News

Hello from the Jenny Taylor, the new Chair of the DCP

Greetings *CPF* readers! I'd like to take this opportunity to introduce myself to you all as your new DCP chair (at least I will be by the time this is published).

I've come to the DCP from chairing the Child Faculty, and my clinical work is with looked after children in Lambeth in South London. Having sworn to various people after a five-year (very enjoyable but hard work) term on the committee of the Child Faculty that that was it for committee work for me for some time, I have somehow found myself on the brink of chairing the DCP. Luckily the DCP executive committee retains a wealth of experience in the Directors of the various units, and I am also hoping that Tim Cate will continue to work closely with us on the marketing strategy that he has so ably led to date. Tim's contribution to the committee and the profession has been fantastic, and I'm sure we would all like to thank him for all the time and energy he has put into the role.

In terms of work over the last month, Tim and I attended a Professional Practice Board meeting where a considerable amount of time was spent thinking about the likely impact of statutory regulation on the profession and on the Society. As you may be aware from Tim's column last month, the finer details of statutory regulation are still being thrashed out, but what we can be fairly confident about is that, in keeping with what many clinical psychologists have been lobbying for for some time, statutory regulation of clinical psychologists is now around the corner. It is currently anticipated that from mid-2008, in order to use the term 'clinical psychologist' one should be registered with the Health Professions Council, although it appears that it will be possible to continue to use the term without being registered until the end of a 'grandparenting' period (we are not sure how long this will be). After the end of this grandparenting period, there may be significant issues both for Trusts and the individuals they employ if those individuals are employed to work as clinical psychologists but are not registered.

Chartered clinical psychologists will be automatically eligible for HPC registration, and in the future, trainees completing approved courses will be automatically eligible for registration. However, if you are a qualified psychologist and are not transferred from the Society's Register of Chartered Psychologists you will have to apply individually to be registered with thhe HPC via the grandparenting route. This will involve paying a fee (currently £400) and submitting details of your training etc. to the HPC. We would therefore advise that you commence the chartering process as soon as possible, as it is likely to take some time given the anticipated increase in numbers applying over the coming months. Further information on applying to become a chartered clinical psychologist can be found at www.bps.org.uk/membership/eligibility/chartered-status.cfm.

We also discussed seizing the upcoming Statutory Regulation as an opportunity to 'relaunch' the professions of applied psychology, for example developing information for the general public explaining to them what being 'registered' means and what they can expect to get from a Registered Clinical Psychologist (the likely term under HPC).

Tim and I also met with Unite (previously Amicus) for one of the regular joint meetings we hold to ensure that the Society is communicating well with the union and moving forward together effectively. One of the areas we discussed was the extent to which Agenda for Change has impacted on or is still impacting on the employment of clinical psychologists. Tim reminded me that it is time for the annual survey of clinical psychology posts, so if a questionnaire comes your way, please find the time to complete it, as this information is vital to help us in keeping an eye on the what's going on out there in terms of employment and vacancies.

Finally, I was invited to speak at the South London & Maudsley Foundation Trust's annual Psychology Conference, in my role as (about to be) Chair of the DCP. This being my inaugural invitation of this kind, it was slightly daunting to present to the trust within which I had trained myself, with an audience which included many former supervisors, but I think it went well. I am looking forward to meeting with many more of you through branch or trust events over the coming years.

Lastly I'd like to wish everyone a very Merry Christmas or Happy New Year or relaxing few days off work if you don't celebrate either of the above.

British Psychological Society, Division of Neuropsychology
Post-qualification Training Day

Cognitive Behaviour Therapy after Brain Injury: Evidence or Assumptions?

Convenor: **Dr Fergus Gracey**

Friday 7 March 2008; Venue: Society London Office,
30 Tabernacle Street, London EC2

Topics to include:

Prof Huw Williams – CBT in neuro-rehabilitation of brain injury

Dr Teresa Ashman (USA) – CBT for depression following brain injury

Prof Ken Laidlaw – CBT in Parkinon's Disease and for post-stroke depression

Dr Barney Dunn – Implications of cognition-emotion research for emotion management in neurorehabilitation

For further information and registration contact:

Dr Stuart Anderson, Sussex Rehabilitation Centre, Southlands Hospital, Shoreham-by-Sea, West Sussex, BN43 6TQ; Tel: 01273 455622 (ext. 6832); e-mail: stuart.anderson@southdowns.nhs.uk

From the Editor's Chair

Welcome to a new format for a *Clinical Psychology Forum* special issue: this issue includes a target paper about service innovation in Doncaster, by Prof. Dave Richards and Dr Rupert Suckling, plus invited commentaries from a range of contributors from the profession. If it is successful, we shall consider future issues that tackle innovative or controversial developments we believe would benefit from a general airing with the membership. I should add that the commentaries were invited to be deliberately discursive and to include a range of perspectives including a service user, clinicians working in primary care, psychology service managers and researchers.

Improving Access to Psychological Therapies has now become a reality for services following the ministerial announcement back in October. This issue of *CPF* addresses this challenge in a number of ways: the target article and commentaries, and a briefing document on developments in the IAPT programme in DCP Update. It is the intention of the DCP Executive to finalise policy responses to the briefing paper at an away-day in the new year.

The article by Richards and Suckling is important since it presents one clear and well-articulated possible answer to the question of how deliver interventions within primary care, that are accessible to the large number of clients who present with common mental health problems. The article seeks to explain the service model, the supporting evidence base upon which it is based (i.e. collaborative and stepped care), and some practical information on how its been implemented in Doncaster. I will not comment further on the target article or the commentaries – they eloquently speak for themselves – but feel it might be useful to draw out some themes which might help the DCP organise its thinking around these developments.

Several themes can be identified from within the commentaries. Firstly, that a full consideration of the model is predicated on the publication of outcomes and user views on the adequacy and effectiveness of the service. It is my understanding that the internal evaluation conducted by the London School Economics is scheduled for publication in the new year, and the external SDO evaluation some time further down the line. Given that it is not an randomised controlled trial, care will need to be exercised in interpreting these initial outcomes because of what we know already about recovery and relapse, especially within depression (Andrews, 2001). It is likely that a sizeable proportion of people treated in Doncaster would have recovered in the absence of any specific intervention and the question of the 'added value' of the Doncaster model will require careful evaluation. Long-term follow-up data will also be crucial in interpreting the overall outcomes. Nevertheless, the data will throw immediate light on what I suspect will be positive changes in increased access and patient satisfaction, together with clinical outcomes.

A second theme implicit in several commentaries was the possible medicalisation of 'sadness', which has been recently debated elsewhere (Hickie, 2007; Parker, 2007). Should health services devote interventions to alleviate depression that may well be associated with socio-economic circumstances such as deprivation and the breakdown in community and family cohesion? What about more broadly based community interventions and the challenge of mental health promotion and defeating the stigma associated mental ill-health? Psychologists have traditionally addressed many of these issues from a more community-oriented perspective than just a therapeutic approach targeting the individual. I'm reminded of the work on the relationship between depression and life events and the importance of non-therapeutic factors such as 'neutralising life events' and 'fresh starts' which might aid people's transition into recovery and might require little in the way therapeutic inputs (Bebbington et al., 1981; Harris; 2001). Do we really understand sufficiently the natural history of depression, its triggers and individuals' vulnerabilities?

Related to this is the question of what interventions should we be offering and at what stages. Some have reframed the Doncaster service as providing support but not long-lasting therapeutic interventions. Nevertheless, the adequate 'dose' of intervention will be revealed in the empirical wash. We should also remember that guided self-help, although a less intensive intervention, is also aimed at enhancing self-determination and efficacy, which may be crucial in facilitating 'fresh starts' for some individuals. It also provides choice in where and how therapeutic advice is available; not all wish for the comfort of the consulting room.

Low-intensity practitioners present real challenges around workforce design and education and training. Are their careers sustainable? What support and supervision are required to ensure that workers are safe and not subject to burn out. These issues are being addressed in the IAPT programme and some of the earlier work has been summarised elsewhere (Turpin et al., 2006). Similarly, the role that psychologists have in training other staff to deliver high intensity interventions should not be overlooked.

What happens if low-intensity interventions are insufficient and what resources are required to ensure access to more traditional high-intensity therapies offering eight or more sessions with an accredited and highly trained therapist? What degree of informed choice should clients expect of the psychological therapies on offer and by whom? How many people will require such intensive interventions and what might be the impact of prior exposure to low-intensity interventions? How does current capacity for high-intensity interventions and waiting lists at Doncaster impact on the numbers of clients requiring their care to be stepped up? How do we ensure treatment fidelity and quality supervision in the roll-out of the IAPT programme? We should be mindful that the original Layard hypothesis (Layard, 2004, 2006) promoted access to more traditional services such as the Newham demonstration site and that there will be expectations from government that such services will also be freely available to those clients in need of more intensive interventions. Nevertheless, it should be recognised that the service in Newham has also been subject to recent service redesign and has incorporated some aspects of Doncaster in delivering low-intensity interventions.

There is also the final theme of how applied psychology should embrace the ideas highlighted in this special issue and the general work of the IAPT Programme. Various commentators challenge psychologists to become proactively involved and warn of the dangers of sitting on the sidelines. The IAPT programme pose significant opportunities and challenges both for psychology services and those psychologists that work within them. We should be particularly grateful that Richards and Suckling chose to showcase their model and have it subject to criticism within *Clinical Psychology Forum.*

Nevertheless, there is some confusion about the exact future role that psychologists may have in these services. It is highly likely that many of the newly created posts for therapists who will deliver high intensity interventions, will be filled by newly qualified psychologists at AfC Band 7. This raises the question for clinical psychology training about whether the current training will adequately prepare graduates who wish to work within these services over the next few years. Should we be actively encouraging trainees to participate more fully in primary care services or treating the common mental health problems in order to prepare them for this future role? The trend in the last decade, particularly in training, has been to focus on more complex problems and their associated interventions.

Similarly, if IAPT services are to deliver effective outcomes, it will be essential that they maintain treatment fidelity with the evidence-based interventions upon which they are based. To achieve this, services will need to pay attention to the training and supervision of existing staff and newly appointed trainees, establishing clinical governance and outcome monitoring systems, and also providing clinical leadership. This should generate further demand for more experienced consultant psychologists within IAPT services.

Psychologists also have an important role in providing specialist advice as to how IAPT services might need to be adapted in order to meet particular challenges in ensuring that they are delivered to meet the specific needs of minority communities or adapted for client groups such as children, older adults or people with a learning disability. Collecting future practice-based evidence and routine outcomes in order to evaluate a range of psychological interventions that currently fall outside of NICE guidance will also be essential to 'future-proof' the IAPT programme. Many of these issues and the important contributions that psychologists have to offer, have been reviewed in the recently published NWW *Good Practice Guide* to the IAPT programme (http://tinyurl.com/y8nzxm).

Clinical psychologists also work across many different services, with clients from diverse care groups, and at different levels of intervention. It is likely the demand for psychological services will increase, particularly around the needs of children and families, long-term disabilities and chronic heath conditions, dementia and older people, to name but a few. Whether NHS investment keeps up with demand is unknown but the psychology workforce has grown exponentially over the decades (BPS, DoH & HO, 2005) and seemingly independent of overall NHS investment; capacity has been driven by ever-increasing demand for psychological interventions. The recent Sainsbury's review of workforce demand (Boardman & Parsonage, 2007) to support the implementation of essentially the NSF for Mental Health predicts around a 50 per cent expansion of clinical psychology staff in the next few years. With the demands from the IAPT programme and elsewhere, are we confident that we are training sufficient clinical psychologists currently? A shortage might be a significant risk to the future implementation of the IAPT programme, especially if it is to be further supported by the next comprehensive spending review into years four to six.

We live in interesting times, and I hope that this Special Issue will prompt members of the DCP to consider seriously and creatively the important issues that it addresses.

Finally, the *CPF* collective will be meeting in December to review progress and will also host a lunchtime feedback session at the DCP Annual Conference. We have also received lots of enquiries from people wishing to join the collective and we hope to select new members at our December meeting. Thank you to all those readers who have expressed an interest in joining the collective. Any ideas for improvement for CPF – please e-mail me at g.turpin@shef.ac.uk.

Graham Turpin
Co-ordinating editor

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Improving access to psychological therapy: The Doncaster demonstration site organisational model

David A. Richards & Rupert Suckling

In this paper we describe the theoretical rationale, evidence base and model adopted by the Improving Access to Psychological Therapies demonstration site in Doncaster.

WORLDWIDE, MENTAL health problems are both common and disabling (World Health Organisation, 2004). The subject has attracted considerable recent policy interest, including a campaign by *The Lancet* (Horton, 2007). For many people with severe mental health disorders the personal impact can be severely disabling.

However, the public health burden (as opposed to personal health burden) of mental health problems is dominated by so called 'common mental health disorders' (CMHD). Anxiety and depression constitute around 97 per cent of the total prevalence of mental health disorders (Office of National Statistics, 2000) and are thought to account for at least 50 per cent of the days lost to disability (Andrews et al., 2001). However, the vast proportion of health and social services mental health spend is on serious disorders such as psychosis. In contrast, significant sums of money are spent on supporting people with anxiety and depression who are out of work, through the payment of incapacity benefit, a form of support to people who are unemployed through long-term sickness.

This cross-subsidy of mental health care has been identified as both unacceptable and ripe for reform. The economist Richard Layard has estimated that the UK spends £7–10 bn on benefit payments to people with mental health problems. As Layard succinctly puts it:

> There are now more people on incapacity benefits due to mental problems (850,000) than the total numbers of unemployed people on Job Seeker's Allowance. If unemployment was once the most prominent source of misery, it has been replaced by mental illness. (Layard, 2004, p8).

Layard also made the point that the cost of providing effective mental health care, particularly evidence-based psychological therapies is tiny in comparison (Centre for Economic Performance, 2006). Through a persistent high-level political lobbying campaign he persuaded the UK government to fund a programme to address the woeful provision of therapy. For despite National Institute for Clinical Effectiveness (NICE) guidelines in anxiety and depression (NICE, 2004a, 2004b), sufficient numbers of recommended treatments are not delivered by services as they are currently configured and funded (Bebbington et al., 2000). Only 24 per cent of people with common mental health problems receive any treatment for their difficulties, mostly in the form of medication (20 per cent), with only 9 per cent receiving another form of therapy or counselling in addition to or instead of medication. Worse still, only 1 per cent of people receive an evidence-based psychological treatment as recommended by NICE (Office of National Statistics, 2000).

As well as the economic argument, other commentators have argued along moral lines. Terms like 'affluenza' (James, 2007) and 'social recession' (Lawson, 2007) have been used to describe the rise of depression or 'unhappiness' (Layard, 2005) in modern societies. All are united in identifying the need to address the problem. While some argue for societal action, Layard has proposed a series of 'treatment centres' to treat depression using evidence based psychological therapies in order to restore people to happiness and economic productivity (Layard, 2006).

The Improving Access to Psychological Therapies Programme (Care Services Improvement Partnership, 2007) is a multimillion pound effort to test the Layard hypothesis that large scale expansion of evidence-based psychological therapies will increase both the happiness and productivity of the population. In order to obtain agreement for the recently announced £173 million increase in spending from the UK Treasury (Department of Health, 2007), the programme has had to embark on a series of 'proof of principle' exercises. The first of these was the establishment of two 'Layard centres' or demonstration sites, where the basic premise that investment in psychological therapies will increase wellbeing and decrease reliance on incapacity benefit is being tested. The two centres, in Doncaster and Newham, adopted different operating principles: the London site a specialist 'replacement/referral' model familiar to specialist mental health services; the Doncaster site a 'collaborative care' model more common in the US and in UK primary care. (For a summary of different organisational models see Bower & Gilbody, 2005a.) Of the two, in terms of usual organisational practices in psychological therapies the Doncaster site is a less familiar model to UK psychological therapies practitioners and service managers. This paper, therefore, describes the clinical organisational model implemented by the Doncaster centre and the theoretical and empirical rationale for its adoption.

Theoretical and empirical background to Doncaster's organisational model

The Doncaster model was designed following reviews of three principle sources of evidence: the clinical effectiveness of low- and high-intensity variants of cognitive behaviour therapy (CBT), the organisational effectiveness of collaborative care and the evidence for stepped care. These evidence-bases were used to design a model of care which would explicitly reflect the philosophy of primary care and public health. Treatment had to be delivered according to these principles and was explicitly focussed on delivering care to high-volumes of people. The Doncaster model had to be able to accommodate an expected referral volume of greater than 5000 patients per annum.

The clinical effectiveness of low- and high-intensity variants of CBT

The most recent reviews of psychological therapies conducted by NICE (2004a, 2004b) recommend CBT for both depression and anxiety. Although CBT is not the only recommended psychological treatment, the skill set and clinical materials required are much more available in both clinical and educational providers than other alternatives (e.g. Interpersonal Therapy for depression). CBT was, therefore, selected as the principle psychological therapy for use in Doncaster. One great advantage in choosing CBT is that variants have been developed which can be characterised as both low-intensity and high-intensity. This allows the same theoretically consistent and empirically valid treatment to be delivered in different 'doses' according to patient need and response. High-intensity treatments usually involve considerable therapist input akin to traditional therapy models. In contrast, low-intensity treatments emphasise patient self-management with much less contact between mental health workers and patients, for example by the use of guided self-help.

In randomised controlled trials, the controlled clinical effect size for high-intensity CBT is large, ranging between 0.89 for depression (Pilling & Burbeck, 2006) and 1.6–2.9 for anxiety disorders (Clark, 2006). CBT is, therefore, less effective in depression than anxiety disorders with an effect size for depression (0.89) just over half that for generalised anxiety disorder (1.7). The effect size for low-intensity CBT for depression is very similar to high-intensity CBT (0.8; Gellatly et al., in press) but more varied and generally less so for anxiety disorders (range 0.18–1.02; Hrai & Clum, 2006), although low-intensity CBT for generalised anxiety is large at 0.92.

The evidence for stepped care

Although the evidence for the efficacy of some psychological therapies is strong, the evidence for their organisation is less so. NICE guidelines for depression and anxiety recommend that treatments should be organised along a 'stepped care' model. Stepped care has two fundamental principles. Firstly, treatments delivered should always be the 'least restrictive', in that the burden on patients should be as low as possible whilst achieving a positive clinical outcome (Sobell & Sobell, 2000). This principle is usually interpreted as the delivery of a low-intensity treatment such as guided self-help, unless other high-intensity treatments are indicated. Secondly, stepped care should be self-correcting (Newman, 2000). This refers to the systematic scheduled review of patient outcomes to assist in clinical decision-making using validated outcome tools such as symptom schedules. Although based on the common sense proposition that it is as harmful to overtreat as undertreat common mental health disorders, NICE guidelines provide little evidence to support the implementation of stepped care.

A narrative review of stepped care (Bower & Gilbody, 2005b) concluded that stepped care has the potential to improve the delivery efficiency of psychological therapy but that the exact form of stepped care to maximise patient benefit is unclear. There are two possible ways stepped care might be implemented. One, the pure 'stepped' approach, allocates a low-intensity treatment to all patients and uses the scheduled review principle to 'step-up' patients who do not benefit from the initial intervention. In contrast, a 'stratified' approach initially allocates patients to interventions at different steps according to objective measures of their symptoms. Both approaches have benefits and disadvantages and NICE hedges its bets by recommending both systems simultaneously (NICE, 2004a). In the stepped approach the danger is that some patients may be inappropriately allocated to a weaker 'dose' of treatment and the duration of their contact with services is extended. In the stratified approach the danger is that services may take a very risk-averse approach and opt to overtreat many people, compromising the efficiency of the system as a whole. As noted by Bower and Gilbody (2005a), the benefits of stepped care could be compromised if complex assessments and treatment allocations require significant resources. Indeed, a stratified approach relies on the ability to accurately predict who would not benefit from low-intensity treatments – so called 'aptitude treatment interaction' (Sobell & Sobell, 2000), the evidence for which is questionable at the very least. In practice, it might be that versions of stepped care take a balance between the two approaches, although the degree of emphasis on stepping or stratifying could alter system performance dramatically.

The evidence for collaborative care

An area where the evidence for organisational models is much stronger is in 'collaborative care' (Von Korff & Goldberg, 2001; Simon, 2006). Collaborative care is a 'systems level' quality improvement approach consisting of a multi-professional approach to patient care, a structured patient management plan, scheduled patient follow-ups and enhanced interprofessional communication (Wagner et al., 1996; Gunn et al., 2006). It has been comprehensively tested in depression management. A recent systematic review (Bower et al., 2006) found that the combined effect size for collaborative care in 36 studies was relatively modest but that the actual models implemented on the ground in trials were extremely heterogeneous. Using meta-regression techniques to identify the critical components of this complex systems-level intervention, the review found that the effectiveness of collaborative care could be optimised by including within it the employment of case managers with a specific mental health training who also receive regular expert supervision. Recent UK trials incorporating these effective ingredients achieved effect sizes between 0.42 and 0.63 (Pilling et al., 2006; Richards et al., 2007). These effects were achieved merely by restructuring the organisation of treatment, since collaborative care is a quality improvement intervention that does not add additional therapeutic ingredients but merely optimises the delivery of existing pharmacological and psychological treatments. Essentially, a case manager ensures that patients remain in contact with mental health care services and that they get the maximum benefit from their chosen intervention, pharmacological or psychological. In the most successful UK protocol, case managers conducted most contacts on the telephone and delivered a mixture of medication management and low-intensity CBT (Richards et al., 2007).

Implementation of the Doncaster model

The Doncaster demonstration site was set up by a wide ranging partnership of health (PCT and specialist mental health trust), employment agencies (Job Centre^{+} and condition management programmes), the voluntary sector (such as Mind), the business community (coordinated by the Doncaster Chamber of Commerce) and vigorous representation from patients. As such the IAPT service is one part of this system that aims to address issues of work and well-being.

Within the partnership, the IAPT Doncaster clinical model is a 'stepped' version of stepped care where low- and high-intensity CBT is delivered by a mixture of case managers and therapists using collaborative care as the organisational delivery model. All patients with depression, and most patients with anxiety disorders, are allocated to a low-intensity treatment programme as the default first step. Most clinical contact between case managers delivering low-intensity CBT is conducted on the telephone following a first face-to-face assessment session, usually conducted by case managers. Scheduled reviews of treatment outcome are automated via a bespoke IT system which alerts case managers and supervisors to review cases at least every four weeks. Clinical decision-making is facilitated by sessional outcome measures and scheduled clinical case management supervision. Patients are stepped up to high-intensity CBT if a clinical review detects a lack of improvement and the patient wishes a more intensive treatment. A small number of patients are allocated directly to high-intensity treatment where no evidence based low-intensity alternative is available, for example for patients with post-traumatic stress disorder. Low-intensity treatments for depression and anxiety include a bespoke written 'Recovery Programme for Depression' (Lovell & Richards, 2006) and commercially available written materials for anxiety disorders (Williams, 2003). Computerised CBT is also available for those patients who choose to use it. For patients who choose not to accept the CBT treatment model offered, other services such as counselling and voluntary sector provision are available via signposting. Case managers also assist patients with pharmacological treatment via medication support, although prescribing decisions rest with the patient's GP.

Fourteen case managers were recruited from the local community. No prior educational level was specified. Case managers were selected on their interpersonal aptitudes and commitment to working in mental health. Very few had had experience of delivering mental health care in the public sector, although some had had personal experience of mental health problems and a number had worked in the voluntary or user-organisation sector. Six additional case managers were previously employed as 'graduate workers' in Doncaster. All newly recruited and existing workers were trained using a specially commissioned programme from the University of York, tailored to the clinical model and the competencies required. The programme was a mixture of classroom-based clinical simulation and workplace supervised practice. Supervision of case managers is undertaken weekly, where all cases flagged by the IT system are reviewed. Automatic trigger flags include all new patients, all patients at four-weekly intervals, all patients with high outcome measure scores and any patient the case manager wishes to have discussed.

Therapists are qualified mental health professionals with an additional qualification in CBT. Therapists see all patients stepped up to high-intensity treatment, either directly or after period of low-intensity treatment from case managers. Therapists also supervise a number of case managers and act as 'duty managers' (see below). Most face-to-face low- or high-intensity treatment occurs in GP surgeries or other community venues. Telephone case management is conducted from a special 'hub' where call centre technology allows case managers to read and input notes and clinical outcome data directly to the IT system whilst talking to patients using hands-free head sets.

Patient pathways in the Doncaster model

The standard patient pathway is initiated by a GP referral after a patient has presented to the GP and the GP has identified an anxiety or depressive problem. Other routes of referral from partner organisations, including self-referral, are also possible. Referrals are made by fax to the central hub, where it is processed. The referral form includes space for the patient's contact details, including telephone number. Ordinarily, the duty manager attempts to ring the patient the same day the referral is received to discuss their needs and the IAPT service. If both duty manager and patient agree to proceed, the patient is allocated a case manager based on a mixture of geographical allocation and caseload. The case manager then contacts the patient, again usually by telephone, to arrange a first appointment within the next two weeks, usually face-to-face in the patient's general practice surgery.

At the first appointment the case manager conducts a patient-centred assessment, including a risk assessment, and asks the patient to complete a battery of clinical outcome measures. The case manager then gives the patient written information appropriate to their problems, discusses treatment options and arranges a next appointment, usually telephony based. If any significant active risk of harm to self or others is detected, the case manager will initiate the appropriate risk management protocol. At the first telephone follow-up contact, the case manager reviews the treatment options offered and initiates a low-intensity treatment CBT programme for anxiety or depression. Mostly, this uses the written materials although case managers also support patients in the same way should they wish to use computerised CBT. Subsequent contacts are generally on the telephone and include sessional outcome measures so that case managers are able to receive online real-time feedback of patient progress as they are conducting all treatment sessions.

The use of real-time clinical outcome measures enables rapid decision-making. Formal reviews of patient progress are conducted every four weeks. Depending on patient progress, decision making may include advising the patient to remain in low-intensity treatment for another four weeks, to discharge from active treatment, to step up to high-intensity CBT or to refer to alternative services requested or required by the patient.

Other pathways exist, including immediate referral to high-intensity treatment for patients where there is no viable low-intensity alternative or where the patient has had previous experience of CBT or a previous unsuccessful trial of low-intensity therapy. Some patients do not accept the IAPT service offered and so are signposted to other partnership services such as counselling, the voluntary sector or the Job Centre$^+$ condition management programme, or advised to return to their GP. Some patients are referred with serious mental health problems and require services from the community mental health services or even crisis services, to which they are directed. The large majority of patients, however, are cared for in the standard pathway.

Development of the Doncaster model

A number of developments to the model were required following initial implementation. Firstly, the volume and nature of referrals necessitated the development of a 'duty manager'. This role, undertaken by an experienced worker or therapist, receives all referrals and contacts the patient directly. In addition to the consistent management of high volumes of referrals, this role was developed to cope with the small number of referrals who required treatment from specialist mental health services. Identification of these patients and negotiation of care pathways was beyond the competence of case managers. A duty manager also enables a consistent approach to the 24-hour contact target for all new referrals, since if this job was allocated to individual case managers it might not be met if case managers were out of the hub engaged in face-to-face work. Finally, duty managers have access to data on individual case manager workloads and can allocate appropriate patients to those case managers with caseload and case-mix capacity.

Secondly, computerised CBT (cCBT) is an evidence-based and potentially useful low-intensity treatment. However, CD-ROM-based programmes do not sit well with the telephony-based collaborative care delivery model in Doncaster. Hardware based in specific venues requires case managers to travel to these sites and remain with patients whilst they are undergoing cCBT sessions. Laptop computers have been purchased to facilitate flexible delivery of cCBT, but travel time is still onerous and if a patient does not attend a planned session case managers cannot always use the time productively in undertaking telephony-based follow-up with other patients. This reduces the efficiency of the Doncaster delivery system. Internet-based cCBT is preferred and Doncaster is now trialling internet-delivered cCBT for both depression and anxiety.

Thirdly, supervision of case managers by CBT therapists takes them away from patient-focused treatment. Furthermore, even with additional training, therapists may not be the best equipped to deliver high-volume case management clinical supervision where the requirement might be to discuss the clinical progress of up to 20 patients per case manager per week. Traditional therapy supervision models adopt a therapist-driven agenda whereas case management supervision requires a service driven agenda. Finally, many therapists find it difficult to give high-volume, low-intensity advice to case managers when they themselves are operating from a low-volume, high-intensity clinical paradigm. As a consequence, the bulk of supervision of case managers is now mostly undertaken by a specialist individual backed up by a specific few therapists with small numbers of case managers each.

Finally, despite a service which sees less than 10 per cent of patients stepped up from low- to high-intensity treatment, Doncaster has developed a small waiting list for high-intensity CBT. This is mainly a consequence of the local difficulty in recruiting qualified therapists and the diversion of therapist time into case management supervision. Although most therapist time is now devoted to face-to-face high-intensity treatment rather than supervision, continuing difficulties recruiting CBT therapists limits the ability of the service to provide even the small numbers of high-intensity treatment required. This factor is likely to be a critical capacity-limiting issue for the national roll out of the IAPT programme.

Conclusion

The Doncaster Improving Access to Psychological Therapies demonstration site is testing a stepped care model of psychological therapies provision where the initial default therapeutic option for almost all patients with anxiety and depression is a form of low-intensity CBT delivered through a telephony-based collaborative care system. The system was designed to reflect a primary care and public health philosophy by enabling easy access and the delivery of effective treatment to large volumes of people with common mental health problems in Doncaster. Case managers, specifically trained for the role, are supervised by workers with additional therapeutic mental health or CBT expertise. Patients who do not improve or for whom there is no low-intensity option are stepped up to high-intensity CBT assisted by an IT patient information management system with automated flags, triggered by response to and duration of low-intensity treatment. The operationalisation of the twin principles of stepped care – a low burden treatment as the initial default and a self-correcting system of outcome-based decision making – is subject to current evaluation. Whilst capacity problems still exist, these reflect the difficulties in recruiting workers with the required skill-set rather than a dysfunction in the model *per se*. Currently, Doncaster is meeting all its patient access targets and clinical outcomes and patient satisfaction, to be reported in a subsequent paper, are excellent.

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British Psychological Society

Qualitative Methods in Psychology Section Inaugural Conference

University of Leeds; **2–4 September 2008**

Conference Announcement and Call for Papers

The Qualitative Methods in Psychology Section of the British Psychological Society is pleased to announce their first annual section conference. The conference theme, Qualitative Psychology: Real World Relevance?, is designed to provoke discussion of the oft cited claim of 'ecological validity' attributed to qualitative research. This claim centres around the bottom-up nature of much qualitative research whereby 'insider' accounts on a given topic are gathered, often within research interview settings.

A range of papers, symposia, posters and workshops will be presented on all aspects of Qualitative Psychology, and the programme includes keynote papers from five leading experts in qualitative research:

Keynote speakers
- Prof. Ken Gergen (Swarthmore College, Pennsylvania)
- Dr Zazie Todd (University of Leeds)
- Prof. Chris Griffin (University of Bath)
- Prof. Andy Miller (University of Nottingham)
- Prof. Nick Pidgeon (University of Cardiff)

The conference aims to showcase a wide variety of methods as applied to a range of interesting, contemporary topics. It will be a forum for discussion of the latest innovations and issues of interest to the Qualitative Psychology community, and will hopefully provide an enlightening and stimulating experience for all. The conference venue is the University of Leeds, a leading civic university in the UK which prides itself on world-class research and facilities. Leeds itself is a vibrant, modern city with good transport links and proximity to the picturesque Yorkshire Dales.

Deadline for submission of abstracts: **29 February 2008.** Each abstract must be submitted using the online submission system. Full details of the Conference can be found on the Society website: **www.bps.org.uk/qmip2008**. Or e-mail: conferences@bps.org.uk

Improving Access to Psychological Therapy: The Doncaster Demonstration Site Organisational Model – Commentary

Paul Gilbert

THE 1980s and 1990s, saw resources focus on 'severe and enduring mentally ill'. The impetuous behind this was the closing of the mental health hospitals, a shift into community care and the growth of psychosocial treatments for people with psychosis and personality disorders. As the 1990s progressed there was increasing awareness of how much and how common abuse, neglect and emotional trauma permeated the lives of those with more complex problems (tiers 3–5 in the stepped care model). This has been an exciting time to be a psychologist because our understanding of 'how the mind works' with developing effective therapies is occurring at a breathing taking pace. cognitive behaviour therapy (CBT), dialectical behaviour therapy (DBT), acceptance and commitment therapy (ACT), cognitive analytic therapy (CAT), mentalising, schema-focused therapies, sensory motor therapies now focus on complex cases. Psychologists have been at the forefront of these developments and this is why the Lord Layard's report and New Ways of Working recommends that they should have leadership roles.

However

Dave Richards and others have repeatedly pointed out that while this focus of limited resources was laudable (greatest resources to those most in need), we are still closer to famine than feast in what is needed – given the epidemiology. The barriers between primary and secondary care, and the increasing neglect of common, but less severe mental health problems (tiers 1 and 2) are serious deficits in services, and people are often dismissed with terms such as the 'neurotic' or 'worried well' (rather than 'worried sick'). This has been highly defensive because of the 'floodgates problem.' Richards and others have been at the forefront of trying to address this difficulty in creative ways. They outline a model that puts graduate workers, case management, self-help with some 'stepped-up care' at its heart. Indeed, there are now a range of different models to deliver guided self-help, for example the Needham Model and Chris Williams' 'five areas model' developed as part of an NHS commissioning process (Wright et al., 2002). Although natural recovery rates are important to note (e.g. Posternak & Miller, 2001, explored the course of depression in 201 clients on waiting lists and found that 20 per cent had improved within the first two months and by six months 50 per cent had improved) there is a growing literature that suggests that, properly resourced and supervised, these kinds of guided self-help services can be significantly beneficial over waiting list controls (Anderson et al., 2003; Gellatly et al., 2007). We await long-term follow-up data.

Therapy verses guidance and support?

There is a fundamental question that is often asked (and we can only raise it here, not answer it) as to whether or not these guided self-help models are best seen as a 'therapy' models. Are we talking about improving access to psychological therapies or improving access to psychological support, life-skill training and coaching? Where does psychological support, guidance, education and advice turn into therapy? Does it matter? Would people (especially younger people) actually be more likely to use 'psychology advice or support centres' than 'therapy' centres? As Richards and Suckling also say:

> Essentially, a case manager ensures that patients remain in contact with mental health care services and that they get the maximum benefit from their chosen intervention, pharmacological or psychological.

In other words, not increased access, necessarily, but better use.

Although much of the recent research in therapy development has been on tiers 3 and above, one fears then that these people, who add up to vast numbers, can have major impacts on their families may not experience IAPT. Those who often require longer therapies, over months and sometimes years, can have maturational issues and require good follow up (as recognised in, for example, DBT). Recent research suggests depressed people do not do as well with current therapies as was previously thought (Fava et al., 2006). These people might still get batted back and forth from primary to secondary care with a few sessions here and there. Those who can pay for experienced, qualified therapists, without time pressure will increasingly do so.

NICE repeatedly makes the point that people providing therapy should be:

- knowledgeable and experienced with the disorder they are working with (thus CBT trained people will need a core profession in mental health);
- knowledgeable and competent with an evidence based approach.

These have been articulated in detail by various Department of Health Documents on core competencies by Roth and Pilling. Although NICE has focused (a little) on tiers 1 and 2 and the value of guided self-help, most of its analysis is from meta-analysis of clearly diagnosed and defined disorders under RCT conditions. Now you can criticise such methods (and many have of course) but we need to ensure training and resources are going to skill people up to work with more complex problems in line with new evidence-based therapies. This is where it gets a bit hazy.

Here's one example. One of the studies in depression that gave CBT good effects sizes was Cognitive-Behavioural Analysis System of Psychotherapy (CBASP; McCullough, 2000; Keller et al., 2000). This integrates a number of different approaches (and regards itself as an integrative therapy), but is highly focused on changing interpersonal behaviour and uses the therapeutic relationships. Fuelled by research on just how powerful our social relationships are as psycho-physiological regulators, depressed people learn how they can be caught up in repetitive interpersonal cycles which lead to adverse outcomes for themselves and others. Where, I wonder, is the push to get this type of therapy established in the CBT roll outs?

Mindfullness was just 'getting going' when NICE published, but now more and more data are accumulating on its value for some people – where is the roll out? DBT has done an excellent job in obtaining good research evidence – where is its roll out? And so on and so on.

Different people may benefit from different things, and diagnosis is a poor indicator of that, so we need better assessments that focus on psychological process to advance IAPT. The importance of building community networks where people learn to help and support each other (e.g. among single parents) could also be advanced.

Other models for IAPT

Common mental health problems are related to problems in living, and range from 'normal reactions' to difficult life situations, through to complex interactions between genetic vulnerability, acquired sensitivities and life events. A huge literature attests to the importance of life events, domestic violence and absence of social support in depression. Targeting domestic violence might do a lot for some people's depressions in some communities. Although, Richards and Suckling mention concepts of affluenza, poverty is far more important. Rates of depression vary greatly with social group, with poor and high unemployment areas having considerably higher rates of a range of health problems (Melzer et al., 2004). Ostler et al. (2001) found depression differs between GP practices and that around 48.3 per cent of this variation could be accounted for by poverty and socio-economic status. There is something like a sixfold increase of risk between the higher and lower socio-economic groups. The increase in asylum seekers and the spread of multiculturalism also poses challenges for our services. We need to address these problems with community-appropriate interventions. The kinds of models developed by Richards and Suckling are (as they themselves note) underpinned mostly by CBT models of depression, not biopsychosocial models or even a clinical psychology ones. Clinical psychologists must address this with some urgency.

Clinical psychologists must also advocate far more strongly that increasing access to psychological therapy, support and guidance must address prevention. Some of the interventions that have been developed for low-grade depressions could be extremely useful to have available in schools for example. Richards and Suckling are clearly building up considerable experience and knowledge of particular types of problem and intervention and I would love to see this experience extended to prevention and more community work.

Conclusion

The development of self-help for tiers 1 and 2 is an important development of the application of psychological knowledge to try to help a large number of people. Richard and Suckling are to be congratulated on this. Their model is well worked out with good supervision for graduate workers and clear boundaries as to what they can and cannot provide for people. The question is where case management support and guidance ends and therapy begins.

Clinical psychologists need to keep reminding governments that if you look at the epidemiology then individual-focused therapies are only going to be one fruit in the basket. We must address psychological problems in our communities, linking better to voluntary services and networking people for mutal support. CBT is not a service-guiding biopsychosocial model (although CBT can be fitted within one). IAPT should also mean access to the most up-to-date and best; that is, access to the new generation of therapies (DBT, ACT, CBASP) where there is good evidence. Richards and Suckling have pointed to some important developments for bringing psychological help to neglected people, but there is a huge amount left to do for IAPT. We have spent decades researching and developing new therapies for more complex cases therapies; we must now find ways to deliver them where they are most needed.

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Division of Clinical Psychology Trent Branch

Integrative Formulation: How to do it and how to use it

Friday 29 February 2008 at Mansfield Civic Centre

Provisional outline of the day

- Introduction, overview of the basics;
- Single model formulation: characteristics and examples;
- Moving towards integrative formulation: Worked examples, based on actual cases;
- Using formulation in different settings: ideas for individuals and teams;
- Recent research and debate on formulation: taking formulation forward as a profession.

Learning objectives

- Revise the basics (definitions, uses, purposes of formulation; issues relating to integration)
- Gain confidence in constructing integrative formulations
- Learn about new ways of using formulation in clinical settings
- Get up to date on relevant research and clinical issues

Prices: Free to DCP Members* £30 to Non-DCP Members

Bookings: Booking forms and further information can be found at www.bps.org.uk/dcp-trent/meeting&sevents

Booking enquires to: Nic Bunker, Clinical Psychologist, Leicester South-East City Community Health Team, Maidstone Centre, St Peter's Health Centre, Sparkenhoe Street, Leicester LE2 0TA; Tel: 0116 295 7070; e-mail: nicholas.bunker@leicspart.nhs.uk

Booking deadline: Friday 15 February 2008

* The committee would also like to request that all applicants send a cheque for £30 with their registration. This will only be used as insurance for attendance, and will be returned on the day to those who attend. This has been implemented as the Branch have suffered heavy losses in the past as a result of applicants failing to attend events. Bookings will not be accepted without an accompanying cheque being sent. Places can be cancelled and cheques returned up to 2 weeks prior to the event

Improving access to psychological therapy: The Doncaster demonstration site organisational model – Commentary

Elizabeth Holford

I AM VERY pleased to have been asked to comment on this article. Having lacked effective psychological help in the past and having failed to reach my potential career-wise, I care passionately about using psychological therapy to achieve the symbiotic aims of good mental health and economic inclusion.

Although originally a researcher and so capable of understanding statistical evidence, this is a subjective response. It is born of personal and family experience and many hours analysing the 'magic ingredients' that made psychological intervention, when at last it came, so effective for me.

The authors set themselves the task of describing the 'the theoretical rationale, evidence base and model adopted by the Improving Access to Psychological Therapies demonstration site'. In my opinion they do this admirably. The principles, processes and problems inherent in the Doncaster model are explained clearly and vividly. So much so that I shuddered with horror at the image of a factory cum call centre dispensing CBT by remote emission, hoovering up vast amounts of scarce skilled therapist time in the process. My reaction is genuine but probably unfair. This is, after all, a description, not an evaluation and the authors refer (tantalisingly) to a forthcoming report that demonstrates excellent patient satisfaction.

As a patient, given a preview of what I would get with the low-intensity model, I would decide to wait for the real (high-intensity) thing. My experience is that what matters is the 3D human dimension and extensive skill offered by face-to-face sessions with a fully trained professional. No two people's difficulties and antecedents are the same. So what practitioners need, in my opinion, is the ability to interpret individual nuances and the confidence to make fine-tuned judgements about how best to help. Otherwise apparent recovery is likely to be a veneer.

But it seems that the Doncaster patients have been helped. As far as I know, there's been no mass outcry about substituting binary digits and soundbites for eye contact, rapport and insight. The practical advantages are real; for example, reduced problems with childcare and travel. Relative anonymity and control over time and place suit some people. Computerised CBT and phone coaching can tide people over until they want or can take up face-to-face sessions. That is, unless they are deemed to have used up their quota of entitlement to psychological therapy (this does happen).

Although the description is good and the evaluation apparently promising, there are, I think, some unconvincing and confusing elements:

- The dose response analogy does not ring true to me. The low- and high-intensity interventions are qualitatively different, not on the same spectrum.
- The Doncaster model is said to be based on 'public health philosophy'. To the layperson, public health means prevention rather than the greatest good for the greatest number as implied in this article (aka 'system efficiency').
- It is rather dispiriting to hear the 'collaborative care' model portrayed as something new and unusual. I was not aware that psychological treatment had ever been expected to work in a 'passive recipient' mode.
- Using 'intensity of symptoms' as the allocation criterion is consistent with

system efficiency but does not square with stated government policy on choice. For mental health patients like me, stark divergence between rhetoric and reality compounds their symptoms and worsens health. (But, looking on the bright side, this could at least push them up to the high intensity threshold.)

- RCT evidence is only as good as the accuracy of the diagnosis. I, and many other service users, have disputed our diagnoses and objected to being pigeonholed for medical and research convenience. Diagnosis in the mental health world is an art. So is it right to apply scientific methods to 'base data' that risks being unfit for purpose?

There are also some areas where information could usefully have been expanded upon. Greater description of the 'aptitude' expected of case managers would be welcome. Whereas there is reference to methods of predicting the ability of patients to benefit from low intensity treatment, little attention is given to the question of predicting the ability of case managers to help patients effectively. It is stated that case managers were selected on their 'interpersonal aptitudes' and commitment to working in mental health and were trained in the 'competences required'. What were the competences and interpersonal aptitudes in question? What was the evidence used to decide that these were necessary qualities and skills for a case manager? A couple of years ago a government policy document introduced the idea of 'lay health trainers' to address unhealthy lifestyles, using phrasing like 'help from next door' rather than 'dictate from on high'. Are the case managers in this mould? Is there a formal expectation that case manager roles will provide a rung on the employment ladder for people who have had mental illness, thereby addressing the incapacity benefit aim? I hope the evaluation will consider the impact of case management on the mental health of the case managers. If there are positive effects, this would be a factor in support of maintaining the role, even though there are heavy supervision demands.

Another area where I would have welcomed more description is on the 'battery of clinical outcome measures' and 'sessional clinical outcome measures'. No doubt these have been through rigorous research and validation, but I cannot discern from the article the questions that patients are being asked. I cannot form any judgement about the impact of these questions, from a patient perspective, and the resulting motivation in 'complying'. I do feel, from personal experience of tick-box 'feelings' and 'symptom' lists, that it would be easy to manipulate the outcome measures. This could be a welcome backdoor route for the patient to express choice in the next step of the patient pathway.

I have some questions that would help me to weigh up the article – some appropriate and fair, some not. What would a physical health analogy be? Needing a heart bypass graft but being coached to take exercise or fit your own stent? What is 'medication support'? It has always baffled me why, if medication is the panacea that doctors claim, support is necessary. Has Richard Layard ever sought psychological help? Have the originators read about workers affected by mass redundancies being encouraged to register as incapacitated rather unemployed? Anxiety and depression are readily, plausibly and unverifiably to hand when the imperative is to get headline figures down. I am not of the 'they used it to brainwash people in China' school of mass CBT criticism, but I do feel that the legitimate mental health problems engendered by collapse of economic communities deserve better than exhortations to make different assumptions about 'McJobs'. Public health philosophy has at its centre the need to tackle the underlying determinants of ill-health (as vaunted in the early years of New Labour - for example Health Action Zones). It seems paradoxical that the Doncaster model, described as based on public health philosophy, is tackling the symptoms rather than causes.

So, a powerful description and a negative response (some would say exaggerated and caricatured). I hope that I am wrong – that vast numbers of people get effective help, with great value for money; that patients and staff emerge sustainably satisfied and fulfilled.

The evaluation report should be eagerly awaited to tell the true Doncaster story –opportunity or opportunity cost? Sliced bread or…?

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CYP
British Psychological Society - Division of Clinical Psychology
Faculty for Children & Young People

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Peter Fuggle. Consultant Clinical Psychologist

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Mary John & Arlene Vetere

IMPROVING ACCESS to psychological therapies is a laudable aim, and one that has long been argued for within the clinical psychology community. In its inception it was both broad and contextual, and strongly grounded in everyday practice. In writing this response, we wish to make it clear that we support the development of the psychological therapies, and the contribution that the clinical and applied psychologies can make to community well-being along side other disciplines. After years of the service-user voice being articulated at a regional level in a way that was recognised, but not responded to, suddenly they had an advocate and a champion in Lord Layard (Centre for Economic Performance, 2006). His position and knowledge base in economics provided a coherent fiscal argument over and above the equality of access argument to mental heath services. David Richards and his team need to be acknowledged and given due recognition for picking up the gauntlet that was thrown down by the Department of Health. It has been no mean feat to develop a curriculum, interview, employ and get premises to operationalise a new service in the time frame. This against a backdrop of perhaps suspicious factions, services and their managers and clinicians feeling challenged by a way of working that is outside the conventional frame of reference and confronts all expectations regarding services.

Richards and Suckling's paper provides a clear framework for how to ensure significant numbers of the general public, who are experiencing common mental health problems, can access services. The service outline as currently presented appears to be projected as the way forward, rather than as one of a number of ways forward when using 'low-intensity workers'. For us, this provokes some concern that small but significant proportions of the community in need of these services will still not access them for practical and therapeutic reasons. No reference or acknowledgement is made to those clients who have literacy difficulties, are in extreme financial difficulties or for privacy reasons will find using the technology difficult. This may create a marginalised group. This is understandable given the agenda to meet the larger-scale issue. However the commissioners and the Service providers do need to develop a model to meet the needs of these groups that may be more expensive. There does need to be meaningful choice.

The model has been developed to support access for adults with mental health problems whilst in reality it attempts to meet the needs of those who are of working age as this is where the financial argument lies. Within the wider political and global health picture the pressure on the Treasury is immense, resulting in the NHS having to confront a tough financial climate. It is understandable that there has to be a cost-benefit to the nation of having a society that is able to sustain itself and within it having a workforce able to contribute to society rather than taking from it. However, there will be some members of the community who will not be in a position to contribute financially in either the short or long term. It may be to the long-term advantage of the community that these individuals are enabled to take time out, for example parents taking parental leave, time out to care for their children, and in response to parental stress and risks of mental health difficulties. These emergent difficulties can arise as a consequence of incorporating a new identity as a parent, the evocation of emotional responses in connection with their own childhoods and its ramifications on parenting, let alone sleep deprivation and general fatigue. Thus from a financial position this group could be at risk of being positioned as taking twice from community resources: firstly, their need to state support; and secondly, their use of services. This is an extremely uncomfortable message to give, let alone receive.

The dominance of telecommunication, whilst worthy from a cost saving perspective, does not appear to take account of the fact that we are a heterogeneous group, within which there will be a subset of the local community who find the approach unhelpful but, we suspect, will feel organised into using this approach. The 'low intensity workers' protocol will have a clear set of expectancies within it encouraging the offer of further telephone support as the standard next step for all the cost benefit reasons outlined in the paper. For those who are depressed and anxious who do not want this option, fighting against this tide, so as to gain access to a series of face-to-face appointments, will be hard.

We were interested to read that Richards and Suckling thought that those disciplines that were used to offering high-intensity, low-frequency intervention would not make effective supervisors. The argument presented was that this was unfamiliar territory and this group could not adapt. This was a surprising conclusion, as many psychologists currently provide supervision to graduate and primary mental heath care workers as well as other care workers in the community. The learning disability services have numerous examples of high-intensity workers providing supervision to care staff within residential and community settings (Baum & Lynggaard, 2006). Equally, it suggests that these clinicians could not benefit from education themselves to adjust to a new way of working. There are supervision programmes that have been developed which take into account the organisational service contexts amongst them the Applied Psychology supervision and consultation M.Sc at Surrey University.

The paper recognises the need for supervision as well as case management. Both are critical to the successful implementation of this service.The stress associated with call centres has been recognised and in this context the 'low-intensity workers' are selling a psychological product which has a differential impact on both the consumer and the seller to that of selling a holiday. The consequent human interaction or therapeutic relationship will be different. The impact on the 'low-intensity workers' themselves needs attention if they are to remain able to listen in an active responsive manner and not to become dominated by through put for its own sake. They will need to have the capacity to remain critical and to be able to respond to unique presenting issues. Experienced clinicians who are able to pick up on both the obvious and the unhelpful subtle negative impacts on the staff will be necessary for the sustainability and quality of the service offered. The use of experienced supervisors who are cognisant with burnout would provide benefits rather than hindrances.

Our major concern, though, lies in the directions apparent in the politicisation of the IAPT agenda and its rather single minded interpretation:

- IAPT seems organised around CBT and its derivatives, despite protestations to the contrary;
- clinical psychology training and provision is broader than a psychological psychotherapies agenda, but we fear this has become obscured; and
- whatever happened to community psychology, where social and community action was rooted in the research and practice around interpersonal support, the development of social support and accessible, responsive and confiding relationships?

We would not wish to preside over a refiguring of the role of clinical psychology that leaves us as providers of a CBT approach to human well being.

Apologists for the IAPT agenda (for which read adult mental health and CBT agenda) make it clear they realise that people and their families, and their communities of support benefit from a range of responses and resources. However, debates and arguments have fast become polarised around the delivery of CBT in its many forms. We are both trained in CBT, and recognise its usefulness. CBT offers us some really important life skills. Speaking personally, these are skills that are learned and developed across the lifespan, in the context of our many and varied relationships. But as an encompassing approach, it has its limitations.

We wish to resist the notion that we are secular priests, in that we help people feel better about difficult living conditions, living in difficult relationships and living with circumstances that are not easily changed, such as domestic violence, homelessness, unsatisfactory intimacy, bereavement, longstanding conflict, intergenerational trauma, chronic illness and so on. Psychological well-being and distress does occur in a context. CBT has enormous potential to reframe, as do many of the other individual psychotherapies, and this can help lift mood and re-energise us for a different approach to problem solving. But it does not have social action as its focus. The RCTs at best can only show that two-thirds of people are helped. Is it wise to think that the remaining third might well find their way to clinical psychology services and to wonder what a range of responses might look like. We take the view that this is a matter of accountability – that choice in public sector services is an ethical issue.

Another striking feature of the Richards and Suckling paper is the use of language in the narrative. We were struck by the use of medical model analogies through out. Given that the entire point of developing this service was to offer an alternative to pharmacology, we think it was unwise to confuse the two philosophies. If the 'dosage' of psychological intervention moves into common parlance, we are going to decrease the community's appreciation and understanding of mental health issues and are likely to increase stigma and prejudice and exacerbate social exclusion.

We recall the Management Advisory Services (1989) review of clinical psychology in the early 1990s in which three levels of conceptual skill and practice were documented:

- generic counselling skills;
- prescriptive approaches;
- formulation.

The uniqueness of clinical psychology at that time lay in the ability to draw on a range of ideas and models and integrate them into a conceptually eclectic practice base. As trainers, we are pleased to see that the theoretical development of CBT is moving in the direction of an appreciation of contextual and relationship determinants of behaviour that may well maintain current stress and distress. We would like to see a move back to social action – to helping people work together in communities, combining resources, developing social support and building and rebuilding trusting relationships alongside the current determination to focus on the individual. Finally, we shall rest more easily when we see that other age groups are given equal consideration, in a more lifespan-oriented approach to well-being in our families, relationships and communities.

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Reflecting on the clinical, organisational and methodological implications of the Doncaster IAPT site: A commentary on Richards and Suckling

Stephen Kellett & Linda Matthews

In this paper we identify the many and varied benefits, but also the potential clinical, organisational and scientific concerns, of the Improving Access to Psychological Therapies (IAPT) demonstration site in Doncaster.

THE DONCASTER MODEL is obviously organisationally distinct from what has come before in the UK in terms of a mental health service delivery model. The model takes an unapologetic 'high volume, low intensity' approach to psychological care, in which the vast majority of contact with clients is via the telephone and 'case management' is the orthodoxy. The Doncaster demonstration site benefits from being new and therefore not apparently entangled in extant NHS organisational systems, which are notoriously anarchic, glacially paced and resistant to change.

The project is certainly innovative and Richards and Sucking need to be praised for taking the clinical throughput bull by the metaphorical horns. The integration of information technology into clinical pathways to support ongoing care decisions needs also to be applauded. The model is also a good example of New Ways of Working (DoH, 2007), whereby more experienced and skilled staff utilise their time to train, direct and supervise the work of less qualified staff. The Doncaster site also enjoys the advantage of close links with the local Condition Management Programme (group-based CBT self-help for Incapacity Benefit claimants), which is a marked organisational advantage. It is worth noting that many parts of the UK may not have benefited from any exposure to Condition Management teams as yet.

Organisational issues

Richards and Suckling (2007) present the model as though clinical work undertaken in the two service tiers ('high volume, low intensity' as step 1 and 'low volume, high intensity' as step 2), are minor variations on the unitary continuous theme of cognitive behaviour therapy (CBT). In step 1 of the model, clients are achieving assistance undoubtedly, but to call this CBT is plainly misleading and would be far better labelled as 'cognitive behavioural skill-based support'. After all, clients are being treated with medication and the IAPT input appears to be a means of rapidly supporting medication management and adherence, whilst adding in some cognitive and behavioural advice. Clients in step 2 are receiving CBT (and also probably medication) and lucid distinctions should be made between the services offered between the two tiers, rather than confusing the issue with the mistaken notion of 'doses.'

It seems that here Richards and Suckling have crucially confused service step, with that of 'dose' of therapy. Dose-effect evidence (Howard et al., 1986) uses the individual session as a natural quantitative unit of psychotherapy, which is universal across modalities. Therefore the IAPT client that receives five sessions of telephone-based case management in step 1, is receiving the same 'dose' of help as the client receiving five sessions of CBT in step 2. Richards and Suckling seem to be implying in some form of medication metaphor, that step 2 CBT is inherently a 'stronger' dose of 'CBT,' than that delivered in step 1. This mistake is unfortunate in that it does little to encourage the positive elements of the initiative and everything to emphasise scaremongering. This is perhaps best evidenced by the latest press release from the chair of UKCP, James Antrichan (October 2007), publically decrying CBT in relation to the £170 million which has been awarded for the promotion of psychological services, based on the initial (and indeed partial, as yet) evidence of the success of the IAPT sites. The accurate definition of steps in the Doncaster IAPT service would allow the boundaries of such tiers to emerge more clearly and would do much to ease any associated service changes in other Trusts regarding IAPT initiatives, to be a smooth and well-handled organisational change process.

Clinical issues

In terms of the stepped care model, Richards and Suckling state that when a client has not progressed or benefited from step 1 care, then they are 'stepped-up.' Though this may make sense in terms of clinical need at the time; from the perspective of a client, then how is this news received and experienced is open to question. Clients often present with failure related schema and it is possible that 'stepping up' may inadvertently trigger such schema, and cause client withdrawal from services or alternatively negate the effectiveness of step two provision. Richards and Suckling also provide the example of clients presenting with PTSD being allocated straight to step 2. This appears fine, but leads us to ask what disorders are and are not allocated straight to step 2 and also the clinical profiles of clients requiring to be stepped up. Clients requiring to be 'stepped up' seem to be somewhat of an irritation to such 'high-volume, low-intensity' services.

Client choice appears an issue (and this is true of most NHS psychology services), in that clients are offered what is locally available and the notion of client choice is poorly considered. Clients are often not in a position to be knowledgeable about what type of service they want or need and services typically collude with this ignorance, by giving clients what they themselves want to provide. The Doncaster IAPT model appears usefully unburdened by risk management issues, but there does appear to be a need for a compromise to be more effectively struck, between the risk-averse practices of secondary mental health care and the need to develop responsive and rapid primary mental health care services.

Methodological issues

Although models of service delivery often have little to do with methodological issues; there are aspects of the IAPT provision that do beg methodological concerns. In short:

- the issue of co-morbidity (particularly that of the co-morbidity of anxiety and depression, which is rampant in most primary care settings (Niles et al., 2005), never appears to be mentioned in terms of the stepped care model:
- the diagnostic validity of the label of a common mental health problem (i.e. anxiety or depression) is not addressed;
- any evaluation efforts will be bedevilled by the normal range of threats to internal validity, inherent and intrinsic to any practice-based psychological evidence (Margison et al., 2000) and particularly that of 'natural recovery phenomena' from common mental health problems.

It is worth noting that it also seems that the PR for the Doncaster site, via the internal evaluation which has focused purely on outcomes (Richards et al., 2007), has raced ahead of the external DoH-funded evaluation, which will focus more widely on comparative costs and outcomes, organisational systems impacts and the patient experience and the acceptability of demonstration services (Parry et al., 2007). Although contemporary evidence is useful and policy moves on apace, the external evaluation should be the anvil against which the questions of clinical and organisational effectiveness are hammered out and ultimately where policy decisions concerning the demonstration sites are made.

Conclusions

The Doncaster IAPT site presents a new means of delivering psychological services in an explicit stepped care model. As such, the site represents a good example of attempting to organisationally address the throughput and management of clients presenting with common mental health problems. A real concern is that:

- in the race to develop services for people with common mental health problems, the needs of clients with more complex psychological disorders will become a commissioning backwater
- the skills and experience of staff delivering psychological care to clients with complex needs (across the modalities) are negated, or seen as unnecessary and expensive irrelevance.

Perhaps better understanding and inclusiveness through dialogue, particularly in relation the next stage of funding coming on stream, will see a shift in thinking in less enthusiastic colleagues. We await the results of the external evaluation of the IPAT demonstration sites with added interest.

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The Doncaster model: A New Ways of Working for Applied Psychologists perspective

Tony Lavender

THE PAPER BY Richards and Suckling (2007) is both timely, given the roll out of IAPT services, and challenging of traditional ways of delivering services. The service at Doncaster has tried to get to grips with delivery problems that have faced psychological services for many years. We will need to develop new ways of working to tackle these problems and the Doncaster model provides some good ideas and experience on which to draw.

Client numbers

The most fundamental issue concerns the number of people with psychological problems requiring therapy. Even a passing familiarity with the epidemiology of psychological problems makes the issue crystal clear. The Office of National Statistics (ONS) survey of psychiatric morbidity indicates that in adults aged 16–65 the prevalence of neurotic disorders (mainly anxiety and depression) is about 160 per 1000 population (Meltzer et.al., 1995). The population of England is approximately 51 million, which means at any one time there are approximately 8 million people with a neurotic disorder. Singleton and Jarvis (2003) estimate the rate of onset of neurotic disorders to be 6 per cent, that is, approximately 3 million new cases each year. Boardman and Parsonage (2005) estimate that about 60 per cent are detected by GPs which means the number of detected neurotic disorders is approximately 4.8 million and the number of new cases per year 1.8 million. Most health service planners' reaction to these figures is similar to my reaction to learning how many light years the edge of the universe is away. Current service designs do not really acknowledge these numbers and whilst the stepped care model will not solve all the issues, the offering of low intensity interventions of the kind described in Doncaster at least provides a way forward.

Neglect of psychological health promotion

These large numbers raise the issue of how the flow or the occurrence of psychological disorders could be reduced. This level of 'unhappiness' in Layard's terms implicates social, cultural and political issues way beyond familial and individual understandings of psychological distress. The services that have been most neglected in mental health are those concerned with psychological health promotion and ill-health prevention. As Boardman and Parsonage (2005) point out, 'there are no nationally accepted models for mental health promotion or guidance' (p.11). It obviously requires a conceptualisation of psychological problems that incorporates the impact of poverty, social exclusion, unemployment and poor employment practices into our traditional familial and individual formulations. Attempts to address social exclusion early in children's lives and creating psychologically healthier family, work and community environments are key.

New roles and career structures

The Doncaster model was never intended to tackle psychological health promotion, but it does begin to try to address the huge demand for psychological services through the use of case managers. These workers were clearly new to the mental health workforce although 30 per cent ($N = 6$) were primary care graduate mental health workers. Once employed, they all received a specially commissioned training programme which was carefully designed to improve competence.

A major issue, that is particularly important from a New Ways of Working perspective, concerns the sustainability of these new roles. In reviewing the primary care mental health worker initiative two major lessons emerged, (Taylor & Lavender, 2007). First, to create sustainable roles thought needs to be given to the career framework associated with these roles. The second lesson was that if the role is to be successful it needs to fit with the service design. Clearly, the case managers fitted in to the Doncaster design. If a similar model is rolled out across the country, this second lesson will be addressed but what is less clear is the workers' career prospects. Much has been invested in these people, but most will not stay as care managers as a career.

There are of course possibilities for them to take further CBT training or develop supervisory skills, but at the moment what this means in career terms remains unclear. Vague hopes about the knowledge and skills framework creating new career possibilities need to be realised. There are possibilities, including integrating into existing career frameworks or moving into a new psychological therapies career framework (Taylor & Lavender, 2007; Turpin, 2007).

Case managers therapeutic roles and evaluation

In the Doncaster model the therapeutic role of case managers appeared more limited than was originally intended. The case managers appeared to carry out reasonably thorough assessment of the problems and risks. They also offered access to CBT reading material, assisted clients in understanding the reading and referred on. It was less clear what else was offered by case managers, as the use of the CBT CD-ROM material proved problematic and the impression given was that it was rarely used. The so called 'non-specific' factors of psychological therapy may be playing a more important role than is recognised. (Roth & Fonagy, 2004). Clearly, the clients' views of what they considered to be helpful would be of considerable interest and hopefully forms part of the evaluation.

Commissioning of new roles

An important issue, related to the sustainability of the new roles concerns how the training will be commissioned. There are serious problems if it is envisaged that PCTs take this role. The problems for PCTs include their lack of experience in commission training, the low priority that will be given to training commissioning and the problems for higher education institutions in having multiple, relatively small contracts with PCTs which leads to high contracting costs. The simple answer involves putting the commissioning in the hands of the strategic health authorities as they have the relevant staff and experience.

Shortage of high intensity therapists

The shortage of high-intensity workers was an emerging problem in Doncaster. Just under 10 per cent of patients are stepped up from low-intensity to high-intensity treatment. Nevertheless small waiting list for high intensity CBT had developed. The problem was put down to local difficulties with recruitment. This is not just a local problem (Lavender et al., 2005), and certainly if such services are replicated this will produce a growing demand for staff able to deliver high-intensity services. The major two sources of such therapists are clinical psychologists and other professionals (in particular nurses and counsellors) with a specialist training in CBT. In recent years, in spite of recommendations for a 15 per cent increase in clinical psychology commissions, there has been a small decrease (Workforce Review Team, 2006). Further, as far as CBT training for other professionals is concerned, there has been little in the way of a systematic attempt nationally to commission such training.

Supervision issues

There are two significant issues relating to supervision raised by the Doncaster model. The first concerns the availability of clinical supervision for both the low-intensity and high-intensity staff. Clinical supervisors are required both during training and also after training as part of the development and clinical governance arrangements. If the major source of supervisors is clinical psychologists and other professional staff with specialist CBT training, and these are in short supply, there are likely to be too few supervisors available. This situation threatens the sustainability of the IAPT initiative nationally. Whilst funding for new staff is included in the IAPT funding, there is a need to free existing staff from some of their duties to offer supervision (Cate, 2007) as well as commissioning more training (i.e. advanced CBT and clinical psychology) of groups likely to become supervisors. It needs to be recognised that training staff for mental health is as important as staff for the acute medical sector and indeed there is a case for redirecting some of the money from overtraining towards mental health (Health Select Committee, 2007).

The second supervision issue is that it became apparent that the staff supervising case managers were not well equipped to provide advice and guidance about how best to carry out these new roles. Richards and Suckling seemed to develop a solution that meant the bulk of the supervision was provided by one individual. It would have been very interesting to know how a single supervisor coped with the number of supervisees and their patients. The training of specialist supervisor competencies seems important to share if the Doncaster model is rolled out and appropriate clinical governance arrangements are to be put in place.

Applied psychologists' role

As far as I understand the Doncaster project, there were few, if any, applied psychologists involved. Whatever the reason, this seems unfortunate as there are clearly a number of roles which they could have taken. This issue is particularly important for the widespread implementation of IAPT because many applied psychologists will become involved in the organisation and delivery of such services, particularly where they have a history of being involved in primary care services. There are particular roles that psychologists might offer, including leading and managing such services, offering supervision (although they are likely to need to adapt from their high intensity work experience), training staff, evaluating the effectiveness of the centres and offering high intensity therapeutic input.

In conclusion, as the national implementation of IAPT gathers pace, psychologists need to be ready to engage in what promises to be a great opportunity to put psychological care more firmly on the map of mental health.

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Our big fat multi-million pound psychology experiment

John Cromby, Bob Diamond, Paul Moloney, Penny Priest, David Smail & Janine Soffe-Caswell

'The 'Improving Access to Psychological Therapies' (IAPT) Programme is a multi-million pound effort to test the Layard hypothesis' (Richards & Suckling, in this issue).

Who are the participants?

In making their case for the IAPT experiment, Richards and Suckling and the Centre for Economic Performance (2006) quote the 'respected' *Psychiatric Morbidity Survey* to outline the scale of mental health problems: one in six of us would be diagnosed as having depression or chronic anxiety disorder (CEP, 2006), and anxiety and depression constitute about 97 per cent of the total prevalence of mental health disorders (Richards & Suckling, 2007).

In a previous survey (Office of National Statistics, 2000) the prevalence of 'neurotic disorder' was calculated on the basis of lay interviews. Neurotic disorders were assessed by first-stage interviews, carried out by ONS interviewers who had been on a one-day course of 'survey-specific training' (p.10). Psychosis and personality disorder, on the other hand, were assessed by second-stage interviews, carried out by 'specially trained psychologists' (p.9). The report goes on to caution that 'lay interviewer administered measures tend to provide higher prevalence rates for disorders than those that are clinician administered' (p.13).

The question of who the participants are in the IAPT experiment is never clearly explained. Richards and Suckling specify 'mild to moderate depression and anxiety'; the CEP refers to 'crippling depression and chronic anxiety' (p.1). Elsewhere we are told IAPT is about providing services to 'people with 'common' mental health problems such as anxiety and depression' (CSIP, 2007a). This problem and its relationship with NICE guidelines is explored in an editorial in the *British Medical Journal:*

> People with mild to moderate depression or the associated mixed anxiety and depressive disorders constitute most of those whose care might be influenced by [NICE] guidelines ... These are mostly subthreshold disorders where identifying the presenting difficulty as a treatable pathology may be inappropriate (Middleton et al., 2005, p.267).

NICE also acknowledges in its *Guidelines for Depression*:

> the most significant limitation [of the evidence base] is with the concept of depression itself. The view of the Guideline Development Group is that it is too broad and heterogeneous a category, and has limited validity as a basis for effective treatment plans'(NICE, 2007, p.10).

It is interesting but also worrying, that services plan to implement recommendations that NICE suggests have limited validity.

Psychological therapy as the independent variable

Let's pretend that there are illnesses called depression and anxiety. Let's pretend that our participants are people diagnosed with mild to moderate depression and anxiety, that they have all been diagnosed with the same screening tool by the same expert psychiatrist. We are now planning to increase the psychological therapy available to these people in order to increase well-being and decrease Incapacity Benefit payments.

In our experiment, the independent variable is the psychological therapy. But do we mean psychological therapy wholesale, or one psychological therapy in particular? Most people working in mental health services are aware that NICE recommends CBT for both depression and anxiety. However, there are problems with the NICE guidelines:

> [There are] significant limitations to the current evidence base … These include very limited data on both long-term outcomes for most, if not all, interventions … In part, these limitations arise from the problems associated with the randomised control trial methodology for all interventions (NICE, 2007, p.10).

Middleton et al. (2005) offer further appraisal of the evidence base:

> [The] contrast between clear evidence based recommendations for the management of severe depression and uncertainty, because of poorer evidence, about the management of mild or moderate depression is the central weakness of the guidelines … Until research has established who is likely to benefit from active treatment, practitioners will continue to be tempted to respond to requests for help by allowing such negotiations to result in a medical diagnosis. This may satisfy the practitioner's desire to do something and the patient's search for help. What it does not do is reflect the evidence base (p.267).

CBT as the independent variable

Let’s pretend that the NICE guidelines are in fact conclusive and that we can say with certainty that CBT does indeed substantially increase well-being over the long term and helps people back into work. Which type of CBT shall we choose? The NICE authors, McIntosh et al. (2004) explain that:

> The nature of psychological therapies [has] *(sic.)* changed and what was described in the 1970s as cognitive behavioural therapy and that described in the 1980s and onwards, may have been describing quite different interventions (p.45).

Indeed, far from CBT being a standardised, distinct technique, Tarrier et al. (2002) suggest that in practice, CBT may actually be indistinguishable from ‘interpersonal psychotherapy’, which is informed by a very different theoretical viewpoint.

At the Doncaster demonstration site, guided by NICE recommendations, they have specifically chosen low-intensity and high-intensity variants of cognitive behavioural therapy, under the framework of the stepped care model. Richards and Suckling explain the difference between high and low intensity variants as follows:

> High-intensity treatments usually involve considerable therapist input akin to traditional therapy models. In contrast, low-intensity treatments emphasise patient self-management with much less contact between mental health workers and patients, for example by the use of guided self-help.

NICE also specifies that ‘Healthcare professionals providing psychological treatment should be experienced in the treatment of the disorder and competent in the delivery of the treatment provided’ (p.19). This is echoed in the *Depression Report*:

> Therapy is not like anti-depressants; it differs according to who provides it. We know how well it can work if it is provided by properly qualified people, and most studies suggest it is much less effective if given by less qualified people (CEP, 2006, p.8).

However, this may be at odds with Professor Richards’ own vision of depression management in primary care, which involves developing teaching for new non-professionally affiliated mental health workers.

Stepped care and collaborative care as independent variables

Let’s pretend that we are clear about exactly what sort of CBT we are providing, exactly how long it is going to last, and that we can be sure that this is provided in exactly the same way each time and that our CBT is therefore both reliable and valid.

But perhaps the independent variable is not psychological therapy, or CBT, but rather access to psychological therapy, or perhaps delivery of psychological therapy. Richards and Suckling assert that these are important aspects influencing the success or otherwise of psychological therapies:

> Although the evidence for the efficacy of some psychological therapies is strong, the evidence for their organisation is less so.

The IAPT expert reference group (ERG)

> made the pragmatic recommendation that the stepped care approach… should be used (CSIP, 2007b).

However, Richards and Suckling acknowledge that,

> Although based on the common sense proposition that it is as harmful to overtreat as undertreat common mental health disorders, NICE guidelines provide little evidence to support the implementation of stepped care.

In order to test out different models of access to and provision of psychological therapies, the Doncaster and Newham sites have,

> adopted different operating principles: the London site a specialist 'replacement/referral' model familiar to specialist mental health services; the Doncaster site a 'collaborative care' model more common in the US and in UK primary care (Richards & Suckling).

We are being asked ultimately to draw conclusions and make comparisons about the effectiveness (and efficiency) of stepped/collaborative care vs replacement/referral models of care before we've even got any definitive answers about the effectiveness of CBT or other psychological therapies. It is difficult to see how we can draw any conclusions about the Doncaster Site experiment, when there are so many variables at play.

The Doncaster demonstration site as a case study

Tarrier et al. (2002) are highly critical of the use of anything other than randomised control trials to evaluate the efficacy of psychological therapies. They argue that 'the RCT is the primary source of evidence for the efficacy and effectiveness of any treatment.' Furthermore, they highlight the methodological problems in evaluating any therapy and how non-specific factors, such as a therapist's theoretical orientation, can have a greater effect on therapeutic outcome than the specific therapeutic techniques themselves.

Let's pretend, then, that this is not an experiment to test the Layard hypothesis. We are, instead, conducting a case study of the Doncaster Site to look at what happens when psychological therapy is made more widely available. Indeed, a team from Sheffield, led by Professor Glenys Parry, has been awarded a contract to evaluate these pilots by the NHS National Collaborating Centre for Service Delivery and Organisation. Funding for this study started on 1 December 2006 and will last for three years. A draft evaluation report will be written in the final year (2009) to allow stakeholders to comment. The final report will be published in conjunction with the SDO in 2010.

Let's pretend that we actually know the results of our study already and that it has been so successful that we now feel in a position to expand on these developments. Actually, we don't need to pretend because CSIP is pretending on our behalf. On 10 May 2007, CSIP published its plans for the next stages of IAPT. They report:

> It is important that we build on the success of the demonstration sites and continue to develop our evidence base. To address this, the Department now seeks to extend the scope and range of the IAPT programme in 2007/8 to support the case for further service expansion by demonstrating that the benefits of the new service can be replicated across the country' (CSIP, 2007c, p.7).

Let's pretend…

Actually, let's stop pretending.

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DCP West Midlands Branch Annual General Meeting

Wednesday 13 February 2008; Uffculme Centre, Queensbridge Road, Moseley, Birmingham B13 8QY

Programme

12.15 Lunch

1.15 **Welcome** – Alan Kessedjian, Chair DCP West Midlands Branch **Branch AGM**

2.0 **Are Psychological Services fit for purpose in the West Midlands?**
Paul Chamberlain, Professional Advisor for Psychological Services, Solihull Care Trust
Ivan Burchess, Consultant Clinical Psychologist, Head of Psychological Therapies, Wolverhampton City PCTl
Richard Ball, Consultant Clinical Psychologist/Clinical Director, Coventry Psychological Services

3.30 Finish

The Committee would like to invite Branch members to lunch (no charge) prior to the AGM. If you intend to come to the lunch, please inform Irene Aggus – irene@aggus.freeserve.co.uk.

Doncaster: What we still need to know and what we can learn from it

Roger Paxton & John Cape

Dave Richards and Rupert Suckling are to be congratulated and thanked for their clear and timely paper which does what it sets out to do: describing the Doncaster IAPT model and the rationale for its adoption. It does not describe clinical outcomes or patient satisfaction, although our appetites are whetted by the last sentence which says that these are excellent and are to be reported in a later publication. Implications are also not considered, and this is appropriately cautious until results are available, However, the work in Doncaster is so innovative and important that we should consider possible implications immediately. In this commentary we discuss some questions not answered by Richards and Suckling and then go on to draw preliminary conclusions and suggest implications.

What Richards and Suckling don't tell us

The first thing we would like to know more about is the people using the service. We are told that they were identified as suffering from anxiety or depression but not the severity of these problems nor anything about co-morbidities. We know that co-morbidities and concomitant social problems are common, and that they present challenges to the translation of efficacy research into practice and to the use of manualised treatments. We know that ethnicity and lack of English as a first language act as barriers to uptake of psychological treatments. How do the case managers in Doncaster and the systems they work with assess and take account of these?

The second thing we would like to know more about is what would happen to the people using this service if it did not exist. Is the Doncaster model improving access to psychological therapies for people who would previously have received nothing except self-care and GP care, or is it providing quicker access for people who would otherwise have waited for conventional psychological therapies?

Thirdly, we would like to know why the model is described as collaborative care. It clearly includes important additional therapeutic ingredients in the form of a new staff group, providing a service that did not exist previously, by innovative means, and using new clinical materials, including a bespoke clinical guide. However, central to most definitions of collaborative care is close structured collaboration between case managers and GPs in the delivery of a common care plan for pharmacological or psychotherapeutic treatment (Von Korff & Goldberg, 2001; Wagner & Simon, 2001). We are told that the Doncaster case managers assisted patients with pharmacological treatment via medication support, but not what this entailed nor any information about liaison between case managers and GPs. Many clinical psychologists, especially when working in primary care, enquire after and support patients' medication adherence and liaise closely with GPs, but this is not collaborative care. Collaborative care models involve high levels of liaison, usually determined by protocols and structured through the GP and case manager sharing a common record system.

Fourthly, we need to know more about how decisions are made to step up patients from low-intensity case management to high-intensity CBT. The authors indicate that fewer than 10 per cent of patients are stepped up, but also that Doncaster has had difficulties in recruiting CBT therapists leading to waiting lists for CBT. Patient flows and referrals are notoriously influenced by capacity limits and waiting times. Would more patients have been stepped up if Doncaster had invested in and successfully recruited more CBT therapists and fewer case managers?

The final thing we would like to know cannot be known yet but is extremely important and must be answered in the future: can the case manager role be made sustainable in the longer term? This role, and especially the employment histories and training of the incumbents, are some of the boldest features of the Doncaster experiment. There is continuing anecdotal evidence of dissatisfaction and high turnover in the rather similar new roles of graduate worker and psychology associate. Firm evidence on this must await the completion of the national evaluation of the new roles, but in the meantime, what is being done and what needs to be done so that if Doncaster turns out to be a success it can be sustained?

Learning from Doncaster

So, notwithstanding these gaps, what can we learn from Doncaster and what should we (clinical psychologists – the intended readers of this journal) do about it? The first and most obvious learning point is that the systems and processes are innovative, impressive and at least partly applicable much more widely. Doncaster has thought big in developing systems that can potentially meet the needs of the whole population with depression or anxiety. By contrast, the systems in use by clinical psychology services are cottage industries serving the needs of a select few patients whom GPs happen to refer from the many they could refer. Doncaster's selection of case managers on the basis of interpersonal aptitude and commitment without regard to prior training or experience is daring. For those of us who struggle daily with NHS information systems the information system described here is only to be dreamed of. The acceptance of and adherence to data-based clinical protocols are things most of us are still discussing. The way in which supervision is specified in terms of functions and processes appears a model of clarity and safety. The emphasis on telephone contact combined with systematic outcomes monitoring is a fresh approach to combining efficiency with safety.

The independent evaluation may find that Doncaster does not work after all, or it may not turn out to be sustainable, but even so, its processes contain lessons for psychological therapy services. Our first conclusion, therefore, is that Doncaster should be a rich source of possibilities for system improvements.

Secondly, it is another prompt for us to consider, clarify and focus our roles and relationships with other services, including further centres like Doncaster which we now know will appear following the Health Secretary's announcement of an additional £170m for psychological therapies. We must work with the new services, supporting and in turn being supported by them. We are typically good at generating new ideas, but much less so at putting them into practice. In the emerging world of multiple providers we need to think and act more quickly, and we certainly have the ability to do so. The *Good Practice Guidance on Improving Access to Psychological Therapies*, just published (CSIP/BPS, 2007), demonstrates substantial changes and not just good ideas by psychology services on service redesign, improving care pathways, supporting other services, developing and using the evidence base and ensuring good governance.

Thirdly, we need to find ways of bringing together our perspectives as therapists on individual patient needs with large protocol-based systems designed to meet the needs of populations. Richards and Suckling report that they stopped using CBT therapists as supervisors of the case managers as the CBT therapists found it difficult to adapt their supervision style to high-volume low-intensity work. Clinical psychologists need to find ways of doing this and ensuring that systems are responsive to individual needs, within available resources, as well as the needs of the population.

Fourthly, as we clarify roles further we must avoid a tug of war between services for common mental health problems and those for more severe problems. Richards and Suckling begin by drawing attention to the huge prevalence and costs of common mental health problems, but only a little over 10 years ago many of us were concerned to reverse the widespread drift of services from people with severe mental health problems to the group caricatured as the worried well. The pendulum must not swing back again: there needs to be a balance.

Finally, having noted that Richards and Suckling did not set out to describe results from Doncaster, we note in passing the usual, but still rather surprising, gap between health policy and evidence. This is not to criticise Richards and Suckling, who note that the evidence for stepped care (one of the central principles embodied in the Doncaster model) is lacking, and indeed Richards is doing something about this by leading a major national research project that is developing and evaluating stepped care systems. On top of this, the announcement of the additional £170m, with glowing comments about the Doncaster and Newham demonstration sites, seems to indicate that conclusions about their effectiveness are being drawn long before the completion of the independent evaluation, due in 2010. The additional funding is very welcome, of course, but wouldn't it be nice if evidence preceded policy once in a while?

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Commentary on 'Improving access to psychological therapy: The Doncaster demonstration site organisational model' by Richards and Suckling

Stephen Pilling & Antony D. Roth

The Improving Access to Psychological Therapies (IAPT) programme is the most important development in psychological treatment services in England since the inception of the NHS, and Richard Layard and his colleagues are to be congratulated for their work in promoting it. Richards and Suckling set out a convincing case for the development of the programme, especially the need to rebalance the distribution of resources between common mental health problems and serious mental illness. Throughout their paper they place considerable emphasis on evaluation, which we see as essential to the success of the programme. If the IAPT programme, which is perhaps too reliant at present on a single therapeutic modality (CBT), is not able to demonstrate (and sustain) effectiveness, then the damage to the provision of psychological therapies will be considerable and possibly irreparable. We therefore believe it is essential that the programme is built on a strong, broad base of evidence for treatment effectiveness and that serious consideration is also given to the training and organisational systems to support the programme. In our commentary we review the evidence put forward and then consider the implications for psychological treatment services and clinical psychology services in particular.

Richards and Suckling identify the low take up of evidence-based psychological interventions as a problem and then go on to suggest that this demonstrates a failure of NICE guideline implementation. Whilst dissemination and implementation of guidelines is far from straightforward (Grimshaw et al., 2004) we are not sure that the evidence they cite supports their argument. For example Bebbington et al.'s (2000) study, was undertaken some years before the relevant NICE guidance was published (e.g. NICE, 2004a, 2004b). NICE guidelines can positively influence practice, as they have Layard, and there is evidence to support this (Sheldon et al., 2004; HCC, 2007). This is important as we believe (along with Layard) that a substantial problem, if not the substantial problem, lies with a basic lack of provision of psychological therapies.

Richards and Suckling first present a brief review of the evidence in support of the model developed in Doncaster. We are sympathetic to this model and admire their commitment to its continued evaluation. In particular, their description of a coherent system for the assignment to low intensity and high intensity interventions shows the potential for improving access to, and the cost-effectiveness, of psychological interventions.

In our report on the competences required to deliver CBT (Roth & Pilling, 2007) we consider low-intensity interventions to be potentially valid interventions in their own right and not a second best alternative. However, it must be acknowledged that the evidence for the long-term effectiveness of low intensity interventions is more limited when compared to high intensity interventions (NICE, 2004a, 2004b). This is a particular problem in depression where the long-term outcomes of treatment are modest and has not been sufficiently acknowledged by Richards and Suckling. In addition, although the limitations of the evidence for stepped care are acknowledged, the evidence for collaborative care, at least as it applies to the UK, may be over stated. The effect size they quote (0.24; Bower et al., 2006) is modest and questions must be asked about its cost effectiveness in the UK. Richards and Suckling also quote effect sizes from two recent UK studies of collaborative care (Pilling et al., 2006; Richards et al., in press) which are larger than those typically reported in US studies, and it is possible that the greater emphasis on psychological interventions in these studies compared to many US studies may account for this.

This raises the question of whether the replacement model may be as effective as the collaborative care model. Some support for this view comes from a recent meta-analysis by Cape et al. (in preparation) where the replacement model had an average effect size of 0.27 compared to 0.29 for collaborative care.

However, these concerns should not stand in the way of the developments in Doncaster or alternatives models: they should be addressed by the rigorous evaluation. The increased investment in psychological therapies must be matched a parallel national research programme into psychological therapies. The collection of routine outcome data, whilst important, will not be sufficient to answer some key questions; large scale randomised controlled trials are required. Not to use the IAPT programme to do so would be a scandalous waste.

In addition to our concerns about the evidence base, Doncaster and the IAPT programme raises questions about the integration of psychological interventions into primary care. This is important as over 90 per cent of common mental health problems are managed in primary care. We are concerned that the focus on a central point for the organisation of services may impair coordination of care (particularly for those with recurrent problems) and that once the enthusiasm of the start-up has faded that this could lead to a rigid and bureaucratic system for referrals. Richards and Suckling set out the arguments for a more centralised system, but other models providing low-intensity interventions such as those developed in Camden (Leibowitz, 2007) have managed similar volumes of referrals whilst achieving greater integration with primary care. Richards and Suckling also set out an impressive system for support and supervision which is based on a protocol-driven approach to treatment. This is important to the success of the programme they describe but also has implications for all professionals delivering psychological therapies. It is to the implications for clinical psychology (and other psychological therapists) that we now turn.

The IAPT programme and the models that will develop from it have significant implications for clinical psychology. We believe that they represent a unique opportunity for the profession to establish a central role in the provision of psychological therapies, but that will only be achieved by a significant restructuring of the way many services are provided. The increased provision of low-intensity interventions, and the stepped care systems to support their implementation, are an essential first stage in the necessary changes. Clinical psychology's role becomes one of supporting the design and management of such systems and of supervising and supporting the staff. This requires more than advanced CBT skills. Essential to this process are two factors: an increased use of protocol driven treatments and an increased emphasis on routine outcome measurement and its use in decision making. Neither has figured large in the work of many psychologists, but they will need to, particularly if we are to demonstrate our value in supporting the IAPT programme. This has implications for training; it is clear that relatively brief training to non-professionals can obtained equivalent outcomes for many individuals with common mental health problems, at least in the short term. Clinical psychologists should support the delivery of such programmes as Dave Richards and colleagues have developed in York and consideration should be given to the prior accreditation of this work when it comes to the selection and training of clinical psychologists. Quality control is major challenge in the provision of psychological therapies as therapist factors are probably the biggest single factor accounting for the variance in outcome of psychological interventions (e.g. Brown et al., 2005). This takes us back to outcome monitoring and the use of a competence framework to guide both supervision and training; they need to be part of routine practice. Evidence- based practice has arrived and the IAPT programme is built on it; psychologists should embrace the opportunity it provides and build alliances in primary care and beyond to ensure that they have a central role in its provision.

Declaration of interests

Both authors are members of the IAPT Expert Reference Group and have received DoH funding for work on competences for the IAPT programme. Steve Pilling has also received funding from NICE for the development of clinical guidelines and research funding to investigate both collaborative and stepped care models for the provision of psychological interventions.

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Psychology: A caring profession? An acknowledgement

Following publication of our study regarding clinical psychologists' knowledge of human rights in the November 2007 issue of *CPF*, we wish to acknowledge the input of Dr Rayhana Bhamjee, Principal Clinical Psychologist at St Andrew's Group of Hospitals, Northampton.

Dr Bhamjee provided supervision of the data collection and made some invaluable contributions in considering the implications of the study's findings. Many thanks to her and apologies that this acknowledgement did not appear with the original article.

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A view from Scotland

Jim White

Working in the Scottish health system, where the debate continues about how best to tackle common mental health problems, I have been intrigued by the way IAPT has developed. Doncaster seems far removed from the initial Layard proposals. Layard is essentially a 'more of the same' variant of the traditional model. Newham, a much more conventional approach, seems likely to fail – working in such a deprived, multicultural area always needed a very different service. Doncaster is attempting something more far-reaching and exciting.

Primary care has never been widely regarded as a specialist area and, subsequently, new specialist skills have, by and large, not been developed. A secondary-care model has prevailed, where individual therapy has dominated service provision and non-therapy roles have been neglected. Excessively long waiting lists remain full of people with complex, severe and chronic difficulties; entry routes to services are generally restricted to professional referral; little preventative or early intervention work is carried out; there is too little joined-up working with health, education, social services, the voluntary sector and communities; techniques overemphasise intrapsychic factors and underemphasise the role of social factors in aetiology and problem maintenance; high DNA and drop-out rates prevail. We have spent too long 'doing something about the waiting list'. Services see only the tip of the iceberg although if Layard really believes that we should create 800,000 mental health 'patients' each year, should we not instead be focusing on the societal factors that cause so much distress?

The Doncaster model: concerns and compliments

Common and enduring mental health problems

Anxiety and depression do not routinely disappear following therapy. They are, often, better seen as chronic conditions. Maybe the essentially 'cure' models we use (including in Doncaster) are not appropriate for a great many people we see. If so, should we expect a service based on short-term intervention guided self-help (which has a patchy history) to succeed in the long-term? I am doubtful about how far we can expect to quickly change people's lives and increasingly look to ideas from the recovery movement.

Is CBT as great as they all say?

There is a world of difference between the (often US) research centre studies with perfect patients treated in perfect circumstances and the people I see in my (CBT) clinic. Few of them would get near a research study. To generalise from research studies to my patients is simply bad science. The few decent studies on NHS patients do not suggest the superiority of CBT. There is no great evidence suggesting that CBT outperforms other approaches in NHS settings (Stiles et al., 2006); that it delivers long-term benefits (Durham et al., 2005) and no evidence for the superiority of psychological approaches (CBT and PCT) over GP treatment as usual (e.g. Ward et al., 2000). As with studies from the research centre world that do not fit with the current cognitive therapy dominance, for example Dimidjian et al. (2006), these studies are too easily ignored.

Deprivation

Deprivation has a massive impact. Put simply, those from more affluent areas attend and complete; those in the most deprived area, where prevalence is greatest, are much less likely to. We can say little about outcome because not enough people complete questionnaires at follow-up (this will be a problem for any NHS study). We do need to look seriously at the 'medicalisation of misery' argument. Many of the people I see are depressed because they think rationally – they understand all too well that they have awful lives. If we are to help those in deprived areas, we need a very different model with a much greater emphasis on the social in psychosocial. It is not clear to what extent this happens in Doncaster.

Attrition

This is a major, and often ignored, problem in primary care work: highly skilled clinicians may spend significant amounts of time sitting alone in a clinic when people fail to appear. Doncaster, by relying on phone therapy, goes some way to alleviating this problem. If someone does not answer the phone, the case manager simply phones the next person on the list. It will be interesting to see if this model reduces attrition rates.

Comorbidity

Why do we set up separate services for anxiety and depression when comorbidity rates are so high? Ideas from the negative affect literature seem more clinically useful. To what extent do people have to tackle both in Doncaster and, if so, how well does fusing two different guided self-help approaches work?

Initial contact

Any service that can contact people the same day they have seen their GP is to be applauded. This also gives GPs a genuine alternative to prescribing antidepressants. Presumably, quickly getting to people who have been motivated to get to their GP may help treatment adherence.

Phone therapy

Clinicians may complain that the interaction is poorer in phone therapy, but there is evidence for this approach and, in any case, it seems to me that clinic-based services can often push service users into an unhelpful passive state. They have to turn up when the therapist has a clinic; they have to get past a receptionist; they are told where to sit and wait until the therapist is ready for them. While we say CBT is collaborative, the person on the receiving end knows who really has the control. By phoning the person in their own home, presumably at a time suitable to them (does Doncaster offer help in the evening?), the person may be more empowered and more easily take responsibility for the therapy.

Caseloads

It has been estimated that the average clinical psychologist would see 60–80 patients per year. Doncaster case managers are expected to see 250. While we would assume they have less severe problems (although that assumption needs to be tested), can case managers keep up that pace? Will they burn out? Become bored doing much the same thing day after day?

The range of interventions

Doncaster mainly relies on two guided self-help programmes and cCBT. This is relatively restricted range. Perhaps the service agreements do not allow for other interventions, such as psychoeducational classes, interactive group work, pure self-help, advice clinics, day workshops, exercise classes, well-being approaches and expert patient-led approaches, that allow a more ‘horses for courses’ approach.

Community recruited case managers

This is the most radical aspect to the project. Choosing locally recruited people based on interpersonal aptitudes makes sense, combined with the relevant training and supervision. We have too often seen CBT simply as a technology and have neglected the human interaction and powerful non-specific factors – is it significant that fewest people appear to want the cCBT?

In a risk-averse NHS, there may be concerns that these workers are not skilled enough but perhaps another question should be asked: what are the potential risks to individuals in the future if they are prevented from accessing primary care mental health services perhaps at an earlier stage in their problems? This high volume service may offer aid in this respect.

It will be interesting to see how these workers compare to the graduate mental health workers. If they are successful, we shall have a huge supply of people readily available, relatively cheap to employ and quick to train in evidence-based approaches such as behavioural activation.

What does Doncaster not offer?

We have a lot more skills than just providing therapy at the sharp end. I would expect that most people accessing Doncaster, like most primary care services, already have severe, comorbid and chronic problems. If successful, should IAPT not expand its role to helping people at a much earlier stage in their journey? Do primary care services have a role in awareness raising to a largely mentally health illiterate society? Large numbers do not go to their GP due to poor understanding, demoralisation, stigma, etc. GPs miss or misdiagnose. Little preventative or early intervention CBT work is carried out. Can we work more closely with community groups? Should we be teaching CBT principles in schools? Should we work at the population level? There are many useful ideas in community psychology that could be utilised.

Implications for clinical psychology

It appears to me, at a distance, that psychology is essentially sidelined in IAPT. Although psychologists seem to be working closely with Layard, the people with the greatest influence in the IAPT projects that are actually funded are led by, in Doncaster, a nurse and, in Newham, a psychiatrist while Chris Williams, a psychiatrist, remains at the forefront of guided self-help. Clinical psychologists are being pushed out of primary care into severe and enduring but if they retain their often too precious approach to change, will they not also eventually lose influence there?

Conclusions

Doncaster is an imaginative, well-designed project. If I had to predict, I think long-term success will be hard to produce but it is a breath of fresh air with many excellent features that we can all learn from. It may also negate the modern adage that waiting lists – like death and taxes – will always be with us.

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Response to commentaries on 'Improving access to psychological therapy: The Doncaster demonstration site organisational model'

David A. Richards & Rupert Suckling

We are grateful to both the editor and the commentators for the opportunity to test the temperature of the reception to the Doncaster model. Not surprisingly, that temperature varies from warm, through tepid to icy cold.

Before responding to specific themes raised by commentators we would like to acknowledge Peter Bower (personal communication, 2007) for reminding us that improving mental health services, particularly in primary care, has five dimensions. Firstly, we must improve access such that service provision should meet the need for services in every community independent of geographic location. Secondly, that such services should effectively improve people's lives in terms of health status, function and quality of life. Thirdly, we must distribute resources efficiently to maximise health gains to society. Fourthly, resources should be distributed equitably across the population independent of culture, creed, class or other social identifier. Finally, what we deliver should be patient-centred and as 'closely congruent with, and responsive to patients' wants, needs and preferences' as possible.

In the UK, previous attempts to improve services have included education and training to primary care generalists. Whilst laudable and arguably scoring well on access, efficiency and equity, such initiatives have not been effective (Gilbody et al., 2003) and could be criticised for poor patient-centredness. Consultation liaison and collaborative care models are systems level interventions that have been developed to retain the advantages of education and training whilst addressing the effectiveness and patient-centredness deficits. Conversely, starting from the opposite organisational position, replacement referral models score highly on patient-centredness and effectiveness but are much weaker in terms of access, efficiency and equity. Stepped care is a system which attempts to address this through improving access, efficiency and equity whilst retaining effectiveness and patient-centredness. Pilling and Roth muse about the mechanisms of effect and the relative efficacy of collaborative care and replacement referral models. It is important to remember that their ideas are indeed speculative and we absolutely agree that they should be tested empirically. As we note above, effect sizes are not the only metric and outcome frameworks based on sophisticated analyses of the concept of access (Gulliford et al., 2001) should be utilised in any analysis.

Neither system is perfect nor clearly defined. Paxton and Cape are quite correct in challenging us about the model of collaborative care we use. We would argue that, far from being as closely defined as they state, collaborative care is a very heterogenous concept (Bower et al., 2006). Our version is based on a protocol developed from a clinical trial (Richards et al., 2006; 2007) and squarely meets three of the four criteria for a systems level intervention: a multi-professional approach to patient care, a structured patient management plan and scheduled patient follow-ups. In terms of the fourth criterion – enhanced inter-professional communication – in our view the case managers have a central role providing information and acting as a treatment conduit for patient-centred consultation liaison from expert clinicians to patients and GPs. This places Doncaster's organisational method firmly in the consultation liaison camp. Pilling and Roth suggest that greater GP integration could be achieved through worker dispersion. We note that there is a tension between centralisation and dispersion. Too much dispersion can damage service equity through multiple and different waiting lists or micro service models. In Doncaster we have wrestled with this tension and our compromise has been to allocate case managers to groups of GP surgeries geographically. We have retained a centralised referral system to allow managers to ensure that access to services is equitable across the borough.

A number of commentators question the concept of a psychological therapy 'dose', Gilbert wonders about the boundary between support and therapy, and Kellet and Matthews go so far as to suggest that almost none of our patients have been getting therapy at all. We disagree. Space precludes us from entering into the 'what is therapy?' debate, but we contend that alternative means of accessing psychological information and support (Rogers et al., 1999) are just as much therapy as the traditional system. Case managers and therapists in Doncaster work through a supportive therapeutic alliance, whether that is on the telephone or face to face.

Lower dose was not meant to imply a lesser intervention. There are many examples from other areas of health care where more intensive interventions have no more efficacy than something far less invasive or burdensome. Indeed, to take the example suggested by Holford, exercise, lifestyle self-management and psychological interventions are considerably more effective than surgical interventions in cardiac rehabilitation (Department of Health, 2000). We certainly agree with Holford, and Pilling and Roth, that low-intensity work is qualitatively different to high-intensity therapy, requiring different competencies. However, many behaviours exhibited by our case managers and by patients in the programme are similar to those one would observe in high-intensity therapy. For the present, therefore, we will have to let the concepts of dose and difference sit, albeit uncomfortably, together.

Some commentators rightly raise the issue of patient choice. We have to remember that our base case is that 75 per cent of people with common mental health problems receive no choice whatsoever and that a bare 1 per cent receive a psychological therapy which has an evidence base. Our view is that in a patient-centred service where patients exercise choice, that choice should be informed and supported by competent workers. We also know that in all healthcare systems, most patients will be guided by those very same workers, indeed will often cede decision making to them. This makes it paramount that workers are trained, informed and properly supervised in information gathering, information giving and shared decision making. Furthermore, choice is not a single event: people can choose more than one intervention at the same and at different times. For Kellet and Matthews to presume that the majority of our patients are on medication and that case managers are merely medication compliance managers would be to severely misread our account. In actual fact, a majority (74 per cent) of patients are helped through a specially designed recovery programme which was written following an extensive analysis of published patient preferences and experiences of help-seeking (Khan et al., 2007), together with ideas from the recovery movement and a recent evidence synthesis questioning the therapeutic dominance of the cognitive paradigm (Ekers et al., 2007), both ideas aligned with suggestions made by commentator White.

John and Vetere suggest that patients may be pressed into telephone treatment and may struggle to express their need for an alternative. The irony is that in most services the reverse is true – one either attends the clinic at the therapist's convenience or one does not receive treatment at all. In Doncaster, the default position may be the telephone, but all initial appointments are face to face, some additional sessions can be organised face to face if the patient requires it, and 25 per cent of patients receive all their treatment in the traditional manner. We arrived at this system after conducting two qualitative research studies of patients and professionals undertaking collaborative care (Richards et al., 2006). Of the two groups, it was the professionals that expressed the most reservations. Patients were very supportive of telephone treatment.

The final aspect of choice arises from our application of the stepped care self-correcting principle through automated supervision. Supervisors are alerted to review patient progress by both clinical outcomes and by time in treatment. Unlike traditional services which rely on therapists to bring cases forward for discussion and where therapists can easily persevere inappropriately when patients fail to progress, in Doncaster all patient progress is reviewed automatically at least every four weeks. At this point new choices, within the low-intensity framework or by a step up to high-intensity treatment, can be discussed. Once on a track, there is no need for a patient to remain on it. New treatment choices are always available. We would like to reassure Kellet and Matthews that case managers are careful not to reinforce 'failure-related schemas'. We agree that the manner in which a treatment programme is explained to patients will set up expectancies and stepped care must be carefully 'sold'. However, previous studies have found that low-intensity treatment is more likely to positively socialise patients to a therapeutic model than be an aversive experience (Mead et al., 2005). In contrast, patients find referral 'downwards' in the expertise chain a far more negative experience (Ben Wright, 2007, personal communication).

A number of commentators ask us for data. It was not our remit to write up the outcomes of the Doncaster demonstration site; we must leave that to another day. However, after one year of collecting and monitoring routine outcome data we felt secure enough in its success to describe the model implemented. In brief, we have received 4000 referrals, 80 per cent of whom exceed diagnostic thresholds for anxiety or depression and two-thirds of whom have had levels of distress at a moderate/severe or severe intensity. These are not people with simple step 1 and 2 problems, as assumed by Gilbert. Nonetheless, our clinical, functional and employment outcomes replicate those observed in clinical trials, figures confirmed by the external evaluation of our data by the London School of Economics. A more detailed analysis is in preparation and will be submitted for peer review shortly.

A further concern in many of the commentaries was the apparent lack of a public health and biopsychosocial focus to the Doncaster model. We are acutely aware of the social determinants of health and the need to redress structural deficits within our current 'social recession' (Lawson, 2007). Once again, space precluded our describing the way Doncaster's partnership is in fact doing this. As we state in our article, the Doncaster demonstration site was set up as part of a wide-ranging partnership of health, employment, voluntary sector, business and patient communities. We do not believe that societal and individual therapeutic actions are mutually exclusive. Our strong conviction is that, as depressed societies regenerate, we must enable those who are currently excluded to take part – whether that be through family life, community engagement, employment or voluntary activity. Depressed and anxious people do not readily engage in community activities within cultures emerging from societal depression. We must make sure those who are social excluded through mental distress have the same opportunities as everyone else. Treating their distress is one important strand of action towards social inclusion. Nonetheless, we agree with Gilbert that embedding mental health care in societies themselves is an important goal and have indeed recently suggested such a strategy (Richards, 2007a).

Many commentators worried about our workforce's structure and its health. Lavender and White wonder about the lack of applied psychology, as indeed we do too. When we set off to design our service we simply had no access to clinical psychology as such, although we did have other personnel with psychological treatment expertise. There are many places in the UK where this situation prevails. We are very grateful for the subsequent appointment of Dr Felix Davies and his applied psychology input, improving the leadership and multidisciplinary perspective to Doncaster's service. There is a lesson here for the UK expansion of psychological therapies. Unfortunately, most applied psychologists have interests and expertise outside of primary care (Lavender & Willis, 2007). Applied psychology expertise may be difficult to source in the early development of new IAPT services.

In terms of worker competence, we know from our systematic reviews (Bower et al., 2006; Gilbody et al., 2006) that specific – not necessarily professional – mental health education predicts better outcomes for patients. Our case managers have received just such training. They are extremely competent in using both specific and common therapeutic factors. Like some of our commentators we worry about the stresses inherent in a high volume service. We know that, as in many fields of occupation, it is not so much the job's 'stress fingerprint' but organisational issues that cause difficulties. Case managers express frustration at organisational barriers such as lack of access to computers, cramped working conditions, long journeys across town and difficulty finding empty consultation rooms. We are mindful of the potential of burnout mentioned by many commentators – indeed high volume working is not to everyone's taste – but we wonder about the comparative situation experienced by therapists after high-intensity treatment of four to six patients daily. Is burnout any less prevalent in this situation?

We reserve our final response for the commentary by the Midlands Psychology group. Neither of us has seen the film they base their title on so we probably missed some allegorical references. Nonetheless, we found their commentary witty and amusing, albeit frustrating in equal measure. This group were the most scathing about the 'Layard' programme and the nature of the scientific endeavour underpinning the growth of CBT-based psychological therapy. It is easy to be critical. Indeed, one of us is a trenchant critic, if not of CBT at least of the CBT community (Richards, 2007b). However, this group offers no coherent alternative vision. We do wonder how they would have responded to the 4000 people who sought help from our service last year and how they would have set up a service to reduce distress, disability and social exclusion. Rhetoric is all very well, but maybe it is about time they set up their own competing 'experiment'. In the mean time, we will continue to refine our model and offer what we believe is a challenging but compelling vision of psychological treatment for the future.

Further information can be obtained at the Doncaster PCT's IAPT demonstration site website: www.doncasterpct.nhs.uk/iapt.asp

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Book Cover

The development of emotion regulation and dysregulation

edited by Judy Garber & Kenneth A. Doge

Cambridge University Press, 2006

I was looking forward to reading this book because emotional regulation is such a currently relevant topic from both a theoretical and clinical point of view.

I was excited to read in the preface that the contributors aimed to overcome the historical differentiations in researching emotional regulation and to provide a multifaceted framework for the topic. The preface also made me hopeful of a systematic discussion of emotional regulation that would help me to integrate the facets of this topic into a systemic or holistic model. Unfortunately, I was disappointed, as the book leaves readers to do all such integrating themselves.

The book presents theories and research findings, involving the interaction of physical, behavioural and cognitive processes of emotion, from a developmental perspective. The chapters outline a wealth of specific and extensive research in the main domains of emotional regulation and its pathological counterparts. The authors have helped me to understand that the development of emotion and its regulation cannot be separated from other psychological (i.e. cognition, behaviour) and physiological processes. Consequently, I see this book as a breakthrough in research on emotional regulation.

The book was first published in 1991 and I read the first digitally printed paperback version published in 2006. The book was not revised or updated for the new edition. Consequently, all research data and illustrating case examples were dated, with some references going back to the 1970s. The style of most diagrams appeared old fashioned and the small type certainly makes it unsuitable for bedtime reading.

Also, each section of the book is a standalone topic and thus the book as a whole lacks flow between the chapters and its sections.

Nevertheless, I think that this book would be a valuable read for trainee psychologists, specialists working with patients with emotional problems and specialists in the field of child and family psychology.

Birgit Gurr

The madness of our lives: Experiences of mental breakdown and recovery

edited by Penny Gray

Jessica Kingsley

This anthology of personal accounts of mental breakdown has an important emphasis on the process of recovery and aims to help foster a recovery ethos in mental health services. The narratives were collected by interview in the mid 1990s and many of the accounts cover personal experiences over the preceding 20 years or so. They may reflect services that have now changed, as the editor acknowledges, but they remain valuable. Such accounts are, of course, available from various sources, but this volume is a worthwhile addition.

The narratives included are mainly reflective, are varied and engaging, and illustrate well how disorienting experiences of both mental breakdown and of mental health services can be. The final section includes the reflections of several professionals and user-consultants as well as the editor's own review. One contributor highlights how unique a person's experiences of both breakdown and recovery are, emphasising the need for professionals and services to respond to clients as individuals. The editor then reflects on two key themes that emerge from the various accounts: the importance of the person's 'decision to recover' and the types of relationships that can empower and support recovery. Books such as this can do a lot to help professionals understand how we can develop empowering relationships and how psychiatric and psychological treatment might be being experienced on the other side of that relationship.

Amy Hodgson

Psychodynamic counselling in a nutshell
Susan Howard
Sage, 2006

At last, a book that explores psychodynamic ideas without leaving me feeling mystified. I have never finished a book on this subject. Consequently, I was delighted by this bite-sized offering – only 104 pages.

Susan Howard assumes no prior knowledge as she introduces John, the client whose journey through counselling brings to life the subtleties of the dynamic encounter. He is joined in session one and a fly-on-the-wall perspective is maintained throughout the next couple of years. John's story, together with other case material and associated commentaries, enrich and explicate both conceptual and process issues that may otherwise feel beyond the grasp of the novice reader.

The book makes no assumptions about its readership, so includes some context for all. For the historian there is a brief tour of the development of psychodynamic ideas. For the budding counsellor there is practical advice on skills such as listening and interpreting. And for the prospective client there are thoughts on what can be expected from counselling and tips on finding the right counsellor.

I would recommend this book to anyone who wants to dip their toes into psychodynamic waters.

Mark Hayward

Silent grief: Living in the wake of suicide,
C. Lukas & H.M. Seiden
Jessica Kingsley 2007, £13.99

Explore an area that is often difficult to face after a person commits suicide – the effects on those left behind. It uses stories from 'survivors' own experiences to illustrate three main parts: 'What's happening to me?', 'What's going to happen to me?' and 'Giving help and getting help'. It is written by a survivor and a psychotherapist and so covers both personal and professional angles in a personable and easy-to-read style.

Much of the book is aimed at the family and friends of the person who died, but the third part, particularly, is useful for professionals as well. Having read the book once, I found myself unexpectedly dealing with the suicide of a client. Dipping back into it, I found more sections useful when actually in the situation than when reading it for information only. Family members may find it quite challenging to read about the experiences of others in the immediate days and weeks after a suicide, but some months along, this book could provide extra support and perhaps a way into thinking about themselves and their needs.

I did not feel that I learned anything new from the book, but I certainly found it offered support and acknowledgement of the different reactions that can be experienced by those left behind after a person ends their own life. That is also the approach the book asks for from professionals when working with family members in this situation.

Sarah Watts

Building a joyful life with your child who has special needs

Nancy J. Whiteman & Linda Roan-Yagar
Jessica Kingsley, 2007

This book is an excellent self-help resource for parents of children who have additional support needs, including physical, developmental and mental health difficulties. It is well written, comprehensive and strikes a good balance between being both positive and realistic. Thus, this is likely to be a book that parents can identify with.

Building a Joyful Life takes readers on a journey of acknowledging the challenges they face in accepting their child's diagnosis and normalises darker moments along the way. Chapters are liberally filled with personal stories from the authors and other parents which helps to illustrate key points and keep the reader engaged. A wide range of issues are covered, including: coping with diagnosis and feelings of grief in relation to this; the importance of parents caring for themselves, their relationships and mental health; reframing negative perceptions and beliefs; looking beyond the child's disability; communicating with professionals and building support systems.

Each chapter contains thought-provoking exercises to be completed by parents. These aim to promote a personal, individualised approach and encourage the reader to work through them at their own pace. Relevant literature from a variety of sources further adds to the credibility of the book.

This book will also be relevant to professionals working in the field and should be helpful in encouraging insight into the emotional experience of the parent.

Eleanor Porter

Eating disorders in children and adolescents

edited by T. Jaffa & B. McDermott
Cambridge University Press, 2007, £40

Eating Disorders in Children and Adolescents is divided into five sections. The first provides some historical background to eating disorders and outlines the developmental perspective within which the remainder of the book is largely situated in. The second section, which examines scientific underpinnings, provides useful reviews of topics such as the development of children's shape and weight concerns and the physical and cognitive changes associated with puberty. A section on evidence-based care includes chapters on individual- and family-based psychotherapy amongst contributions discussing aspects of medical management and service delivery. The final section explores public health perspectives with a focus on prevention.

The section on 'abnormal states' covers the expected areas of anorexia, bulimia and binge eating, while also providing valuable contributions on topics such as selective eating and eating disorders in children with disabilities and chronic illness. I was particularly pleased to see an entire chapter devoted to eating disorders in young males; unfortunately, this chapter amounted to only seven pages excluding references. However, when considering the book as a whole, the conciseness of individual chapters can be reframed as a major strength – the book can be dipped into for an excellent and easily readable primer on an area of interest.

The similar depth of coverage given to topics such as neuroimaging or refeeding syndrome as given to the coverage of psychological interventions perhaps reflects a primarily medical target audience. However, the quality of the writing of the contributions provides an up-to-date and accessible insight into medical aspects for non-psychiatrists. This book might serve as an excellent primer for psychologists wishing to develop a broader multi-disciplinary awareness.

A further strength of the book is the balance it strikes between discussing eating disorders at a generic level and the specific considerations of an adolescent population. The book appears readily accessible and of value to clinicians working with young people who wish to develop an up-to-date understanding of eating disorders in this group, and also to those familiar with eating disorders in an adult population seeking a primer on the literature pertaining to children and adolescents.

Phil Moore

DCP Update

Since the last issue of CPF was published there have been many developments around the IAPT programme. I currently represent the Society on the IAPT Expert Reference Group and also sit on the Programme Board in my role as Associate Director for IAPT Workforce. I thought it might also be helpful to summarise recent developments around the IAPT programme following the ministerial announcement and indeed I was asked to prepare a briefing paper by the Society's Chief Executive, Tim Cornford, as to how I saw these developments impacting on the profession.

This is essentially a personal view, but I have tried to identify areas where the impacts of IAPT might be significant and suggest ways in which the Society **might** *wish to respond. In discussion with the DCP Executive we have agreed to arrange an away day in January where we can consider in greater detail the impact of IAPT and finalise the Division's guidance to its members, service providers and commissioner around the role that psychology has to play in IAPT implementation and in addition to the NWW AP Good Practice guide around IAPT published this summer.*

Graham Turpin

Improving Access to Psychological Therapies: A briefing paper

Professor Graham Turpin

Following the Government's announcement in October 2007 of the first phase of investment in psychological therapies amounting to additional annual funding, rising to £170m in the third year, major attention has been drawn to the possible consequences that this might have for the profession of applied psychology, applied psychology training courses and the British Psychological Society. The purpose of this paper is to summarise the likely future developments in expanding psychological therapy services and to outline the opportunities for psychology both as a discipline and profession to drive this important health agenda forward. The target audience for this briefing paper are the Society's Board of Trustees, and its various Divisions and Training Committees.

Background

For many years it has been recognised that the provision of psychological therapies, particularly within primary care, is inadequate and leads to uneven access, which often results in long-waiting times and little effective choice of therapy other than medication for the majority of patients presenting with common mental health problems. Over the last decade the Department of Health has attempted to raise the profile of psychological therapy or 'talking therapy' services within the provision of mental health care. This has been promoted following the unequivocal demonstration of the effectiveness of psychological therapies, particularly CBT, through the publication of NICE clinical guidelines for a range of common mental health problems. More recently, Lord Layard (2006) has stressed the personal and economic benefits of therapy provision particularly in relation to well-being and the impact of poor mental health on employment, productivity and the benefits system.

In September 2005, a national programme (Improving Access to Psychological Therapies: IAPT) managed by the Department of Health (DH) /Care Services Improvement Partnership (CSIP) was announced to promote increasing access to therapies and to collect evidence of the impact of psychological therapies on desired outcomes in order to marshal the arguments to the Treasury for a significant investment in these services over the following seven years. Two demonstration sites were established at Doncaster and Newham, followed by several Pathfinder sites announced in May 2007. All these services were designed according to the principles of 'stepped care' and the delivery of evidence-based interventions, primarily CBT.

The Society has been well engaged in this process: it has a representative on the Expert Reference Group (ERG) advising the programme and many other members of the ERG and the Programme Board are psychologists. Many of the NICE guidelines within mental health have been originated from the BPS Centre for Outcomes Research and Effectiveness (CORE). In 2006, the BPS Professional Practice Board organised a dedicated symposium to which Lord Layard was invited and the Board endorsed in principle many of these developments. In 2007, under the auspices of the overarching New Ways of Working for Applied Psychologists project, a good practice guide was published to support the contribution that applied psychologists could make to the IAPT programme. Further workshops and symposium are planned and Lord Layard will be a keynote speaker at the Society's Annual Conference in Dublin.

In addition, Professor Graham Turpin

The Department of Health announcement

Health Secretary Alan Johnson today announced a substantial £170 m expansion of psychological therapies to provide better support for people with mental health problems such as anxiety and depression.

Millions of people suffer from depression and anxiety. These are the most common of the mental health problems, which account for 40 per cent of the numbers on Incapacity Benefit.

Treating them is estimated to take up about a third of GPs' time.

Psychological therapies have proved to be as effective as drugs in tackling these common mental health problems and are often more effective in the longer term. NICE guidelines on treatment for depression and anxiety recommend therapies, such as cognitive behavioural therapy (CBT).

Building on two demonstration projects, the Government will next year roll out psychological therapies to twenty new areas before increasing services to cover the whole country over the next few years.

Health Secretary Alan Johnson said:

> 'More than one in six people suffer from mental health problems at any one time. For many people prescribing medication is a successful treatment but we know that psychological therapies work equally well.
>
> 'Today's announcement shows the government's commitment to mental health. Improving access to psychological therapies will give people with mental health problems a real choice of treatment, helping to reduce dependence on medication.'

By 2010/11, the NHS will spend £170m per year on psychological therapies, with more than £30m in 2008/09 and more than £100m in 2009/10. Over the next three years, this investment in Improving Access to Psychological Therapies (IAPT) will mean:

- 900,000 more people treated for depression and anxiety
- 450,000 of them are likely to be completely cured (as expected with NICE guidelines)
- 25,000 fewer people with mental health problems on sick pay and benefits
- 3,600 more newly trained psychological therapists giving evidence-based treatment
- all GP practices having access to psychological therapies as the programme rolls out
- average waiting for psychological treatments down from the current 18 months to a few weeks (in line with urgent outpatient waiting times in the rest of the NHS) as the service rolls out

who is Associate Director (with Roslyn Hope) for the IAPT Workforce Programme is also a member of the ERG and sits on the Programme Board. He is also currently Director of the DCP Professional Standards Unit and an elected Trustee from the Society's Representative Council.

What is likely to happen? Consequences for the profession

Investment will be directed to two areas: enhancing current service provision and service redesign to increase capacity, and the design and training of the workforce to support implementation. The latter will be especially important in the first years of the programme. It is important to note that the IAPT programme is multi-professionally based and it is likely to support a range of providers including existing NHS services, and third sector and private sector providers. Commissioning will be located at a local level and will include PCTs and PBCs. However, it is likely that allocations, particularly those associated with Education and Training will be managed via SHAs, working together with CSIP, although this is yet to be finally decided. It will be important in order to ensure the fidelity of the IAPT Programme that commissioning is not devolved in the initial stages to Primary Care Trusts.

Enhanced service provision

With respect to enhancing current service provision, the exact nature of the commissioning process has yet to be determined. It is likely to be determined at a local level but informed by an appropriate IAPT service specification. Current suggestions include the commissioning of two additional sites per SHA; these would be of a comparable scale to the two national demonstration sites and might encompass the Pathfinder sites that have just been established in July 2007. Pathfinders are likely to given the opportunity to upgrade but not forced to do so. These new additional sites would likely need to train and recruit workers (e.g. graduate workers) to deliver low intensity interventions, as well as trained high intensity therapists such as CBT therapists, counsellors and psychologists.

Opportunities. Many of the opportunities for the profession of applied psychology have already been identified generally through the BPS/CSIP New Ways of Working for Applied Psychology project, and more specifically through the 'Good practice guide surrounding the contribution of applied psychologists to IAPT'. Although the recent announcement stressed the contribution of staff other than psychologists, the workforce planning that has been undertaken clearly relies on applied psychologists to contribute to management, supervision and provision of high intensity interventions within these services.

Accordingly there will be opportunities for employment and advancement for applied psychologists, which will arise from the expansion of these services. This is particularly important, given the DH forecasted levelling off or downturn (DH Internal review) in demand for psychologists elsewhere within the NHS.

Threats. The commissioning and tendering process for these new services is likely to be highly competitive and will involve existing NHS services, and the voluntary and private sectors. To date applied psychologists, especially clinical psychologists have tended to be employed within the NHS. A potential threat, therefore, is the profession's lack of preparedness to work in partnership with either the voluntary or private sectors. The DCP's current initiative in setting up a marketing strategy may assist this process. There may also be competition between different types of therapists for posts, but the demand for competent therapists will be high and may well exceed supply. This might threaten the development and provision of other psychological healthcare services (e.g. people with learning disabilities, older people etc.).

Actions. The Society and the profession have the opportunity to promote the contribution of psychological therapies to the general well being of the public. Specific actions might include:

1. The Society continues to support the dissemination of good practice guidance around psychological therapies through

activities such as NWW AP etc. It must stress the unique and important contributions that applied psychologists have to make to IAPT services.

2. The Society considers how it might support its members in contributing effectively in these services by provision of training materials and training events. Specific areas might include understanding IAPT/stepped care service models, CBT and training in other evidence-based therapies, business skills and working in independent practices, etc.
3. Consideration is given to promoting further the Society's role in promoting public education around mental health issues through website provision. There are opportunities of creating partnerships with CSIP and the BBC Health web in developing websites and self-help materials.
4. Exploration of partnership working with major charities (e.g. Rethink), the voluntary sector (e.g. Mental Health Providers Forum) and private providers (e.g. The Priory).
5. The Society continues to monitor the demand for psychologist's posts within the NHS to calibrate DH assumptions about ongoing demand. This should be an independent process co-ordinated by the PPB workforce group and is especially important given the recent suggestion of the discontinuation of the annual risk analysis by the NHS Workforce Review Team.

Education and training

With respect to education and training, the following new training provision has been identified:

1. Psychological awareness: Introductory 'psychological awareness' training, including an introduction to CBT, for all relevant staff. Courses could be around two days' duration and located within the workplace. Might co-ordinate with training around 10 Essential Shared Capabilities and Capable Teams.

2. *Low intensity/ high volume interventions:* Training staff (AfC bands 4–6) in low intensity psychological interventions. Staff might be graduate primary care workers, experienced voluntary sector staff, psychology assistants/ associates, existing NHS staff (i.e. CPNs, counsellors etc.) Courses could be around 12 months in duration and include at least 30 days' training and would also include a substantial work-based component consisting of supervised clinical work. They might target intakes from graduates (primarily psychology graduates) leading to a post-graduate diploma or certificate or experienced workers from either the NHS or voluntary sector. Accordingly, it is possible that some degree or foundation degree level courses might be established. Currently a national demonstration site has been commissioned by Skills for Health to examine the development of curricula and a qualifications framework to support the delivery of low intensity interventions. Courses could be either degree (including foundation degree) or post-graduate certificate/diploma.

3. High intensity psychological therapies: Training staff (AfC bands 6–8) in high intensity psychological therapies. These will be evidenced-based and primarily in the first few years will focus largely on CBT. Existing NHS staff wishing to up skill their therapy skills to enhance CBT competency will be targeted and might include trained professionals such as nurses, OTs, counsellors and some applied psychologists, alongside non-professionally aligned staff such as graduate workers or experienced workers from the voluntary sector. Courses would be around 12 months in duration and consist of 30 days-plus substantial training and supervision within the workplace implementing CBT interventions. They would largely be postgraduate certificate or diploma level although some degree level training might be envisaged.

4. Supervision and leadership training: Supervision training and development skills necessary for the clinical leadership and governance of IAPT services. To ensure effective service delivery and faithful delivery with respect to the IAPT service specification, it will be important that services offer expert supervision, continuing training and development, good audit and governance functions, research and development, together with effective clinical leadership. It is likely that there will be significant training requirements within these areas. Initially, the focus will be on training senior staff about clinical (CBT) supervision and case management supervision. Courses would be of variable duration and might be offered by a range of providers including in-house NHS, HEIs and professional bodies. A range of awards might, therefore, ensue.

Opportunities. Applied psychology courses have traditionally been involved in many aspects of training that have been identified above. Whereas there is currently no planned expansion in applied psychology training, there will be major investment in the other training areas. Courses, therefore, need to consider:

1. Costs-benefits of diversification into these other areas?
2. Can low/high IAPT intensity training be incorporated alongside applied psychology training?
3. What types of courses, durations, qualifications, entry requirements are required?
4. Potential local partners: other psychology courses, CBT and graduate worker courses?
5. Sharing curricula and course materials for low/high IAPT training (See MHChoices website).
6. Enter into partnerships with other providers (e.g. local CBT courses) to provide a range of IAPT courses.

And the Society might consider:

7. The Society might consider establishing a training arm, similar to the Royal College of Psychiatrists, in order to provide training both to psychologists and other health care professionals. A major training provider gap currently is short courses in 'Psychological awareness' which could be offered eventually to all NHS staff. Such materials could be centrally produced.
8. Examine consequences of these developments for the popularity and relevance of undergraduate psychology courses.

Threats. In the short-term, it will be important for psychologists to demonstrate that their skills and competences are relevant (i.e. fit for purpose) to IAPT services and are also cost-effective. Commissioners need to be reminded that there is range of skills that are essential in the delivery of quality psychological therapy services other than just the provision of face-to-face therapy skills. In the longer-term, there is likely to be an ever-competitive market place around the provision of psychological therapy services.

Undergraduate psychology degrees might end up competing with undergraduate courses for psychological therapies. Many undergraduates are attracted to psychology courses because of their interest in psychotherapy and helping others. It will be important to ensure, again that undergraduate courses are also perceived as making a contribution to the IAPT programme and are considered as fit for purpose in preparing psychology undergraduates to work within the NHS, especially in 'non-psychologist' roles.

Actions. The Society and the profession have the opportunity to enhance its contribution to training in psychological therapies. Specific actions might include:

1. Group of Trainers in Clinical Psychology encourage courses to draw up, without delay, action plans as to how they might respond to this agenda.
2. The Society considers establishing a Training Unit to commission national training materials, and the provision of London or regionally-based and/or in-house training.
3. A PPB group to sharpen and develop the concept of 'psychological Awareness' and associated constructs such as 'psychological safety' or 'psychological first aid'.
4. To ensure that accreditation processes accurately reflect the competencies that applied psychologists are trained in. This is particularly important with regard to CBT competencies: we require a detailed statement of basic competence.

5. Ensure effective liaison with HPC around both the regulation of psychologists and psychological therapists will be critical.
6. Systems are introduced to recognise specific or advanced competencies particularly in CBT. This could be linked to post-qualification CBT training courses and specialist registers. Other areas might include the new Mental Capacity and Mental Health Acts.
7. Attempts are made to examine joint accreditation with other relevant professional organisations such as BABCP.
8. The Society continues to monitor in partnership with the Workforce Review Team, the demand and supply of applied psychologists, especially outside the area of IAPT. It will be essential that the future supply of applied psychologists is sufficient to meet the ongoing demand for psychological service provision outside of IAPT, and also the direct requirements of newly established IAPT services.
9. If necessary, to press for the expansion of applied psychology training to help with the provision of supervisors and high intensity therapists for IAPT and to allow further development in areas of under-provision and increasing future demand (i.e. child, learning disability, serious mental disorders, chronic conditions, older people and dementia services).

Summary

There is likely to be a revolution in the delivery of psychological therapy services over the next decade and the Society and its members should ensure that they are well positioned to help drive this important government agenda forward both for the benefit of the profession and the services that it renders for the public.

The Statutory Regulation of Clinical Psychologists

A position paper from the DCP Executive

This position paper has been approved at meetings by the DCP Executive and Representative Assembly during October, 2007. The current version has been updated following the publication of the two HPC consultations surrounding Statements of Proficiency and Threshold Qualifications.

Introduction

The statutory regulation of psychologists, and the provision of effective protection of the public from either incompetent or unfit practitioners, has been a strategic aim for the British Psychological Society for at least the last twenty years. This has resulted in the Society's operation of a well-respected voluntary register of Chartered Psychologists and ongoing discussions with various governments as to how this register could form the basis of statutory regulation.

The lack of statutory regulation has resulted in only incomplete protection of the public since those psychologists who have been found to be either incompetent or unfit for practice, and have been struck off the voluntary register, can effectively continue to practise and offer services to the public. Moreover, the profession has also suffered since it has not generally received recognition by the government or in law since it has not been afforded the status of a statutorily regulated health profession.

Within the last five years, substantial progress has been made in achieving the required changes to legislation to underpin statutory regulation of psychologists. The establishment of the Health Professions Council (HPC) in 2001 afforded the opportunity for psychologists to be regulated by this new body. Extensive negotiations took place between the Society, the Department of Health and HPC about this possibility, which lead to a public consultation in March 2005. This resulted in an overwhelming rejection by members of the Society of HPC as being either a desirable or effective organisation to regulate psychologists. Concerns that were expressed revolved around the quality of HPC standards, accreditation of training courses and curriculum, CPD procedures, scrutiny of overseas candidates etc. and the apparent exclusive focus of HPC on health service delivery.

Given the widespread concerns about HPC's suitability as a regulator, the Society developed and published an alternative proposal constituting the Psychology Professions Council (PPC). This proposed new body would regulate all professions and practitioners that utilise psychological knowledge and principles in their dealings with the public. The proposal received good support from the Society's membership, together with support from the major organisations involved in the voluntary registration of psychotherapists. Indeed, the Division of Clinical Psychology actively supported the proposal of PPC and the work that gone into elaborating the workings of such a body. It is also worth noting that the DCP and particularly its training committee (CTCP) and the trainers (GTiCP) were some of the most vocal critics of HPC and its procedures.

Unfortunately, despite protracted periods of discussion and consultation, the Department of Health has judged this alternative proposal as being impractical and unworkable and instead is about to publish a public consultation around a Section 60 Order which would enable HPC to take up a statutory role in regulating certain applied psychologists, instead of the Society's voluntary register. Although such legislation has yet to be approved by Parliament, HPC has also commenced the necessary process and procedures to enable the establishment of a HPC register of practitioner psychologists. Specifically, this has been to establish a Professional Liaison Group to report to the Education and Training Committee on a set of Standards of Proficiency for Psychologists and also the definition of a threshold level of qualification.

The purpose of this briefing paper is promote further discussion within the DCP about the issue of statutory regulation in order to help shape and formulate the Division's, and ultimately the Society's response to a series of consultations around regulation organised by both the Department of Health and HPC. If, having read this briefing paper you wish to either confirm or amend some of the proposed DCP recommendations, please e-mail either myself or the incoming Chair, Jenny Taylor. The current document is based on discussions at the last face-to-face meeting of the PSU in September 2007, and meetings of the DCP Executive and Representative Assembly in October where it was approved.

The announcement of a public consultation surrounding the Section 60 order leaves little doubt around the government's intention to regulate psychology through the HPC. Although the DCP would agree with the Society that this is not the desired outcome, the rationale underlying this briefing document is that the outcome is inevitable and hence the Society needs now to actively engage in constructive dialogue in order to influence the detail of the Section 60 order and the HPC procedures as they affect psychology. The DCP is pleased to learn that the Society is now proactively and constructively pursuing such a policy with the Department of Health and is having regular meetings with HPC.

Issues

Protected title

Although the Society, through the Representative Assembly, together with the DCP has supported the proposal to protect the generic title of "Psychologist", the draft Section 60 order makes it clear that the government will not support such a title since it considers that this would result in either a lower level of protection or the crimalisation of a large section of the profession (e.g. academic psychologists) who are considered not to be subject to regulation. It is likely that the term "Registered …. Psychologist" maybe adopted but qualified by seven adjectival titles representing the domains of applied psychology.

Consultation within the DCP would support such an outcome as long as "clinical psychologist" is clearly protected.

Statement of proficiencies

The PLG set up by HPC to establish and recommend statements of proficiencies for applied psychologists is seeking to distinguish between generic proficiencies versus specific proficiencies as indicated by individual adjectival titles. The Society's current position is to specify a mixture of generic and specific statements of proficiency. There are problems, however, with the current wording of HPC generic statements of proficiency, which are expressed in terminology specific to health care professions and not wholly appropriate for some areas of applied psychology outwith health.

The DCP should support the revision of the language of the existing HPC generic statements of proficiency to ensure that they are relevant generally to the domains of applied psychology. It would also wish to ensure that specific statements of proficiency accurately reflect the knowledge and competences underpinning each of these separate domains.

Threshold levels of qualification

HPC through its Education and Training committee has to recommend a minimal standard of qualification. Based upon current levels of award, HPC had initially considered this to be most appropriate at a masters level. However, the Society has argued that accreditation criteria for courses leading to Chartered status have been set at Doctoral level descriptors which are equivalent to Masters level plus appropriate additional experience. Setting an overall threshold at Masters level would not do justice to the minimal standard of qualification for doctoral level training in clinical psychology nor for those other courses in applied psychology (i.e. educational, health, counselling and forensic) that have been individually set at a doctoral level. HPC has decided not to make a recommendation currently on the threshold standard but to suggest a number of options which might include different threshold standards for each of the domains of applied psychology.

Useful Weblink

Visit the statutory regulation pages on the Society's website for all the latest news

www.bps.org.uk/statreg

The DCP position is that it is essential that the doctoral standard for clinical psychology is not eroded in this process and that the competences currently offered to the public by chartered clinical psychologists as reflected in doctoral training are maintained.

Other issues

CPD: The DCP is keen to ensure that high levels of scrutiny apply to ongoing CPD by HPC registrants. It would wish the current system of CPD required by the Society to be continued and used to support CPD events organised by the Society and the maintenance of post-qualification registers.

Overseas-trained psychologists: Given that there is no current European or International standards defining either the scope of practice of clinical psychology and its associated training, the DCP has concerns for public protection, in as much as psychologists trained overseas and using the title 'clinical psychologist' based on their home qualifications, may in fact have few of the competences or care group experiences comparable of a UK-trained clinical psychologist. Moreover, it is unclear what procedures the HPC have currently for non-EAA migrants wishing to practice in the UK. Psychologists trained in Australia, Canada, India, New Zealand and other former commonwealth countries and the US have previously made a significant contribution to UK psychology services. Such psychologists have a potential contribution to make to the diversity of service provision.

The DCP would wish to see rigorous and well-informed procedures for the adaptation processes surrounding both EAA migrants and overseas clinical psychologists.

Chartered psychologists who currently are not members of an existing Division: Although the

DCP is sympathetic to those individuals who currently have not joined or do not fulfil the membership criteria of the seven domains proposed by the DH, it currently does not see a solution this problem.

The DCP recommends that all members in the above category either apply for Division membership if eligible or apply to HPC for membership of one of the domains via the HPC grand-parenting route.

Neuropsychologists and post-qualification registers: The DCP is concerned about the impact of the current proposals on clinical neuropsychologists. Unfortunately, many neuropsychologists will fall into the above category, and we are unable to suggest a solution, especially for those trained overseas. For clinical and educational psychologists, who are also members of the Division of Neuropsychology, we would supprt a proposal to have an additional post-qualification register which recognises the distinctive competences practised by neuropsychologists. Otherwise, there is a real danger that a branch of psychology essential for quality stroke, brain rehabilitation and dementia care might loose its distinctiveness and be less available to the public.

The DCP considers that post-qualification registers recognised either by the BPS or HPC might be appropriate to capture the distinctiveness of neuropsychology and also other specialised competences such as psychological therapies (i.e. the existing BPS Specialist Register for Psychologists Specialising In Psychotherapy), in depth psychometric assessments, forensic and issues related to the New mental Health Act, for example.

Notes from the Chair

Tim Cate *bids farewell and sets a quiz*

This month's travels

By the time you read this, Jenny Taylor will have taken over as chair of the DCP. The reins – or whatever metaphor you prefer – will have been handed over at the Division AGM, held our Annual Conference in London.

I have remained busy to the end, visiting the Group of Trainers and the Northern Branch of the Division since I last wrote here. I have also taken part in one of the regular joint meetings between the Society and the trade union Unite, discussing the cuts that have taken place in some services.

A particularly memorable trip was my two-day visit to Northern Ireland. There I made two presentations on the Increasing Access to Psychological Therapies project: the first to members of the DCP branch and the second to a wider audience of psychologists, commissioners and workforce planners.

I also took part in a meeting and away day of the Society's Professional Practice Board, but as this issue of Forum is not exactly on the slim side I shall leave other hands to report the most newsworthy items next time.

Farewell

So what to say about the last two years? Clearly, the Division's restructuring and our new emphasis on services to the membership have been critical. With the advent of statutory registration it is likely that the Society itself will come under pressure to evolve in a similar way.

The New Ways of Working for and Improving Access to Psychological Therapies projects continue to develop. As this issue of Forum reflects, members have varying perspectives of these initiatives, but I can at least claim that they have made my two years as Division chair interesting.

My own initiatives have centred on developing DCP strategies on leadership and on marketing our services. I have been co-opted to continue working on the latter strategy, so I shall be around for a while yet.

It remains only for me to say how much I have enjoyed my two years as chair of the DCP. I have presented to nearly all the subsystems of the Division – some of them more than once. It has been an honour to meet you all and I shall never forget my years as chair.

A competition

Finally, some lines from two of my favourite films. A bottle of wine to the first e-mail I receive identifying them:

> ‘I've seen things you people wouldn't believe. Attack ships on fire off the shoulder of Orion. I watched C-beams glitter in the dark near the Tanhauser gate. All those moments will be lost in time like tears in rain. Time to die.’

And:

> ‘A thousand nations of the Persian Empire descend upon you. Our arrows will blot out the sun! ‘
>
> ‘ Then we will fight in the shade!’

A conference organised by the Midlands Psychology Group

Beyond Belief: Resisting cognitivist dominance in psychological work

Friday 29 February & Saturday 1 March 2008
Midlands Art Centre, Birmingham

The aim of the conference will be to challenge the dominance of cognitivism in psychological work, as well as the ruling business ideology that supports it. Members of the Midlands Psychology Group will introduce the following themes:

❍ Feelings: Embodied experience;
❍ Resisting cognitivism;
❍ The social context of distress;
❍ Clinical psychology: A NICE business

A central aim of the conference will be for people to reflect on and discuss their own experiences, with a view to creating supportive networks.

Speakers to include: John Cromby, Bob Diamond, Dave Harper, Guy Holmes, Paul Kelly, Paul Moloney, Penny Priest, David Smail and Janine Soffe-Caswell.

Anyone with an interest in the applied practice of psychology and the future of mental health services is encouraged to attend. Places are limited. For more information see **www.midpsy.freeuk.com/conference.htm**

Closing date for applications: **25 January 2008**

Cost for two days (including lunch, tea and coffee): £80 waged, £30 unwaged

Application forms are downloadable from the website. Once completed, please send to Paul Moloney, Counselling Psychologist, Adult Learning Disability Service, 40 Tan Bank, Wellington, Telford TF1 1HW, including cheque for full amount, payable to *Midlands Psychology Group*.

Self-help

2 December
Well, here I am again – Felix says I could make this an annual event, doing his diary for him. Not sure where to start – boring girlie stuff I? Xmas shopping done, mostly on-line. The leather gloves for F may be a problem since his nasty scalding on bonfire night. Yet another DS lite for Tim. So glad F insured the first one. Mind you, with Felix's disaster proneness, if it wasn't for insurance, we'd be in the workhouse.

5 December
Really excited. Felix says he'll look after Tim and the twins for two days while June and I hit Southampton to check house prices, shops and exclusive restaurants (joke).

5 December (late)
Long and rather lovely talk with Felix about his session with his clinical psychologist today. Apparently he wanted to talk about how upset he was about the letter in *CPF* criticising his column and she wanted to analyse what he was saying sexually (as in the symbolism of a man having his column criticised). Psychologist said not to worry about the letter because the editor made them all up anyway but wouldn't it be better to talk about real worries. So he talked about June and me going away! Said he was convinced I was on the razz! *Lovely* session upstairs making him feel better.

15 December
ON THE RAZZ!! Fab time with June in town this afternoon – we spent an hour just gasping at the house prices. We might have to live near the docks at this rate. June says it will be easy for us to visit cousin Molly in Fishguard but I'm not sure I trust Felix not to fall into the Solent. Then – CLUBBING. This is great. June seems to have found a hot matelot complete with striped jersey. Pick up line of the night? 'If you vant a French loveur, I am 'ere 24/7 for you Cherie.'

16 December
Terrible headache. Met some girls last night and June's first comment was, "Look at her, she can hardly walk." Half an hour later neither could we. June's sailor reappeared about 1 this morning and I don't know where she is. Hope she's OK. Not sure whether to write down what happened to me – it's one thing Felix seeing this – it's quite another having 3000 clinical psychologists analysing me. Will have a go at this CBT diary thing to see how anxious I am.

16 December (two minutes later)
That's enough of that. Every time I tried to rate anxiety, a different thought popped up. Like 'Anxious about Felix finding out about Saturday night' was immediately followed by 'Anxious I'll come across as a pathetic woman for being anxious' – followed by 'Get a grip, Felix might have been on the razz too' – and then, 'Bastard, I'll sort him out.' Anxiety suddenly stopped.

18 December
Felix not razzing at all AND managed to keep the kids away from A&E. Showed him diary. Didn't even ask about 15 Dec tho' he's worried about house prices.

25 December
June and gang coming for drink later. All the cooking done. Felix in festive mood. Just opened present from him – Gogol's *Diary of a Madman* and a vibrator!

25 December (later)
F really apologetic about forgetting batteries. Settling down to Gogol and thoughts about matelots.

Felix Q