motivations, often with reference to past formative experiences and current care relationships.
- Systemic therapy – a distinctive approach that aims to study, understand and treat disorders of the interactional whole (rather than an individual person), for example the family or a group of individuals.
- Integrative therapies – recently developed treatments created from a combination of elements from one or more other treatments.
- Counselling – typically brief interventions that help people cope with challenging circumstances by providing space for reflection and by restoring their capacity to resolve problems.

Psychological therapies

Psychological therapies encompass a broad range of interventions, including talking therapies, which follow different theoretical models (e.g.

cognitive–behavioural, psychodynamic and systemic models), as well as different forms of delivery, for example individual, group and family treatments.

Not only can psychological therapies reduce symptoms – just as medication can – they can also lead to other outcomes: from helping a person to cope with an adverse change in circumstances (one of the main goals of counselling), to helping people to make lasting changes in their personality (a frequent goal in longer-term treatments), and to improve their ability to develop and sustain relationships; psychological therapies can also help to manage long-term physical health condtions.

The importance of psychological therapies has been recognised in the past. However, various barriers have contributed to the failure of service provision in healthcare settings (Box 2).

Box 2 Problems with the delivery of psychological therapies

Problems associated with treatment

- Perceived lack of efficacy of psychological therapies
- Lack of a theoretical framework for psychological therapies
- Few distinct models of effective service delivery
- Inadequate information for staff and prospective patients
- Cost in relation to the resources available

Problems related to workforce

- Lack of suitably trained staff
- Poor access to staff education and training in psychological therapies
- Lack of opportunity to use skills already acquired
- Poor access to supervision and little time for this
- Inter-professional rivalries restricting access to psychological therapies for service users
- Multiplicity of qualifications/accreditation bodies complicates recruitment and planning
- Absence of statutory regulation

Organisational problems

- Lack of leadership and vision
- Cultures favouring risk aversion over understanding and feelings
- Belief in quick fixes rather than sustained recovery
- Resistance to creation of reflective opportunities for staff
- Poor integration between services/with primary care
- Failure to provide appropriate facilities
- Poor access from primary care, as most psychological therapy services are located within specialist mental health trusts – tension as to which group of patients are prioritised

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In primary care, psychological techniques and interventions can be of real benefit, especially when an individual's emotional distress does not warrant psychiatric consultation, or is expressed through medically unexplained physical symptoms.

Many important psychotherapeutic interventions are provided as components of a holistic care package, with comprehensive care plans, including physical and social treatments. Often the quality of such interventions is dependent on an organisation's ability to deliver these

care packages in ways that ensure the components reinforce, rather than work against one another. It is crucial to have a common, psychologically informed framework that allows each individual's needs and strengths to be understood, and an overall care plan to be formulated.

Box 3 Case study

Joe, a 32-year-old unemployed ex-care worker, had a long history of medically unexplained abdominal pain. His GP noticed self-inflicted cuts on his arm and knew of his troubled family circumstances. Joe accepted referral to a psychiatrist. He was offered medication that helped his mood swings. Joe's psychiatrist also suggested a review by a psychotherapist.

During the psychotherapy sessions, Joe was able to draw associations between his pain, his self-harm and his family experience of emotional neglect. Unhelpful medical interventions were stopped and Joe entered a skills group to support him not to self-harm. The psychotherapy also enabled him to lead a more 'nourished life' (his term) by seeking out supported employment and new social commitments

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Initiatives related to this report

TREATMENT EFFECTIVENESS

The NHS has taken a broad approach towards evidence-based practice in psychological therapies, using outcomes that include efficacy, effectiveness, commonalities in therapies and quality of service delivery (Parry, 2000). There is considerable evidence in support of psychological therapies across a range of presenting problems, therapeutic modalities and settings.

However, researchers have not consistently been able to differentiate between the different treatment approaches and modes of delivery, except in the case of specific disorders (see Appendix 2 for examples). Outcomes in therapy are less likely to be predicted by modality than by factors such as the nature of the therapeutic relationship.

A review of research evidence for psychological therapies called *What Works for Whom* (Roth & Fonagy, 1996) lists treatments whose efficacy has been confirmed by prospective, controlled outcome studies for most mental disorders in adults, with a similar review of treatments for children (Fonagy *et al*, 2002). A subsequent review addressed research evidence for the timing and location of psychological interventions, as well as therapist qualities that affect outcomes (Roth & Fonagy, 2004).

The Department of Health publication, *Treatment Choice in Psychological Therapies and Counselling* (2001), provides evidence-based guidelines for practitioners to make informed assessments about the potential effectiveness of treatment options for common mental disorders and some somatic syndromes. Psychoses, addictions and childhood disorders were excluded. The guidelines identify practices to be avoided, such as attempting a short treatment when only a more intensive treatment is likely to succeed.

The National Institute for Health and Clinical Excellence (NICE; www.nice.org.uk) has issued clinical guidance to health professionals based on evaluations of cost-effectiveness as well as research evidence. The guidelines recommend psychological treatments for depression and anxiety, obsessive–compulsive disorder, bipolar disorder, post-traumatic stress disorder, eating disorders and schizophrenia, with work on personality disorders forthcoming.

The Cochrane Collaboration (http://www.cochrane.org/) provides a more extensive review of the evidence for and against psychological therapies in physical and mental health. For a summary of these recommendations see Appendix 2.

Counselling in primary care is effective when delivered for up to 6 months for individuals with mild to moderate mental health problems. In the longer term (8–12 months) there appear to be no differences in outcome compared with usual GP care, with similar costs. Current evidence suggests

that counselling may also be a useful adjunctive intervention to other mental health treatments (NHS Centre for Reviews and Dissemination, 2001). Distinctions between 'counselling' and 'psychotherapy' are being eroded, particularly in primary care settings. Although most psychological therapy delivered in primary care is labelled as 'counselling', many 'counsellors' employed there are also qualified psychotherapists.

Of the other therapies as listed in Box 1, cognitive–behavioural therapies (CBTs) receive most research support across a range of disorders. Their brevity and structure renders them relatively easy to evaluate. Psychodynamic therapies, which emphasise developmental factors, are recognised in the treatment of chronic emotional difficulties including personality disorders and some physical symptoms. Increasingly, hybrid or integrative therapies have been designed for specific applications, for example DBT (dialectical behaviour therapy) for self-harm. These newer therapies are especially likely to have accrued an evidence-base during their development. Some therapies, such as mindfulness-based cognitive therapy, have proven valuable in the prevention of further episodes of illness.

Treatment provision

The provision of care in the NHS for people with mental illness has improved in several areas following publication of the *National Service Framework for Mental Health* (Department of Health, 1999). An emphasis on meeting the needs of people with severe and enduring mental illness has helped to increase provision of interventions such as behavioural family therapy which assists the recovery of people with schizophrenia. Its example can also illustrate the hazards of training staff to provide interventions, without a concerted plan for them to use the skills they have gained. A review of the national service framework (Department of Health, 2004*a*) acknowledged the need for greater availability of psychological therapies and for front-line staff to have relevant therapeutic skills. Patient groups and mental health charities have also emphasised the need for greater and more consistent provision of psychological therapies, training and research through the initiative 'We Want to Talk' (Sainsbury Centre for Mental Health, 2006).

The guidelines issued by NICE have had a major impact on provision of psychological therapies. For instance, clinical guidelines for anxiety and depression (NICE, 2004*a*,*b*) strongly advocate psychological interventions. The recommendations for CBT from NICE in these and other guidelines have challenged the mental health and primary care services to deliver these therapies.

An increasing number of people receiving incapacity benefit are unable to work because of mental health problems. The economist Lord Layard (2006) argued that the provision of accessible and adequate psychological therapy services, following NICE guidance, would be self-financing. The recognition and effective psychological treatment of people with anxiety and depression would result in more individuals returning to work, fewer claiming state benefits, and more effective acute medical care owing to a reduction in the number of service users with medically unexplained symptoms.

Such arguments, together with positive outcomes from two national demonstration services located in Doncaster and Newham, have resulted in a major investment of £173m by the Department of Health in the Improving Access to Psychological Therapies programme (Department of Health, 2007*a*).

Box 4 Improving access to psychological therapies

- National initiative with phased implementation over 3 years in the first instance
- Service delivery of psychological treatments organised around the principles of stepped care
- Aims to ensure NICE guidelines for psychological treatments are widely implemented
- Provides evidence-based psychological treatments for anxiety disorders and depression
- Will concentrate on cognitive–behavioural treatments in first phase
- Delivery through dedicated psychological therapy services open to self-referral
- Centres offer rehabilitation and employment support as well as talking treatments with aim of reducing avoidable unemployment
- New clinical staff will be trained while employed at the centres

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The IAPT programme is based on 'stepped care' (Bower & Gilbody, 2005) where provision is stratified and patients are matched with the level at which they can receive the least intensive treatment likely to meet their needs. While IATP focuses on anxiety disorders (including obsessive–compulsive disorder and post-traumatic stress disorder) and depression, the stepped model can be used to differentiate a wide range of interventions that will be needed for a comprehensive improved access to psychological therapies.

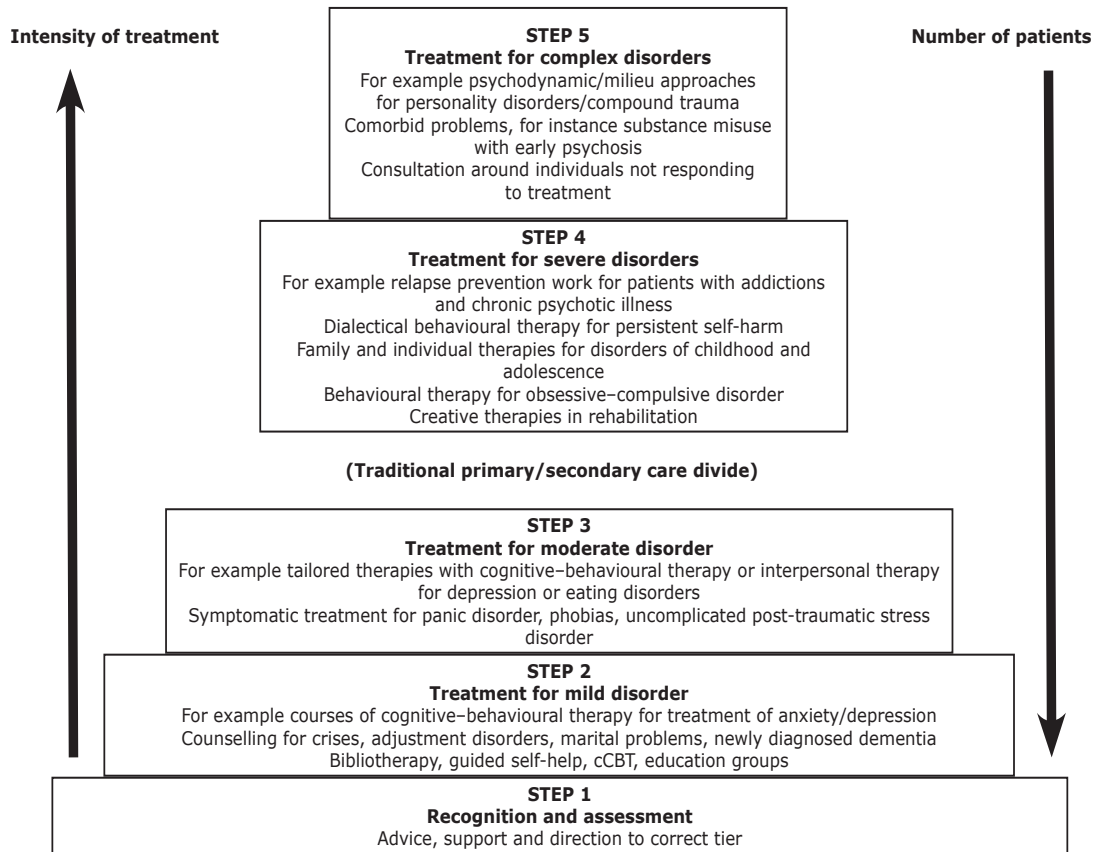## PSYCHOLOGICAL THERAPIES WORKFORCE

Traditionally, the workforce delivering psychological therapies has comprised clinical psychologists, psychiatrists, nurse practitioners, child and adult psychotherapists and counsellors. The IAPT programme will change this by introducing 3600 newly trained therapists (Department of Health, 2007*c*; Turpin *et al*, 2006). The new training will vary according to the future role of the therapist. 'Low intensity' therapists will learn to introduce first stage treatments such as supported self-management, bibliotherapy and computerised CBT. 'High intensity' therapists and trainees will be recruited from existing staff including nurses, counsellors, allied health professionals, social workers and applied psychologists. They will be trained to deliver comprehensive individual CBT techniques. Experienced graduate workers, and some of the new low intensity workers, may also go on to train as high intensity CBT therapists.

A major factor determining the IAPT programme's success will be the ability of therapists to gain access to good quality supervision, while training and when practising. Their supervision should be linked with the routine measurement of clinical outcomes and should address the needs of therapists and service users. Specific training for supervision will be available within the IAPT programme, with supervision competencies developed by Roth & Pilling (2007). Services involved will need to select experienced clinicians to supervise and train less experienced staff.

A further major change will be the intended regulation of all new and existing non-medical psychological therapists by a single body, the Health Professions Council. The Council will promote the convergence of accepted standards for training, supervision and continuing professional development. In preparation for this, Skills for Health (www.skillsforhealth.org.uk) has been scoping the competencies underpinning the delivery of psychological therapies. If these initiatives are to be successful, a consensus among

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FIG. 1 MODEL OF STEPPED CARE

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Intensity of treatment                                              Number of patients
        ↑
        |        ┌─────────────────────────────────────┐
        |        │              STEP 5                  │
        |        │    Treatment for complex disorders   │
        |        │  For example psychodynamic/milieu approaches │
        |        │    for personality disorders/compound trauma │
        |        │  Comorbid problems, for instance substance misuse │
        |        │         with early psychosis         │
        |        │  Consultation around individuals not responding │
        |        │              to treatment            │
        |     ┌──┴─────────────────────────────────────────┴──┐
        |     │                 STEP 4                         │
        |     │        Treatment for severe disorders          │
        |     │  For example relapse prevention work for patients with addictions │
        |     │           and chronic psychotic illness        │
        |     │   Dialectical behavioural therapy for persistent self-harm │
        |     │  Family and individual therapies for disorders of childhood and │
        |     │                 adolescence                    │
        |     │  Behavioural therapy for obsessive–compulsive disorder │
        |     │       Creative therapies in rehabilitation     │
        |     └────────────────────────────────────────────────┘
        |
        |          (Traditional primary/secondary care divide)
        |
        |   ┌──────────────────────────────────────────────────┐
        |   │                   STEP 3                           │
        |   │          Treatment for moderate disorder           │
        |   │  For example tailored therapies with cognitive–behavioural therapy or interpersonal therapy │
        |   │          for depression or eating disorders        │
        |   │  Symptomatic treatment for panic disorder, phobias, uncomplicated post-traumatic stress │
        |   │                     disorder                       │
        |  ┌┴────────────────────────────────────────────────────┴┐
        |  │                    STEP 2                              │
        |  │            Treatment for mild disorder                 │
        |  │  For example courses of cognitive–behavioural therapy for treatment of anxiety/depression │
        |  │  Counselling for crises, adjustment disorders, marital problems, newly diagnosed dementia │    ↓
        |  │    Bibliotherapy, guided self-help, cCBT, education groups │
        |  ├────────────────────────────────────────────────────────┤
        |  │                    STEP 1                              │
        |  │            Recognition and assessment                  │
        |  │       Advice, support and direction to correct tier    │
        └──└────────────────────────────────────────────────────────┘
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Adapted from *Commissioning a Brighter Future: Improving Access to Psychological Therapies. Positive Practice Guide* (Department of Health, 2007*c*).

the public and health professionals as to what the role of a psychological therapist or psychotherapist comprises, and how therapists' unique skills and competencies can be defined. The General Medical Council will continue to regulate medical psychotherapists and the Postgraduate Medical Education and Training Board (PMETB) will set their training curriculum.

Within the NHS workforce in England, the introduction of 'New Ways of Working' has led to description of a career structure for all non-medical psychotherapists (Department of Health, 2005, 2007*b*). Within New Ways of Working, it is also proposed that psychiatrists should focus on the care of the minority of service users with the most complex needs. In doing this, psychiatrists will require more in-depth training in the use of psychotherapeutic skills. Accordingly, the need for support from consultant psychiatrists in psychotherapy will increase as psychiatrists adopt New Ways of Working. It has been extended to applied psychologists, with publication of a good practice guide to support the development of IAPT services (CSIP, 2007).

Box 5 New Ways of Working

- Reorganisation of mental health workforce
- Based on 'capable teams'
- Sharing of clinical responsibility
- Psychiatrists should concentrate on complex cases
- Extended roles (including psychotherapeutic roles) for other professionals

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Training

More students are entering medical school as graduates. The General Medical Council (2003) has emphasised the importance of doctors' ability to offer satisfying encounters to service users, as well as good technical care. However, a doctor's interest in psychological aspects of medicine can depend upon the quality of learning experiences received at medical school, where early experience of helping individuals through supervised therapies can be highly motivating (Schoenberg, 2007). During medical training, psychiatrists usually stress the main forms of mental disorder and their treatment, including the role of psychological therapies.

The training curriculum for GPs already pays attention to their need to be able to advise service users about psychological therapies and to help them make a choice to which they can commit (Royal College of General Practitioners, 2007). It recommends that GPs have knowledge of CBT and simple behavioural techniques and what they can be used for, problem-solving therapy, and the basics of systemic and strength-focused therapies and self-administered therapy.

Most mental health professionals have received some training in psychological treatments, from brief basic introductions, to extensive exposure to one or several therapeutic modalities. In the NHS, consultant psychiatrists in psychotherapy, adult and child psychotherapists and many clinical and counselling psychologists receive the highest standards of training. Current training initiatives for other psychiatrists should ensure that most, if not all, can become competent to deliver some basic psychological treatments early in training. However, only those psychiatrists training to become consultant psychiatrists in psychotherapy have been required to continue training in psychotherapy, although many do so electively.

Review of needs for psychological therapies

PROCESS ADOPTED BY REVIEW

The survey conducted for the present report looked at the state of service provision and identified current gaps and needs for future training and research; the faculties of the Royal College of Psychiatrists and primary care consultees responded. The review team comprised a group of stakeholders familiar with the full range of mental health provision (including that in primary care) supported by a professional policy analyst. Leaders of NHS mental health trusts and primary care trusts in England and Wales were invited to contribute observations and opinions on the above, as well as on organisational issues. Both Colleges have approved the final report.

PRIMARY AND UNMET NEEDS OF PATIENT GROUPS

In many mental health services, psychological therapy provision is 'patchy, uncoordinated, idiosyncratic, potentially unsafe, and not fully integrated into management systems' (Department of Health, 2004*b*). Although IAPT as a national initiative addresses these issues within its remit, it poses challenges of its own concerning integration with existing and complementary sources of therapy – in both primary and secondary care. There needs to be greater coordination of the provision that currently exists.

There is considerable unmet need for treatment with psychological therapies of different modalities, in all patient groups, for various mental conditions, in both primary and secondary healthcare. This was affirmed repeatedly in responses to the survey from the faculties and sections of the Royal College of Psychiatrists and from the Royal College of General Practitioners, as well as leaders of mental health and primary care trusts. These are summarised in more detail below.

A Healthcare Commission report (2006) found that more than a third of individuals seeking counselling failed to receive it. The *Depression Report* (Layard, 2005) found psychological therapies as vital in the treatment of anxiety and depression and concluded that 10 000 more therapists were needed to fully meet the needs identified. The provision of therapies for in-patients and prisoners is particularly inadequate. A study by the Sainsbury Centre (2006) found that only half of psychiatric in-patients had access to supportive talks with staff, stressing the need not only for all mental health professionals to have therapeutic skills but also time to deploy them.

In primary care, up to one-fifth of GP consultations are for medically unexplained symptoms. Similarly, up to half of the attendees at acute out-patient clinics have medically unexplained symptoms (Morris & Avery, 2007). Individuals with such symptoms are likely to have an underlying psychological problem, which, if correctly identified, may respond to one or more of a number of interventions (Henningsen *et al*, 2007), such as CBT, antidepressants and counselling.

Individuals with long-term physical conditions such as diabetes and chronic obstructive pulmonary disease are more likely to have depression and/or anxiety. In diabetes, for example, depression is two to three times as common as in the general population, and is associated with a greater self-perceived symptom load, increased healthcare consumption and increased contact with primary care services (Cohen, 2008). Psychological therapies are needed to treat service users with moderate to severe psychological reactions to physical illness; brief treatments for self-harm are another priority.

REPORTED NEEDS OF MENTAL HEALTH SERVICE USERS

OLDER ADULTS

Elderly people represent a large group with unmet need, particularly for treatment of depression. Recommended therapies include CBT, interpersonal therapies and family therapies, but these are reported to be almost totally unavailable for older adults. Individuals with dementia are an additional priority, as are older service users with challenging behaviour.

CHILDREN AND ADOLESCENTS

An urgent need was reported for more psychological therapies for children and adolescents, especially those aged 15–18 years, including young service users in forensic psychiatric and custodial settings. Therapies for mild or moderate depression and for eating disorders are particularly helpful. There is little reported capacity to provide CBT, family therapy and other therapies, including DBT and interpersonal therapy.

WORKING AGE ADULTS

Identified unmet needs in this group included therapies for long-term, moderately severe depressive and anxiety disorders, including CBT for more than 10–12 sessions, as well as group treatments to boost self-esteem and assertiveness. Seriously unwell individuals whose response to other therapies has been inadequate have a high priority, for example in treatment-resistant depression, chronic psychoses, eating disorders and severe personality disorders. A substantial if uneven lack of psychotherapy and CBT was reported for individuals with illnesses judged likely to benefit from psychological treatments combined with medication.

REHABILITATION SERVICES

Adult service users have been found to benefit from both CBT and family interventions; cognitive analytic therapy is also valued. The Rehabilitation and Social Psychiatry Faculty also recommends treatments such as social skills training and cognitive rehabilitation.

Substance misuse services

Needs here are even greater in this service user group than the experience of these services suggests, as approximately 40% of in-patients in general adult facilities have substance misuse problems. Unmet needs were identified for motivational interviewing, relapse prevention and other cognitive–behavioural interventions.

Mentally disordered offenders

Provision of psychological therapies remains patchy for this group. Staff needs are also considerable, as this group's varied needs require expertise in cognitive–behavioural and psychodynamic approaches. There should be at least one medical psychotherapist available for each secure unit. Psychological therapies are needed to reduce recidivism and to treat underlying mental disorders.

People with learning disabilities

Therapeutic needs are not always recognised for people with learning disabilities, their families and carers. The usefulness of creative therapies may not be reflected in actual service provision. Therapy techniques need to be tailored to individual needs. Family, cognitive–behavioural, narrative or psychodynamic therapies are needed to help with anger and anxiety management, as well as the effects of bereavement, sexual and physical abuse.

Other identified clinical needs

There is also a lack of provision of therapies for individuals with complex and often serious emotional problems who require high-intensity psychological treatment, but fall into the gap between primary care and specialist services – the 'neglected majority' reported by the Sainsbury Centre for Mental Health (Hague & Cohen, 2005).

Finally, the need for more skill in working with families and the usefulness of family therapies was emphasised in relation to all patient groups. This includes prophylactic work in primary care, where early parental guidance can assist children's subsequent psychological development. Socially excluded groups, namely linguistic, religious and minority ethnic service users, are poorly served and need culturally adapted group or family therapy.

Identified organisational needs

The organisational factors listed in Box 2 (p. 11) as impeding the delivery of psychological therapies can also hinder basic psychiatric care. While not everyone will be offered therapy, all service users and staff benefit from a service which understands psychotherapeutic principles and provides opportunities for containment and reflection, where the service users' and staff's concerns are recognised (Garner, 2008). Our healthcare institutions can function as a form of social defence, a way of avoiding experiences, doubt, uncertainty, anxiety and guilt (Menzies-Lyth, 1988). The quality of life for service users is inextricably linked with the quality of life for staff (Roberts, 1994).

Staff bring in to their work ordinary human feelings, images and prejudices, both conscious and unconscious. While inevitable, this needs to be thought about within teams and in sensitive supervision. It is important that staff do not work unsupported, in isolation from peers.

Service users are not always easy to care for or to be with. Thinking about what staff are doing and how they are reacting should be given a far higher priority than it usually receives from organisations. Remediation would need to involve recruitment policies, management practices, training and clinical supervision. But it is essentially about staff having time, space and permission to reflect on and to share reactions. A forum to discuss and understand work-related problems and feelings may prevent them from being enacted. Staff need to recognise negative as well as positive feelings, and to feel they can voice them, to be able to use their personal and professional skills to service users' benefit (Garner, 2004).

Psychotherapeutic techniques that can be used in clinical work include those associated with communication: the ability to listen, to empathise, to show openness to service users' emotions, making sense of their experience and using personal emotional response as a source of understanding. Staff need to be able to contain anxiety and despair without feeling compelled to act, while using realistic judgement to decide when action is necessary. They need to identify distorted perceptions of the staff/service user relationship and to be able to bear hostility and criticism without retaliation. Concepts such as therapeutic alliance, staff/service user collaboration, transference and counter-transference apply in all interactions with service users (Garner, 2008).

Box 6 Case study

At a ward review to discuss the care of Mrs Green, admitted with a moderate depressive illness, staff from different disciplines seemed annoyed. They told the consultant Mrs Green should be discharged as she had turned down all attempts to help her. The consultant was inclined to agree: he had not warmed to her either. After taking a more extensive history, it seemed that the staff could be re-enacting the rejection Mrs Green had felt from her mother, whom she had felt was more interested in her baby brother than in her. Once they understood this, staff became more patient with Mrs Smith. In her turn, she started to accept suggestions offered to her, as part of a slow but steady recovery. She was discharged at a time that was right for her health, rather than one reflecting others' retaliation for her lack of cooperation.

IDENTIFIED TRAINING NEEDS

There is a constant need for training across the primary care and secondary care workforce, and among managers and commissioners of services. Unless service gatekeepers and referrers are psychologically minded, it is difficult for their patients/clients to be adequately prepared for psychological therapies or referred on appropriately. Non-medical professionals in primary care, such as health visitors, nursing staff and graduate workers will need to raise their awareness of emotional problems and the potential role of psychological interventions if they are to work successfully with new IAPT services. The needs of GPs and psychiatrists will continue to be reviewed by a joint education advisory group sponsored by both Royal Colleges. Managers

and commissioners need to understand the interdependence between clinical provision (and the availability of appropriate supervision) at different steps of service, between service and training, and the factors that promote safety as well as effectiveness.

Training priorities for general practitioners

Postgraduate training for general practice, like other specialties, is undergoing significant review. The Tooke report (2008) recommends extending training from 3 years to 4 or 5 years and this could give GP trainees the opportunity to gain significantly more experience in psychological therapies and mental health than is currently the case. This can be more closely integrated with the professional training of psychiatrists (as summarised in Appendix 3 and Table 1).

Table 1 Psychological training needs for psychiatrists and general practitioners

Psychiatry	Common to both	General practice
Therapeutic case formulation	Communication skills	Detection of prodromal distress
Broad knowledge of therapeutic principles	Experiential case discussion	Crisis management for service users in treatment
Supervised experience in extended therapy provision	Supportive interventions	Familiarity with first-line interventions for common mental disorders
Appreciation of primary care	Knowledge of evidence base	Provision of very brief focal interventions
(Additional skills for chosen specialism)	Counselling on treatment choice	
	Motivational interviewing	

Future basic training for GPs would include the principles and practice of psychological therapies, with the theory behind the different treatment modalities. General practitioners should be trained in patient-centred care, so they can assess and diagnose a broad range of mental disorders, including obsessive–compulsive disorder and severe mental illness as well as depression, phobias or anxiety disorders. This would enable them to identify the best resources for further help, including self-help.

General practitioners should acquire skills in problem solving, simple behavioural activation and motivational strategies for behavioural change. Introducing service users to simple and computerised CBT techniques would enable GPs to participate in 'stepped care' models, while experience of working with their own reactions and feelings will help in consultations with taxing or 'heart sink' individuals. These skills can be acquired in a variety of settings, including IAPT services. Trainee selection, supervision and mentoring, and participation in led case discussions would be key to developing GPs' psychological mindedness.

While continuing professional development is essential for all GPs, it is not mandatory for them to undertake it in psychological therapies; those with a special interest in mental health may want to do so. All regional deaneries run training and continuing professional development courses. Psychologists, psychiatrists, and GPs with a special interest in mental health could provide

training in psychological or mental health issues, assisted by service users with relevant personal experiences.

Training priorities for psychiatrists

All psychiatrists will be expected to develop their knowledge and skills in psychological therapies throughout training. There will be different components for the first 3 years (core training) and the final 3 years of specialty training. Recommendations for these are summarised in Appendix 3.

The first priority for future training will be changing a medical workforce that has basic psychological awareness, into a workforce capable of delivering basic psychological treatments with the same efficiency and effectiveness as pharmacological treatments. Current national training initiatives, including the new curricula being developed through Skills for Health (http://www.skillsforhealth.org.uk/), as well as the new IAPT treatment centres and training programmes, can support this process.

The second priority will be to continue to develop the nature and extent of provision of psychological treatments to individuals with a more severe mental illness and for those with complex needs requiring treatment by mental health services. The success or failure of these developments in the next ten years will largely depend on consultant psychiatrists owing to the depth of their experience of severe mental illness and knowledge of physical treatments.

The consultant psychiatrist in psychotherapy will have a vital role in both of the above changes. In addition to their core medical and psychiatric experience, their specialist training ensures they have experience of all the major forms of psychological treatment and are expert in at least one. They are trained in supervising, teaching and providing consultation to groups of other health professionals. They are adept in the assessment of new service users across a broad range of possible treatment options and in devising programmes of psychotherapeutic care which are sensitive to psychiatric settings. They will usually be responsible for the clinical management of individuals with complex needs not readily met within other services. They play a key role in the development of psychotherapy training opportunities for other psychiatrists. Consultant psychiatrists in psychotherapy can be pivotal in ensuring the organisation in which they work supports reflection and psychological mindedness across staff groups.

Research needs

Psychological interventions are considerably under-researched in comparison with available physical treatments for mental disorders. Attempts to summarise the evidence for the effectiveness of psychological therapies are hampered by the relative lack of research into the outcomes of some treatments relative to CBTs. Potentially significant studies frequently do not corroborate each other's findings, as is often noted in the NICE guidelines and systematic reviews. Comparative studies need to take account of factors beyond diagnosis, such as previous exposure to trauma, likely to influence individual's response to psychological therapies. Future outcome studies also need to pay more attention to, and to report, whether and to what extent service users accept the treatments they receive so that future choices can be anticipated.

There is also an urgent need to research the relative effectiveness of interventions in specific settings, such as secure mental health units, where the applicability of findings of research into efficacy is uncertain and additional barriers to investigation exist. In primary care, there is a particular need to identify the most effective steps in micro-interventions that could be used during routine consultations. As well as the impact of individual treatments, the relative impact and cost-effectiveness of alternative models of delivery, such as the stepped care approach, need evaluation, as does the introduction of training in effective supervision.

Moreover, the benefits of organisational factors, such as staff's psychological awareness, routine outcome measurement, or provision of supervision and regular clinical audits on the overall effectiveness of services, requires urgent attention from researchers. The economic impact of psychological therapies could extend to effects on costs of hospital admission, investigation, treatment and follow-up, attendance and treatment at GP surgeries, social care, and costs of state benefits. These should be better understood.

The emphasis of research on symptomatic outcomes rather than social, psychological or instrumental functioning needs to be addressed to provide better evidence as to which forms of psychological treatments improve functioning and survival rates. Research is also needed to map the needs of socially excluded, linguistically isolated and minority ethnic groups, and then to develop cost-effective models for culturally competent psychotherapeutic practice. More research needs to be directed to improving the quality of therapies provided under ordinary working conditions. This is likely to need to focus on therapists' personal contributions within a treatment model, and the identification of microskills linked with effective practice.

Box 7 Under-researched areas

- Prevention of common mental disorders
- Effectiveness of psychodynamic, interpersonal and systemic therapies in relation to specific patient populations
- Design of effective micro-interventions in primary care
- Outcomes of psychological therapies in forensic settings
- Development of patient-oriented outcome measures
- Optimal combination of psychological and physical treatments
- Impact of variations in therapist competence on outcomes
- Clinical- and cost-effectiveness of different service models (including stepped care) for delivering psychological therapies
- Impact of psychological awareness and supervision training on staff and service users

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Meeting future needs

Psychological therapies cannot assist people in a vacuum. Good interpersonal relationships, social networks and community cohesion have a major impact on individual's health and prospects for recovery.

The three fundamental requirements for sustainable and beneficial provision of psychological therapies are:

1 psychological therapists who are psychologically minded in their attitude and behaviour, as well as technically proficient

2 a facilitative host organisation which recognises that psychological therapists and psychological treatments need particular forms of human and material support to work well

3 treatment appropriate to the particular patient group.

These three factors are closely interrelated, as shown in Figure 2.

While references to skills will be found throughout the report, 'culture' needs further introduction. Aspects of the setting in which therapies are considered under 'Making services coordinated, responsive and safe', pp. 27–29.

ESTABLISHING A THERAPEUTIC CULTURE

Psychological mindedness is key to therapeutic relationships. It sums up an attitude that successful professional therapists bring to their work, irrespective of their theoretical persuasion. Psychological mindedness is an additional requirement to the generic *Ten Essential Shared Capabilities of Mental Health Workers* (National Institute for Mental Health in England & Sainsbury Centre for Mental Health, 2004).

Psychological mindedness can motivate clinicians who, having little previous training, take an active interest in psychological therapies. It refers to a form of understanding that can be actively encouraged, or discouraged, within an organisation. Good psychological therapies require psychologically minded therapists working in psychologically oriented organisations.

A second message is that progress will depend upon acknowledging psychological mindedness as a common value that all parties can adopt. Historically, attitudes have been major obstacles to the wider use of psychological therapies, as much as structures or resources. Examples have included the stigmatisation of people who seek therapy, unjustified scepticism concerning its effectiveness, as well as the failures between different groups of therapists to respect one another's work. In each case, changes in attitude have been necessary to help improvement in service provision. In helping to

focus on what is common to all forms of therapeutic work, an emphasis on psychological mindedness should assist the process of attitudinal change.
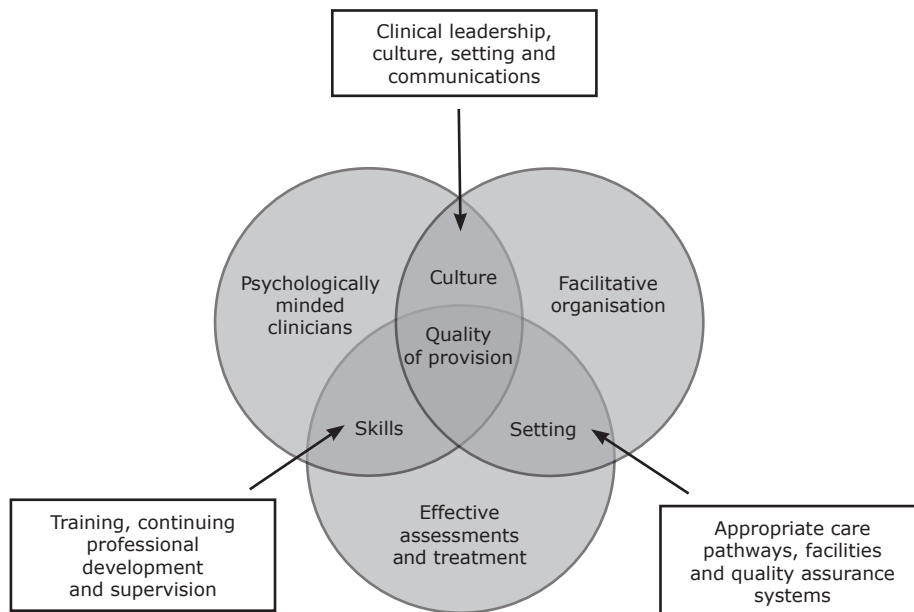
BOX 8 DEFINITION OF PSYCHOLOGICAL MINDEDNESS (Conte *et al*, 1996)

Psychological mindedness involves:
- ready access to feelings
- willingness to understand oneself and others
- an interest in the meaning and motivation of thoughts, feelings and behaviour
- valuing discussion of problems and motivation to change.

FIG. 2 CONDITIONS FOR IMPROVING PROVISION OF PSYCHOLOGICAL THERAPIES

Making services coordinated, responsive and safe

INTEGRATION ACROSS PRIMARY AND SECONDARY CARE

Primary care currently has the advantage of being person- and locality-centred and can tailor its organisation and delivery of services to reflect the needs of its service users. Whether this can be preserved in future models of primary care provision in the NHS should be a matter of concern. Improving Access to Psychological Therapies services are likely to require complex medication and risk management from within primary care, as well as clear care pathways linking them to the care steps provided through secondary services.

In practice, the division between primary and secondary care services usually leads to service users receiving help almost exclusively either from one arena or the other. This could be improved if both services are willing to effect change and to continue to build on initiatives such as mental health graduate workers, as well as collaborative models of enhanced care provision.

In principle, stepped care models ensure service users receive the least complex intervention from which they are likely to benefit. The transition from one level of care to another could become more seamless with active collaboration from primary and secondary care in devising a common pathway or 'ladder' they can each welcome and work with easily.

Polyclinics in which most routine healthcare needs would be met have been proposed. They might lead to better alignment of primary and secondary care. If they resulted in greater psychological mindedness, large numbers of service users could benefit. Very robust clinical leadership would be essential in ensuring staff education worked to this end, and that service delivery was psychologically informed.

THE VOLUNTARY SECTOR

Through the IAPT programme, local voluntary sector agencies may play an increasing role in the provision of CBT and other psychological therapies. The sector has a long history of providing a wide range of social and psychological therapies, often free of charge or at low cost, both nationally and locally. Voluntary agencies can be crucial in helping people attain emotional stability prior to starting formal treatments. General practitioners have a key role in encouraging individuals to make full and appropriate use of these opportunities.

Many voluntary sector organisations receive funding from primary care trusts and are based within community settings. Self-referral may be possible and therapies may be tailored to minority groups. Most voluntary sector organisations employing therapists expect them to be qualified and under clinical supervision, although some employ trainee therapists. As elsewhere, those seeking therapies should check the provider is *bone fide*, namely that they are registered with the Charities Commission and employ staff accredited by professional bodies such as the British Association for Counselling and Psychotherapy (www.bacp.co.uk) or the British Association for Cognitive and Behavioural Psychotherapy (www.babco.org.uk).

Social exclusion and ethnicity

Social exclusion is detrimental to overall well-being and to mental health. This is evident in the poor mental health of offenders, refugees, asylum seekers and the poor physical health of individuals with addictions and those with severe mental illness. Factors contributing to exclusion include poverty, poor housing, social isolation and prolonged hospital admissions.

Old age is also a potent factor in social exclusion, as is the tendency of people who were socially excluded earlier in life to remain so in facing challenges like retirement or bereavement. The risk increases further in individuals with learning disability or dementia. Provision of psychological therapies for the elderly is meagre compared with other age groups (Evans, 2004), and yet the outcome in older individuals who can access psychotherapeutic help is comparable with that in younger service users (Garner, 2003). Some older service users, sensing they may not have another chance for therapy, do well in a short time (Ardern *et al*, 1998).

In a culturally, racially and ethnically diverse society, psychological therapies and psychotherapy should be provided in culturally sensitive ways. Therapies should be adapted to meet the needs of people irrespective of gender, age, race, sexual orientation and religious beliefs.

Bhui & Morgan (2007) discussed the requirements for 'racially inclusive' and 'culturally competent' practice in psychotherapy. The principles, which might be extrapolated to other disadvantaged groups, have implications for training and core competencies both of generalists and specialists in mental healthcare.

Box 9 Cultural competence

Cultural competence entails:
- to be skilled in exploring racial and cultural identity
- to understand that life events with racial elements are a social reality which may also have internal representation
- to understand the primitive feelings that may accompany racial encounters and conflicts
- to notice and incorporate expression of culture and race in therapeutic work.

Safety of service delivery

As with any potentially therapeutic treatment, there is a risk of harm that may be caused in psychological therapy. The facilities within which

the treatment is conducted are crucial to ensuring both physical and psychological security. Physical safety requires careful attention to the accommodation in which therapy is carried out, ensuring there are facilities service users can use as they recover after an unusually stressful session, as well as means for therapists to summon help in an emergency at any time.

Psychological security can depend upon the privacy afforded by adequate soundproofing and freedom from interruption, visual evidence that rooms used have been designed for therapeutic work rather than for other needs, and allocating rooms so that service users have a consistent base during their treatment.

Practitioners can harm individuals receiving psychological therapies through intended and unintended actions. Unethical practice may range from financial or sexual exploitation of service users to maintaining collusive or protracted relationships that are therapeutically unproductive and wasteful. Future professional regulation for all psychotherapists will mean the public have similar recourse to sanctions in the event of unethical practice by non-medical therapists as they currently do with medical professionals.

It is essential that staff undertaking therapies have full training, regular supervision and maintain a reflective attitude to practice. A clear structure for the support of therapists is needed, with separate clinical and managerial supervision. Therapists must maintain and develop their technical skills. They should also establish and maintain professional boundaries that are appropriate and safe for all parties.

The temptation to act under emotional pressure in ways that are unhelpful can be considerable, and may take many other forms than sexual exploitation or frankly unethical practice (Royal College of Psychiatrists, 2007); two examples are given in Box 10.

Box 10 Case vignettes

1. Dr Smith's wife had died of breast cancer. He was throwing himself into his work, telling colleagues he was fine. A female client came to him with a suspicious lump in her breast and he referred her for urgent investigation. She said she was worried about what may happen next. He said the surgeon would advise her. When she looked tearful at his response, he prescribed her an antidepressant, rather than discussing her feelings with her.

2. Mr Jones, who had depression, seemed weak, lonely and helpless to Dr Evans. She prided herself upon her caring attitude. She arranged time at the end of her clinics for him. When he seemed too troubled to talk, she held his hand. To fill the silence, she told him about how a close friend got through his own depression. After the sessions, Mr Jones would hover outside the clinic. When he saw a male friend come to collect Dr Evans, he went home and tried to hang himself.

Situations like the ones described in Box 10 may be avoided if, instead of working in isolation, clinicians are aware of their own emotional needs and vulnerabilities and they have regular opportunities to reflect on and discuss their relationships with service users with a third party.

Commissioning future psychological therapy services

The IAPT programme is changing the pattern of commissioning for psychological therapy services for common mental disorders. Primary care trusts that introduce IAPT services will be commissioning a single package of stepped care and training across their community. However, the funding announced to date is not guaranteed to meet every trust's needs. Many of those intending to apply for this funding will have to wait until the later years of the programme's roll out. As the earlier review of current clinical needs illustrates, many people's needs will not be met within IAPT in its current form, leaving them dependent on other sources of psychological therapy. Their requirements need to be met through additional commissioning addressing: the needs of people of all ages already attending secondary mental health services; the very large numbers of people attending other medical services whose symptoms are unexplained and amenable to psychotherapeutic treatments; and the small number of individuals needing to access specialised services in other localities such as residential therapeutic communities for people with severe personality disorders.

The following points therefore need to be considered in commissioning psychological therapies services.

1   Commissioning should be based on accurate assessments of the needs of particular groups of service users. These include the needs of minority groups for treatments delivered with cultural sensitivity in accessible locations.

2   Interventions are delivered by adequately trained and supervised staff in safe settings, and have evidence for their effectiveness (evidence might be in the form of local outcome data).

3   Commissioning ensures real service user choice. Individuals with the same condition do not respond equally to a given intervention, while an active preference by individuals for the method used is associated with better outcomes.

4   Care pathways should exist to ensure individuals with long-standing and more complex conditions are identified and provided with more intensive interventions according to need without delay.

5   As in other areas, practice based commissioning gives an opportunity for individual practices, or practice clusters, to commission healthcare services that meet individual's particular needs, while contractual and financial control systems remain with the primary care trust.

6   Opportunities to re-design services for people with long-term physical health conditions amenable to psychological treatment should be taken. Polyclinics could reduce the consequences and costs associated with medically unexplained symptoms among acute out-patients, but only if they are commissioned to provide integrated mental health assessments and psychotherapeutic interventions.

7   Specialised commissioning decisions, for instance for in-patient therapy, should be informed by advice from clinicians familiar with a service user's condition, any treatments proposed and locally available alternatives.

8   Tariff arrangements should recognise differences in intensity between psychological interventions, and the need for expert clinical assessments that can help primary and secondary care teams to continue to work with service users more effectively.

9   In line with existing guidance (Care Services Improvement Partnership, 2005), the psychological therapies workforce needs to include consultant psychiatrists in psychotherapy who have the medical and psychiatric skills necessary to advise on the impact of specific illnesses and on the combination of physical and psychological treatments.

10   Commissioning should support training by ensuring:

■   services providing training treat some individuals with less complex needs, enabling trainee therapists to obtain adequate clinical experience under supervision, and

■   there is a sufficient number of consultant and GP trainers to meet the increased expectations for training in psychological therapies among both psychiatrists and GPs.

Conclusions and recommendations

The Scoping Group's conclusions and recommendations are summarised in the Executive Summary (pp. 7–9) and in the text of the leaflet accompanying this report. Its 12 principal recommendations are as follows:

1 **Improved psychological health** requires:
   □ attention to every patient's social well-being
   □ psychological awareness from health professionals
   □ access to psychological therapies when indicated.

2 **Equitable provision of psychological therapies** will involve:
   □ investment across all patient groups
   □ greater awareness of minority needs.

3 **Effective stepped care** requires:
   □ coordination between all service levels
   □ efficient matching to the right intervention
   □ joint development by stakeholders.

4 **Delivery standards** should:
   □ promote patients' safety
   □ address quality of care
   □ require monitoring of outcomes.

5 **Service commissioning** needs to:
   □ be clinically informed
   □ address needs beyond Improving Access to Psychological Therapies (IAPT)
   □ support training.

6 **Organisations providing therapies** need to:
   □ promote psychological mindedness
   □ have a psychological therapy champion
   □ help clinical teams to function effectively.

7 **The therapeutic workforce** should:
   □ enhance its clinical skills
   □ include a wide professional mix
   □ encourage interdisciplinary training.

8   **Future research** needs to:
- extend current evidence of outcomes
- optimise practitioners' consultation skills
- evaluate service models.

9   **Future service and practice guidelines**:
- should be based on a common strategy
- need to simplify documentation.

10   **General practitioners** need to:
- influence future care pathways
- have more training to develop therapeutic skills
- help primary care teams become psychologically aware.

11   **All psychiatrists** should:
- use suitable interventions with patients and their families
- ensure gaps in provision of therapies are addressed
- support development of colleagues' therapeutic skills.

12   **Consultant psychiatrists in psychotherapy** are needed to:
- care for complex cases and to train others
- help colleagues adopt new ways of working
- put these recommendations into practice.

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Appendix 1. Psychological therapies in medical training curricula

Undergraduate training

This is an area where psychiatrists and general practitioner (GP) teachers should work closely together. General practitioners need to ensure students understand the ways in which people can present with mental health problems in primary care. They may also give students experience in the use of basic therapeutic techniques. Undergraduate curricula should offer continuity between teaching in psychiatry and primary care, to enable students to receive sufficient training in developing effective, therapeutic relationships with patients.

Postgraduate training

General practice

The imminent extension of the length of training and revision of curricula offer opportunities both to increase general psychiatric knowledge (including identification of people with early psychosis) and to introduce training on specific themes that will enhance competence in the medical and psychological management of common mental disorders, medically unexplained symptoms and the care of people with severe mental illness who are relatively stable. In addition to existing expectations that GPs can use strength-focused, brief psychological interventions, they might increase their familiarity and skills at handling crises during treatments being conducted by other therapists. These aims would be promoted by placements in community mental health teams and in the developing IAPT teams.

General practitioners and psychiatrists

Psychiatrists also stand to benefit from sharing of training resources, especially during the first two years of their core training in psychiatry.
Components of training that might be shared include:

■ communication skills to engage service users from wide variety of backgrounds

■ awareness of own biases and reactions from experiential learning

■ proficiency in provision of supportive interventions

■ knowledge of evidence-base of available interventions

■ learning to provide informed advice about treatment options.

PSYCHIATRY

A common stem ('core' training) in years 1 to 3 precedes further specialist training in one or more chosen branches of psychiatry in years 4 to 6. Requirements for trainees in years 1 to 3 will include:

■ understanding principles of major therapeutic models

■ having experience of conducting treatments in at least two modalities

■ acquiring basic proficiency in case formulation.

During specialist training years 4 to 6, continuing training in psychotherapy will reflect a specialty's needs. Skills required within all the main specialties are a sound knowledge of the evidence base for relevant interventions, a capacity to monitor the impact of interventions provided by others and competence in delivering and guiding other staff in supportive interventions. Other skills are:

CHILD AND ADOLESCENT PSYCHIATRY

■ Working familiarity with family-based interventions

■ Able to plan and provide behavioural interventions

FORENSIC PSYCHIATRY

■ Working familiarity with interventions to reduce offending behaviour

■ Understanding the impact of organisational dynamics on service users and staff

■ Supervised work with individual(s) with psychotic or personality disorder

GENERAL ADULT PSYCHIATRY

■ Brief interventions for crisis management, for example attempts at suicide

■ Maintaining working relationship with individuals with personality disorder

LIAISON PSYCHIATRY

■ Supervised experience in treatments for unexplained medical symptoms

■ Combination of psychological and physical treatments in hospital settings

Old age psychiatry

- Supervision in individual and group work with elderly service users
- Ability to conduct family interventions with elderly service users and relatives

Psychiatry of addiction

- Techniques for relapse prevention and contingency management
- Expertise in motivational interviewing

Psychiatry of learning disability

- Supervised experience of adaptation of therapeutic techniques with this client group
- Familiarity with use of creative therapies with this client group

Psychotherapy

- In-depth training in one psychotherapeutic model and familiarity with at least two others
- Familiarity with use of psychotherapy in a wide range of settings
- Ability to work with individuals, groups and families
- Assessment and formulation of new patients
- Supervision of other healthcare professionals in training
- Expertise in providing consultation to clinical teams in complex cases
- Expertise in combining physical, social and psychological treatments

Social and rehabilitation psychiatry

- Undertaking interventions with families and carers
- Experience of integrative interventions

Appendix 2. Support for psychological therapies among individuals with various mental health disorders

This is a partial summary of evidence presented in Roth & Fonagy's second edition of *What Works for Whom* (2004), the Department of Health's *Treatment Choice in Psychological Therapies and Counselling* (2001) and information from various Cochrane reviews. An absence of supporting evidence for treatment effectiveness should not be interpreted as representing a lack of treatment effect nor a contraindication or a reason for withdrawal of service provision.

Therapeutic modality \ Disorder	Depression	Post-partum depression	Bipolar disorder	Phobia	Panic disorder ± agoraphobia	Generalised anxiety disorder	Obsessive–compulsive disorder	Post-traumatic stress disorder‡	Schizophrenia	Alcohol misuse	Drug misuse	Anorexia	Bulimia	Personality disorder	Sexual dysfunctions	Physical symptoms	Childhood disorders	Disorders of older people
Cognitive–behavioural therapies	**	*	*	** Social (+exposure)	**	**	*	**†	*		* Cocaine	*	**		**	* Chronic fatigue, chronic pain, hypochondriasis	** Depression, obsessive-compulsive disorder, general anxiety disorder, conduct disorder	** Depression; * Anxiety, sleep
Interpersonal therapies	**	*	*										**				* Depression	
Structured/focused psychodynamic	*							*				*		** Borderline personality disorder		* Irritable bowel syndrome, hypochondriasis	* Mixed anxiety and depression	** Depression
Dialectical behaviour therapy														** Self-harm in borderline personality disorder				
Cognitive analytic therapy												*						
Behavioural treatments (e.g. exposure, contingency management, relaxation)	*			**	**	**	**		**	**	** Cocaine				**	* Chronic pain	** Behaviour problems in autism	** Depression
Family and couple interventions	*		*							**	* Cocaine	*	*				* Conduct disorder	
Community reinforcement approaches										**	** Cocaine							
Motivational interviewing										**								
Social skills training/psychoeducational			*						*	**				* Avoidant				

		Opiates					Adolescent conduct disorder	Attention-deficit hyperactivity disorder
Supportive (expressive) therapy		*						
Multimodal/ multisystemic							**	*
Problem-solving therapy						** Primary care		
Primary care counselling						* Adjustment disorders and short term only		

** clear evidence of effectiveness
* some evidence of effectiveness
† Includes eye movement desensitisation and reprocessing therapy
‡ No support for critical incident debriefing as an intervention and some evidence to suggest it may worsen symptoms

Appendix 3. Psychological provision: quality checklist for assessing providers

The following checklist refers to the performance of a single provider of psychological therapies, whether a mental health trust, polyclinic or group practice. When an organisation hosts more than one psychological therapy service, its typical performance should be rated; 24 points provide a comparative estimate of overall quality and a basis for planning improvements.

	Action needed	**Still struggling**	**Doing well**
Organisation			
Leadership	Little evident	Patchy framework with nominal leader(s) failing to harness widespread support	Identified leader who makes an inclusive framework for managing delivery of psychological therapies work
Strategy	Little evident	Strategic statements exist but are divorced from practice and/or those they affect	Active strategy owned by workforce and consumers. Regularly reviewed and informs developments
Interface with organisation's other services	Psychological therapies delivered without reference to other clinicians' input	Working channels of communication with referrering general practitioners/mental health professionals	Therapy staff have regular working contact with other clinicians
Culture			
Psychological awareness	A distancing or even persecutory attitude towards staff and patients pervades the organisation	Isolated attempts are made to increase a realistic appreciation of the feelings and thinking behind others' behaviour	Psychological mindedness is prized in the organisation. There is a clear programme to raise psychological mindedness
Educational ethos	No attempt is made to share therapeutic understandings and skills	Occasional, informal seminars are provided by staff for colleagues	Staff employed as therapists share knowledge and skills with colleagues daily
Reflective practice	Opportunities for reflecting on clinical practice are not part of job plans	Staff make *ad hoc* arrangements to reflect on practice	Systems are in place for groups of staff to reflect regularly with a supervisor on clinical or team experiences

	Action needed	**Still struggling**	**Doing well**
Practitioners			
Role	Roles are ambiguously defined and their holders confused	Roles are formally defined with links between responsibilities, past training and experience	Roles follow national recommendations for relating responsibilities to training and experience
Professional development	Development planning and appraisal do not take place	A system for review exists but it does not support personal development	An appraisal system helps staff identify and resolve developmental needs in psychological therapies
Skill mix	Skill mix is not known or all practitioners are at a comparable level	Incomplete attempt to match spread of need across psychological therapies' workforce	Appropriate use of less experienced/trainee staff found alongside specific resources for cases of high-risk/complexity/having concomitant medical problems
Skill maintenance			
Clinical supervision	Routine case management discussed, but no dedicated supervision of therapeutic skills	Supervision typically *ad hoc*, with little attempt to match frequency and level with therapists' needs	Regular clinical supervision provided by expert therapists independent of line management arrangements
Further training	Neither provided nor encouraged	Occasional provision of courses, without analysis of training needs	Further training opportunities are made available in line with personal appraisal and service needs
Capacity to train others	Staff provide almost no formal training	Contributions to programmes of professional education are not sustained	Clinical service provides a base and supervision for psychological therapy trainees on placement
Treatments			
Assessment capacity	Assessments meet logistical needs only (who goes where)	Assessment outcomes limited to narrow set of treatment options (who gets what)	Assessments available that provide predictive clinical formulations (what is needed, why and what may happen)
Appropriateness of treatments	Little relation between treatment offers and typical client wishes, problems and abilities	Available treatments generally appropriate to context and typical client needs	Careful matching of treatment offered to assessed client wishes, needs and capacities
Effectiveness	Treatments provided lack evidence for their effectiveness	Treatments provided resemble those with a known evidence base	Detailed outcome data are available from local use of these treatments

	Action needed	Still struggling	Doing well
Cost-effectiveness	Inefficiencies are introduced because treatments are routinely too long, too short or not of the optimal type	Treatments separately represent an efficient means of realising the outcomes expected	Choices across treatments are made to ensure the least intensive intervention, which is likely to succeed, is offered first
Adaptability	Therapists have little capacity to amend standard packages of care if treatment needs to be changed	Therapists can amend treatment offers within narrowly defined limits	Therapists obtain regular feedback via reviews or ratings that inform assessment of continuing treatment needs
Delivery			
Speed	Long waiting times with minimal monitoring	Differentiated waiting lists or integrated stepped care system	Short waiting times for all locally provided treatments with active monitoring of these
Convenience	Long travelling times likely; no provision outside office hours	Some dispersal of service or flexibility in opening times	Maximum travel time is stated and supported. Opening hours meet groups' varying needs (full-time workers, mothers of school-age children etc.)
Interface between primary/secondary care	Contacts largely restricted to crisis resolution and emergencies	Attempts at joint working flounder through low priority they receive	Mutually agreed protocols supported by regular, friendly and beneficial liaison
Social inclusion	Little attempt to correct clear disparities in provision	Barriers to access for some groups remain despite attempts to diversify	Total provision reflects demographic profile of local population
Setting			
Signposting	It is guesswork whether a client's needs are likely to be met or who will meet their needs	Some of the different providers' roles are defined, but there is little coordination between them	Treatments are provided by a service with clear criteria and within a coherent care pathway
Facilities	Not adapted for provision of talking therapies and/or unsafe for their delivery	Meet basic safety requirements but are not conducive to ongoing discussions of personally sensitive material	Facilities offer safety, privacy, stability and comfort
Quality assurance systems	No systems for monitoring service uptake or impact	Crude monitoring systems exist, such as an undifferentiated waiting list	Transparent systems for routine monitoring of the accessibility of the service, waiting times and user experience

Appendix 4. Abbreviations used

ADHD	attention-deficit hyperactivity disorder
BABCP	British Association for Behavioural and Cogntive Psychotherapy
BACP	British Association for Counselling and Psychotherapy
CAT	cognitive analytic therapy
CBT	cognitive–behavioural therapy
cCBT	computerised cognitive–behavioural therapy
CPD	continuing professional development
CSIP	Care Services Improvement Partnership
DBT	dialectical behaviour therapy
GAD	general anxiety disorder
GMC	General Medical Council
GP	general practitioner
HPC	Health Professions Council
IAPT	Improving Access to Psychological Therapies
IBS	irritable bowel syndrome
IPT	interpersonal therapy
MBCT	mindfulness-based cognitive therapy
MHP	mental health professional
MUS	medically unexplained symptoms
NICE	National Institute for Health and Clinical Excellence
NHS	National Health Service
NSF	National Service Framework
NWW	New Ways of Working
OCD	obsessive–compulsive disorder
PRIMHE	Primary Care Mental Health and Education
QA	quality assurance
PCT	primary care trust
PD	personality disorder
PT	psychological therapy
PTSD	post-traumatic stress disorder
UKCP	UK Council for Psychotherapy