A new workforce to deliver IAPT: a case study

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Abstract
Two years ago, we published within this journal a scoping article (Turpin *et al*, 2006) concerning the urgent need to review and enhance the workforce responsible for delivering psychological therapies to people seeking help for common mental health problems in primary care (London School of Economics, 2006). We estimated that the demand for such interventions, the service models that might deliver increased capacity for psychological treatments, the implications for workforce numbers and the impact that this would have on education and training. Much of the thinking that was adopted within the review was based on current development work around the mental health workforce led by the National Workforce Programme sponsored by the National Institute for Mental Health England (NIMHE) on New Ways of Working (NWW).

The current paper reflects on the process and the added value that NWW has contributed to what is a radical new venture, which has been described by the lead evaluator of the pilot Improving Access for Psychological Therapies (IAPT) phase, Professor Glenys Parry, as '*the industrialisation of psychological therapies*'. More specifically, it reviews the implementation of a national programme designated as IAPT, which was commissioned on the basis of the NWW work, and the evidence accrued from the IAPT national demonstration sites at Doncaster and Newham, together with the efforts of Lord Layard and the New Savoy Partnership.

The first year implementation of IAPT is described, together with the lessons learned from the roll out. As the programme has developed, it has become important to ensure that clients also have a choice of evidence-based interventions. NWW has provided a means to help practitioners come together from a range of therapeutic orientations and professions to contribute to this more diverse workforce. Finally, it is argued that NWW has been instrumental in helping managers and professions alike think more flexibly about service models and provision, and how to develop a new workforce competent to deliver such an innovative service.

Key words
New Ways of Working (NWW); Improving Access to Psychological Therapy (IAPT) programme; psychological therapies; psychotherapy; low- and high-intensity psychological therapists; cognitive behavioural therapy (CBT); stepped care models

Introduction

Two years ago, we reviewed the background to workforce planning that underpinned the development of the IAPT programme (Turpin *et al,* 2006) within this journal, although at that time it had yet to be agreed that IAPT would

be rolled out nationally within England. Then, we focused particularly on estimating the demand for psychological therapists and based this on various epidemiological estimates of morbidity, presentation rates and detection rates of people with the common mental health problems within primary care. Using various different crude estimates of demand, we also attempted to estimate the gap in supply by summarising what was known about the workforce numbers of existing psychological therapists. On this basis, there appeared a shortfall of up to 10,000 therapists if the demand for psychological interventions for anxiety and depression was to be met. We thus considered service models and issues surrounding skills mix in order to develop new directions in service design and delivery aimed at scaling up services. Notably, we examined stepped care models (Bower & Gilbody, 2005) and how by deploying differently trained and skilled therapists (low- and high-intensity workers) greater capacity might be realised when compared to a traditional psychotherapy referral system and service.

Since the publication of that review, much has happened. Workforce capacity tools have improved and more accurate estimates of demand have been made. On the basis of these and similar calculations (Layard, 2006), additional resources were sought from the government and in October 2007, it was announced by the Secretary of State for Health that £173 million would be invested in IAPT. A national implementation plan (Department of Health, 2008) was published in February 2008. This outlined a stepped care service model essentially consisting of a team of around 40 therapists; 60% designated as delivering high-intensity interventions and 40% delivering low-intensity interventions. Work was commenced on identifying the competences required to deliver the interventions identified and recommended within the National Institute for Health and Clinical Excellence (NICE) Guidance, and national curricula were published for both low- and high-intensity interventions. Essentially, these interventions were based around collaborative care for depression, in the case of low-intensity interventions, and CBT for anxiety disorders and depression, in the case of high-intensity interventions.

The monies to support the rollout were distributed proportionately through the strategic health authorities (SHAs), and commissioners working for primary care trusts (PCTs) were asked to bid for additional resources to support the local implementation of IAPT services. From February 2008 until October 2008, 35 new services were commissioned, together with 22 new training courses for low- and high-intensity workers. Further details of the courses and new staff and trainees recruited are described later in this paper. In November 2008, the Secretary of State also announced at the New Savoy Partnership Conference the importance of providing choice to clients within primary care as to the types of evidence-based psychological therapies on offer (IAPT, 2008a). Currently, the IAPT programme is considering how that choice can be translated with respect to the activities of the current workforce and the implications for future training.

The above developments have been described in more detail elsewhere (www.iapt.nhs.uk; Clark & Turpin, 2008; Layard *et al*, 2006; Richards & Suckling, 2008; Turpin *et al*, 2008). Although we will describe the implementation of IAPT and the lessons learned, the key purpose of this paper is to critically assess the contribution that NWW made to the thinking behind workforce development and the implementation of the IAPT programme. We will review the principles from NWW that have impacted most on the design of the IAPT workforce, how these principles have helped engage diverse stakeholders in a complex and sometimes controversial initiative, and attempt to identify the unique contributions that NWW have made to the process.

Principles of New Ways of Working

Figure 1 summarises the principles from New Ways of Working, which we believe have helped direct and implement the development of the IAPT workforce. These principles had been identified through previous NWW projects that had examined specific professions such as psychiatrists (Care Services Improvement Programme *et al*, 2005), the mental health workforce (Department of Health, 2007a) and psychologists (Lavender & Hope, 2007).

Workforce design informed by users' needs

A fundamental principle that workforce design is predicated on, is that services are designed specifically, and collaboratively, with the needs of service users in mind. For IAPT, this has meant a public health approach on estimating the demand for services and has been largely influenced by the pioneering work of the Sainsbury Centre for Mental Health (Hague & Cohen, 2005; Boardman & Parsonage, 2005). Service users and carers from the two national demonstration sites at Doncaster and Newham, together with those working within the national IAPT team; have also

Figure 1: NWW principles and IAPT

1. Ensuring that the skills and competences of ALL staff are being used to meet the needs of service users and carers in a more efficient and effective way.
2. Approaching workforce development through service design and the development of care pathways.
3. Ensuring that workers have the right competences consistent with evidence-based practice.
4. Developing new roles to bring new people and new competences into the mental health workforce.
5. Developing the roles of existing staff to enable them to take on more or different tasks.
6. Using senior staff to supervise and develop other staff.
7. Ensuring the engagement of all stakeholders from diverse professional groups to service users in resolving together workforce development issues.

informed the nature of service provision. This is in contrast with the traditional top-down service planning model, whereby the availability and the contents of packages of care were decided largely by professions and the (in)adequacy of available resources. Moreover, it reflects the strongly held preference for talking therapies relative to medication advocated by many mental health charities (eg. *We Need to Talk*, Mental Health Foundation *et al*, 2006)

Care pathways and service models

In order to design services that can adequately meet the demand to satisfy users' needs, it is important to identify care pathways that efficiently and effectively offer appropriate and timely care based on the assessment of individual need. These care pathways may also be organised hierarchically within a service model to ensure the most effective delivery of care to optimise capacity and capability. Within the IAPT service, the type of service model chosen has been stepped care (Bower & Gilbody, 2005), whereby a series of incrementally more complex/intensive interventions are offered to the client according to the severity of their problem, the risks identified, the training and competence of the therapist, and the setting in which it is offered. Organising the service around a series of incremental steps means that clients need only access the least burdensome step sufficient to resolve their clinical problem. This avoids placing undue burdens on the clients in terms of numbers of sessions attended etc, and optimises the use of limited resources by the service. However, when the intensity of the intervention is insufficient to meet the client's needs and their problems remain unresolved, the individuals are stepped up to a more intensive treatment within the programme. This requires that stepped care services and their workers routinely monitor clinical outcomes and consider making clinical decisions around stepping up and down.

New and extended roles

The IAPT stepped care model is specified in the national implementation plan, and essentially involves two kinds of practitioner: those trained to deliver high-intensity interventions and those trained to offer low-intensity interventions. High-intensity practitioners are psychological therapists who are able to offer intensive psychological therapy, usually cognitive behavioural therapy (CBT) on a one-to-one basis and for around 12 sessions. These are staff who are already largely qualified practitioners, who are extending their roles beyond their original scope of practice. Low-intensity practitioners are now known nationally as 'psychological well-being practitioners' and deliver low-intensity interventions that include: guided self-help; computerised CBT; collaborative care and medications management; signposting to other services, and may usually require as few as two to six sessions, the majority offered by telephone following an initial assessment (Richards & Suckling, 2008). These trainees are drawn from either graduates, usually, but not exclusively, psychology or from people from local communities; this is a new, non-professionally affiliated role.

Evidenced-based competences

In order to deliver a stepped care service, it is important to be able to identify the range of evidence-based interventions that need to be available, the competences of therapists employed to deliver this range of interventions, and the training required to engender these competencies. Within IAPT, the workforce team worked in collaboration with Skills for Health in order to identify the competences

necessary to deliver the IAPT programme. Initially, this led to the scoping of competences underpinning the various different CBT interventions associated with research trials on which NICE guidance had been based. This work has been widely published (Roth & Pilling, 2008) and has now been extended into National Occupational Standards through Skills for Health and also encompasses other psychotherapeutic modalities, including psychoanalytic/psychodynamic systemic and family, and humanistic–person-centred/experiential therapies (Centre for Outcomes, Research and Effectiveness, 2009).

Education and training of new roles

The IAPT workforce team used the above competences to define the nature of the IAPT workforce. This constituted the two newly defined roles as previously described: high- and low-intensity (HI/LI) practitioners, as described previously. It also surveyed the availability of psychological therapies training courses and the range and skills mix of existing staff within services. It became apparent that the existing training courses either within CBT or for graduate workers would require significant modifications to deliver these newly identified competences. Two nationally agreed curricula were also developed and published to support the training of these two new roles (Department of Health, 2008) and training courses have been established and commissioned by the SHAs.

In addition to the specification of education and training, IAPT has also produced advice around job descriptions, person specifications and Agenda for Change bandings relevant to the new workforce (IAPT, 2008c). It is important to emphasise that recruitment was to either low- or high-intensity roles, and was deliberately not tied to particular professions. Indeed, workforce data collected from the worker registration form demonstrate that a wide range of professions are represented within both the low- and high-intensity qualified and trainee workforce.

Figures 2 through ***5*** summarise the make-up of the IAPT workforce identified from the workforce data collected so far within the first year of implementation. Due to not all SHAs having verified their workforce returns, these profiles may not be totally accurate, but reflect our best and current estimate of the IAPT workforce profile. ***Figure 2a*** shows the relative numbers of low- and high-intensity qualified staff and trainees. The overall characteristics of the workforce do not appear to differ from similar services that also provide for mental health: workers are predominantly white and female. With regard to ethnicity, it should be stressed that there are wide regional variations, and that training providers within London and the Home Counties have been particularly successful in recruiting students from the BME communities. ***Figures 3***, ***4*** and ***5*** illustrate the professional backgrounds for high-intensity qualified staff and trainees, and the backgrounds of low-intensity trainees. The qualified high-intensity IAPT workforce is currently predominantly made up of CBT therapists, counsellors, nurses and psychologists. By contrast, trainees recruited this year reflect nursing, counselling and graduate workers; applied psychologists and psychotherapists appear to be less well-represented

Figure 2a: Numbers of IAPT low- and high-intensity trainees and qualified staff

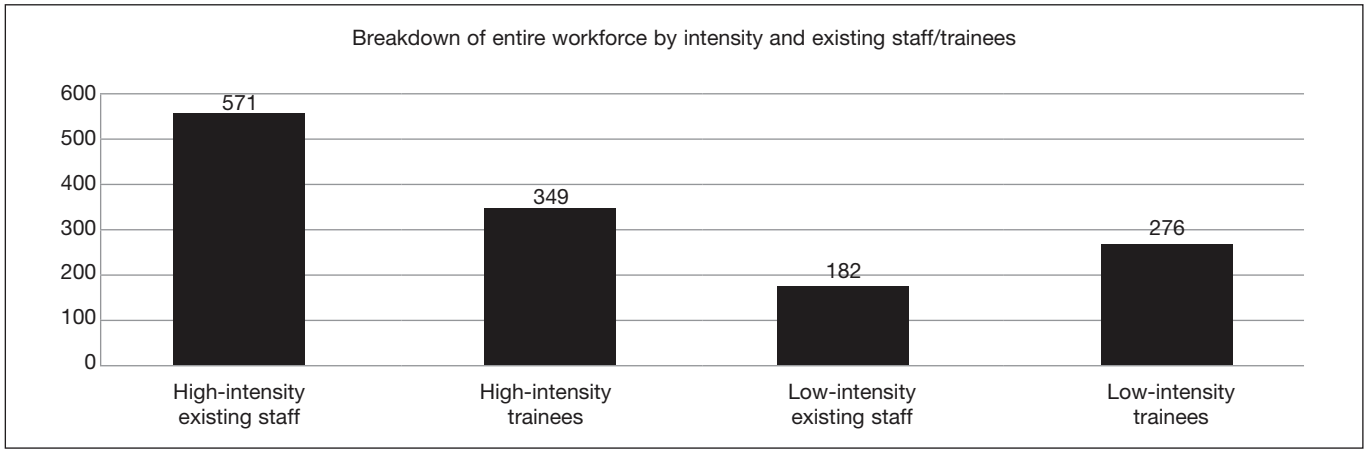


Figure 2b: Gender of staff

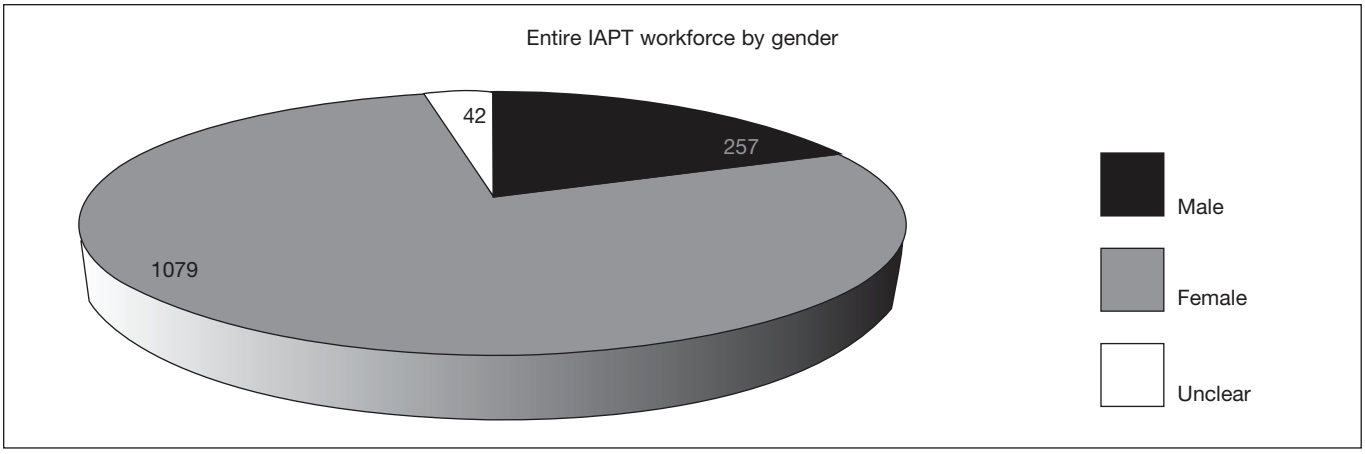


Figure 2c: Age of staff

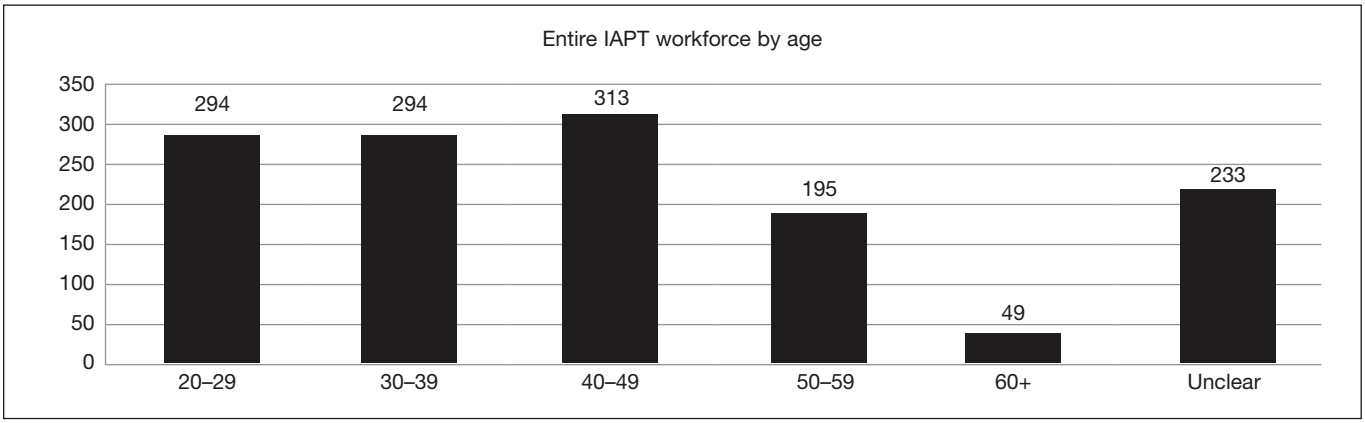
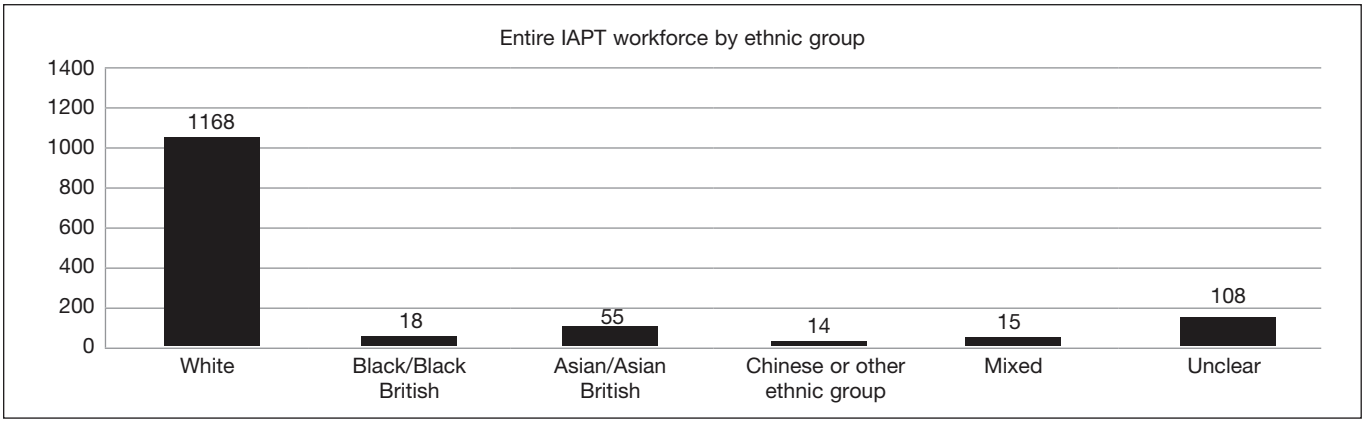


Figure 2d: Ethnicity of staff



on training courses compared to their presence within existing services. This has been identified as a possible barrier to IAPT obtaining optimum clinical outcomes from its workforce. The low-intensity trainee workforce appears to draw on various health care support workers, psychology assistants and people working within administrative mental health roles. Again, as with ethnicity, it should be stressed that there are wide regional variations in the workforce profiles of IAPT staff, which probably reflect differences in recruitment policies, service redesign initiatives, and differences in how commissioners have planned new IAPT services alongside existing services.

Enhancing and extending the competences and roles of the existing, qualified workforce

Should we assume that our existing qualified workforce

Figure 3: Make up of the IAPT high-intensity workforce

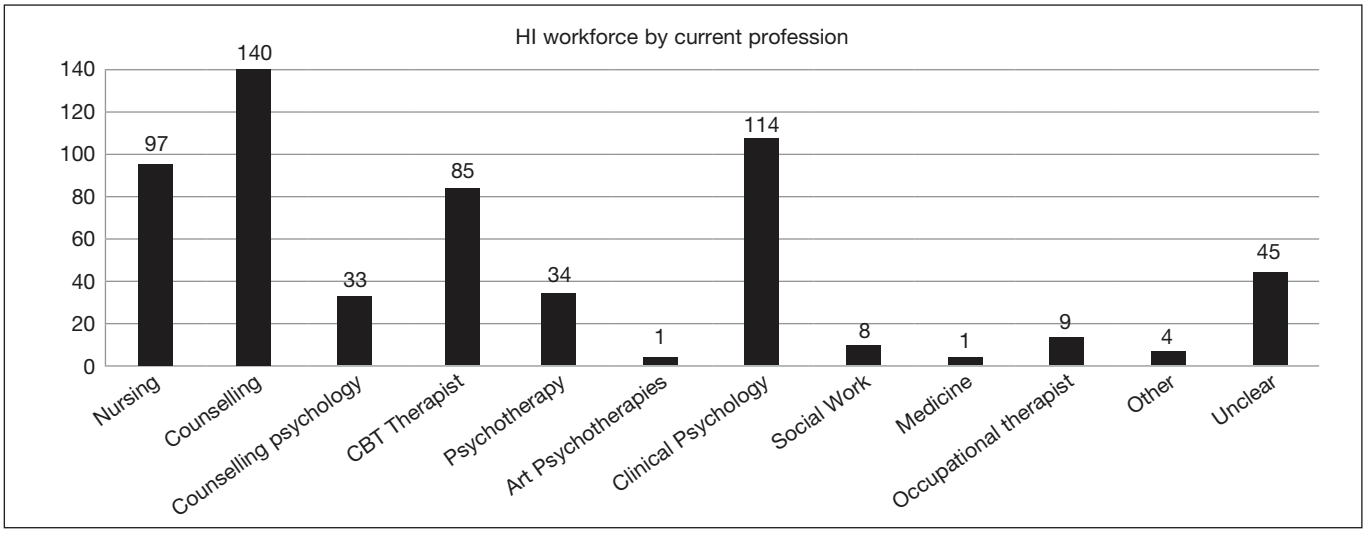


Figure 4: Backgrounds of high-intensity trainees

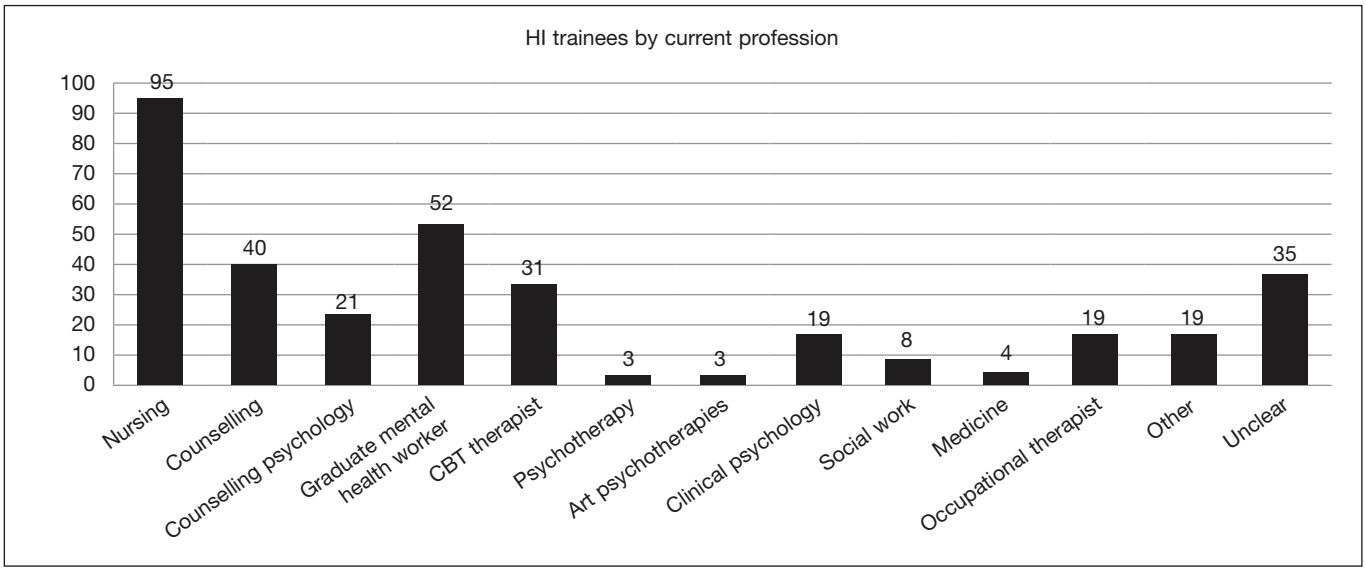
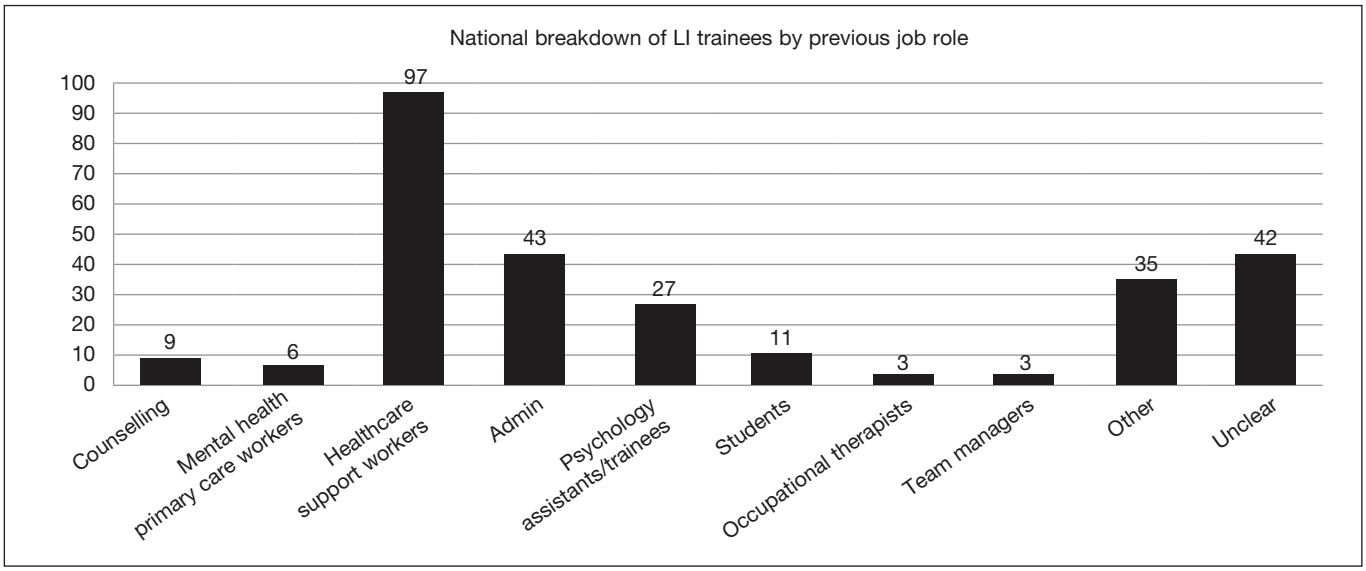


Figure 5: Backgrounds of low-intensity trainees



is competent and fit for purpose? How do we tell? Is it via people's membership of professions, through educational qualifications, accredited training courses and workshops? This has been a key issue for IAPT since the monies for new implementer sites have been targeted at those existing services, where a third of the staff already have the competences to deliver high-intensity interventions and, hence, will be able to supervise the high numbers of trainees who will be working within the service. However, many people trained in CBT some years ago, and without the recent requirements for ongoing continuing professional development (CPD) from either regulators or professional bodies, are likely to require further training and updating if they are to match the competences of the new IAPT trainees. There will also be staff working in existing services who may wish to upskill and extend their existing roles (eg. community psychiatric nurses, social workers etc) or therapists who have trained in one modality and wish to offer therapy in another modality (eg. psychodynamic counsellors wishing to train in either IAPT or CBT). Continuing professional development, therefore, has a critical role in ensuring that the existing workforce is fit for purpose and competent, but also promoting flexibility so that existing staff can be trained in new and perhaps more appropriate competences and skills.

Using senior staff to supervise and develop others

Until the implementation of Agenda for Change, career frameworks and progression tended to be determined by qualifications and the time served in post. This has often resulted in senior clinicians performing job roles such as offering regular and routine outpatient psychotherapy sessions in ways that may not differ from their more junior colleagues. New Ways of Working, together with the Agenda for Change, has shifted the focus from the individual to the job and its requirements. This has challenged many professional groups, since it has required senior or consultant members of the profession to measure up their contribution and cost to the service against their own job role. For example, is it cost-effective that highly trained and paid consultant psychiatrists should routinely offer outpatient clinics whose functions could be delivered either by more junior staff or other members of the multidisciplinary team? Within IAPT, this has required senior clinicians, often from psychology, to become more involved with clinical leadership and service development issues. In addition, an important aspect of the IAPT service model is that all staff receive ongoing expert supervision around clinical outcomes (IAPT, 2008b) Indeed, we have argued elsewhere that a quality psychological therapy service is not just dependent

on the competences of its therapists, but also individuals who can offer clinical leadership, provide aspects of clinical governance, service development and research and development, and also link to user advocacy, social inclusion, diversity and equality issues, employment and work, and medicines/physical conditions management (Turpin *et al*, 2008; Turpin, 2009).

Ensuring the engagement of all stakeholders

'*Look out, not up*', is the mantra of the new Department of Health approach under the leadership of David Nicholson. Psychological therapies, however, is a field fragmented with rivalries and turf wars among different disciplines, few of which make sense to the public, or allow for any forward-looking vision; indeed, the collective mantra has tended to be: '*… but always look behind you*'! Given the NWW focus on creating a new competence-based workforce, IAPT's approach to investment in NICE-compliant services, and the backdrop of an NHS enjoined to deliver world class commissioning through increased tendering of new services, it was inevitable that our enterprise would create anxieties and tensions for the existing workforce. In some cases, and on occasion as an unintended consequence of the way local commissioners have decided to interpret national commissioning guidance, IAPT's introduction has been associated with redundancies and redeployments due to service redesign. Above all, the dominance of CBT therapies within IAPT as the first-phase treatments of choice has also given rise to significant tensions both throughout the counselling and psychotherapy communities, among existing service providers in primary care and the third sector, and within the national programme team. Although not all hearts and minds are persuaded of IAPT's starting out point during this first-phase, a stakeholder engagement strategy has been developed in order to 'keep the show on the road', enabling benefits to service users to be kept at the forefront, and ongoing tensions necessarily lived with as the programme evolves towards a second phase, underpinned by more consensual principles articulated within the Statement of Intent (IAPT, 2008a).

It is here, however, that we would argue, at least in relation to NWW and workforce development, that the central stakeholder engagement strategy has succeeded, primarily through the emerging outcomes of the project New Ways of Working for Psychological Therapists. We should also acknowledge the courage of the IAPT Programme Board in being brave enough to collaborate with the New Savoy Partnership and allow the programme to stand up and be counted at the annual Psychological Therapies in the NHS conference, as well as supporting the New Ways of Working project within IAPT. If judged in the longer term, we do succeed as a national programme in making a real difference to peoples' lives – relieving distress, transforming lives – as we say, it will also be a considerable tribute to the courage of the profession itself, since no one is under any illusion about the demands for change and embracing evidence-based practice, which NWW and IAPT have placed on the workforce.

Notwithstanding, therefore, acknowledged ongoing conflicts, it is worth describing by way of conclusion how we are articulating a common vision and common challenge for the workforce, which has enabled IAPT to move forwards with continued stakeholder support.

New ways of working for psychological therapists

This programme began in 2008 and is intended to conclude in late summer 2009. Our first challenge has been around the choice of NICE guidelines: if the inspirational call from Lord Layard was for us to step up to the plate and really engage with how to reduce distress levels across the UK (IAPT is an NHS programme), why depression and anxiety for adults as opposed, say, to alcohol or work or exam-related stress? Clearly, there had to be a starting point, but this has caused uncertainty among commissioners and clinical leads on how to prioritise NICE guidance implementation strategies locally. Given that new, updated NICE guidelines for depression are due this autumn, it remains to be seen how their recommendations will be reflected in the evolving IAPT programme. Professor Peter Fonagy and this paper's lead author co-chair a NWW working party to address these questions.

Our second challenge has been around which therapists and our source of workforce supply. Granted that NICE guidelines currently privilege CBT interventions, not exclusively and not without disagreement, but in the main, which practitioners are best placed to deliver these? NWW cuts across monopoly practice and traditional professional boundaries, which is why it represents

a challenge to all those professions who seek to hold on to what may be their elevated status.

But if endemic interdisciplinary rivalries in this part of the field are coupled with an effective absence of workforce planning in mental health locally, what may result is a confusing smorgasbord of different titles, job descriptions, qualifications and pay structures, so that even for professional colleagues within teams, say, a psychologist and a counsellor, it is often the case that neither understands the training and potential capabilities of the other. Our aim is to describe the existing range of training and professional backgrounds, and to begin to describe a common and inclusive career framework for psychological therapists.

Finally, we have been considering what constitutes a capable IAPT team. Who is in the team, who is out, and who plays in what position? This is an area where randomised control trials (RCTs), however definitive in establishing treatment efficacy, are unable – on their own – to provide answers. Pragmatic RCTs can certainly contribute to the evaluation of different team configurations, but unless a wider range of practice-based evidence is brought to bear on comparing different models, the science of improving quality will ossify. In grounding their work in examples of how different IAPT teams have evolved different solutions to the same challenges, this part of NWW aims simply to offer a realistic picture of how IAPT translates successfully into various workforce configurations at the coalface. This is important for the ongoing sustainability of IAPT teams and services in the future.

In Aldous Huxley's novel, *Brave New World*, the system was designed to pre-empt distress by removing the problem of choice in life. Two years on, in order to deliver the commitments within the Statement of Intent, opportunity around expanding choice in psychological therapies is precisely the territory where our '*brave new workforce*' must not fear to tread (Huxley, 1932).

Conclusion

We believe that the principles espoused by NWW have provided direction and pragmatic ways of resolving some of the many complex and demanding workforce development challenges thrown down by the IAPT programme – at least in the short-term. The IAPT programme thus far has been specifically based around evidence for CBT and the demonstration of therapeutic competence in CBT. Ultimately, as is made explicit in the Statement of Intent, the IAPT programme must successfully embed itself alongside and in partnership with the rest of the psychological therapies workforce; otherwise its future is unsustainable. This has required the programme to engage with a multiprofessional agenda involving a wider range of therapists and practitioners beyond CBT, with experience of working both within the NHS and third sector, across a range of professions and professional bodies, and also across diverse therapeutic approaches and models. Has using the experience from previous NWW projects allowed the IAPT programme to avoid some of the problems experienced from introducing new roles into settings not prepared for their deployment, such as the previous primary care graduate worker programme (Harkness *et al*, 2005)? We have argued that NWW has indeed enabled implementation at points where otherwise the programme may have faltered, while reflecting that the honest answer to this can only be a qualified yes at this point. The emergent findings from the independent evaluation led by Professor Glenys Parry of the two pilot sites, Doncaster and Newham, provide a clear message around the central importance of stakeholder engagement, much in keeping with NWW principles described here, and in time and effort invested in building professional links with existing services. On reflection, IAPT's extremely rapid delivery schedule has probably not allowed sufficiently for this, and the central programme team has acknowledged they have been less strong on providing guidance to commissioners around the crucial importance of integrating IAPT with existing services, a task that is now being addressed. In terms of workforce planning, any approach, which deliberately sets out to create a 'brave new workforce' is open to the criticism that it may be overlooking the potential contribution of the existing workforce. The fact has been hitherto, however, that accurate data on the psychological therapies workforce is lacking and a part of our challenge, being taken up within the New Ways of Working for Psychological Therapies project, is to build this infrastructure as the IAPT programme rolls out and as workforce reform gets underway. Finally, we would like to think that in another two years from now, we could return with a further paper for this journal, to examine whether NWW has helped steer and implement expanded choice and successful integration, resulting in

more coherent, patient-centred care pathways, as well as improved access to psychological therapies within one of the most ambitious and radical developments in mental health that England has seen.

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