



Department of
**Health, Social Services
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AN ROINN

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

MÁNNYSTRIE O

**Poustie, Resydènter Heisin
an Fowk Siccar**

A STRATEGY FOR THE DEVELOPMENT OF PSYCHOLOGICAL THERAPY SERVICES

June 2010

FOREWORD

I am delighted to launch *A Strategy for the Development of Psychological Therapies in Northern Ireland*. In doing so, I believe that improving access to psychological therapies has huge potential to improve outcomes for individuals, families and carers, and for the wider community. This psychological therapies strategy is part of my commitment to *Delivering the Bamford Vision – Action Plan (2009-11)*.

Improving provision of psychological therapies makes good sense. It can, for example, help individuals and families by providing early psychological interventions and, for established conditions, much can be done to relieve anxiety, depression and distress.

It is expected that psychological therapy services will be integrated into stepped care models for provision of mental health and learning disability services. In addition, links need to be made to other services for other long-term conditions, neuro-disability and challenging behaviours.

This strategy highlights the need for information to be available to the public on what services and interventions are available to them. I aim to promote early intervention, self help and support in the community, but I also recognise the need for specialist services for people with complex conditions, particularly those arising from mental health and learning disabilities.

Services will need to be redesigned around the needs of individuals. Regardless of the settings in which these services are delivered, they will be person-centred and flexible. In addition, services will be delivered to agreed principles and standards, and by competent and skilled staff, who are appropriately supervised and accredited by relevant professional bodies.

The recommendations contained within this document will have far reaching implications for the commissioning and provision of psychological services, not just in the statutory sector, but also in the community and independent sectors.

Relevant actions within the Bamford Action Plan (2009-2011) are being implemented through the HSC Bamford Taskforce, which is jointly led by the HSC Board and Public Health Agency. Through this mechanism, I expect to hear of timely progress to implement the recommendations contained in this strategy.

Michael McGimpsey MLA

Minister for Health, Social Services & Public Safety

CONTENTS

Page No

EXECUTIVE SUMMARY

- SECTION 1**
- Aims & Objectives of the Psychological Therapies Strategy
 - Strategic Context
 - The Impact and cost of Mental Disability
- SECTION 2**
- Definition of Psychological Therapies
 - Scope of this Strategy
 - Psychological Interventions – Which Ones? – Applying the Evidence Base
 - Current Service Provision of Psychological Therapies
- SECTION 3**
- Principles for Commissioning of Psychological Therapy Services
 - A Stepped Care Model for Mental Health and Learning Disability Services
 - Integrating Psychological Therapies into a Stepped Care Model
- SECTION 4**
- Operationalising a Stepped Care Model
 - A Stepped Care Model for Adult Mental Health Conditions
 - A Stepped Care Model for Children and Young People
 - A Stepped Care Model for People with a Learning Disability
- SECTION 5**
- New Ways of Working – Workforce Development
 - Staffing Requirements
 - Training, Accreditation and Supervision
 - Links to Professional Regulatory Bodies
- SECTION 6**
- Implementing the Strategy
 - Monitoring and Evaluation of Services
 - Promotion of Research
 - Development of a Regional Psychological Therapies Group

BIBLIOGRAPHY

REFERENCE GROUP MEMBERSHIP

APPENDICES

- A** Psychological Therapies – The Major Schools
- B** NICE Psychological Interventions for Common Mental Health Disorders

EXECUTIVE SUMMARY

INTRODUCTION

This strategy has the overarching aim of improving the health and social wellbeing of the population of the Northern Ireland by improving access to psychological therapies and by being more responsive to service user's needs.

Many people in our society suffer from debilitating conditions, as a consequence of their relatively poor physical, emotional, behavioural and/or mental health. These can affect all age groups, for example, children and young people with emotional and behavioural disorders, young mothers with depression and adults of working age who, because of their ill-health may have relationship difficulties and find it hard to support their family and hold down a job. Older people too may have psychological problems, including those arising from their physical disease and from social and mental health conditions, such as isolation, depression, anxiety and bereavement. In addition, it is acknowledged that carers need psychological support, to maintain and improve their mental health and to assist them to look after their loved ones with long-term physical, mental health and learning disabilities.

Improving mental wellbeing in our society, through improved access to psychological interventions makes good sense. It can help individuals and families, for example, through early intervention and, for established conditions, much can be done to relieve anxiety, depression and distress regardless of the cause of the underlying condition. Psychological interventions can help people to be independent and to live as valued members of their community.

Even in economic terms psychological interventions have benefits, for example, by improving an individual's physical and mental health outcomes, their ability to work and be economically productive. In addition, improved mental and social wellbeing can help prevent anti social behaviour and family breakdown in children and young people, reduce the burden of anxiety and depression, and input into the rehabilitation of offenders. Also, by assisting in the maintenance of independence it can reduce reliance on medication and on residential and hospital care.

How to Read this Document

This document is divided into sections with recommendations contained throughout the sections and summarised below.

SECTION 1 – This section outlines the aims and objectives of the strategy. The strategy mainly relates to adults and older people’s mental health services, child and adolescent mental health services, and learning disability services. However, it is envisaged that appropriate links will be made to other services such as forensic mental health services, physical and neuro-disability services including challenging behaviour.

The strategic context for development of this strategy in the *Bamford Review of Mental Health and Learning Disability (2007)* and the DHSSPS *Delivering the Bamford Vision- Action Plan (2009-11)*. In addition, it is acknowledged that 40 years of civil unrest has led to much Troubles - related trauma. The impact of disability on individuals, families and society can be profound, not just in human cost but also in economic cost.

SECTION 2 – This section contains a definition of psychological therapies and further outlines the scope of the strategy. Psychological therapy services should be a core component of mental health and learning disability service provision and should be delivered by staff with the appropriate skills and competence relevant to the level of interventions required.

The strategy recognises the importance of evidence based interventions and the need to translate evidence base into practice. In doing so, it acknowledges that evidence base can change; hence, commissioning and service provision should also change to reflect modern evidence-based practice. The current serviced provision within HSC organisations and primary care is highlighted. It is recognised that the community, voluntary and independent sectors play a valuable role in service provision. Further detailed mapping of current capacity/demand will be required across primary, community and secondary sectors.

SECTION 3 – This section outlines the principles for service commissioning and highlights that there should be a service specification for the commissioning of

psychological therapy services, recognizing the importance of national and regionally agreed standards and guidelines. Psychological therapies should be embedded into stepped care models for service provision. Services should be tailored to individual needs, and low and high intensity interventions provided by a range of professionals with the skills and competence to do so. Where appropriate, staff should be accredited and registered with relevant professional organisations and regulatory bodies.

SECTION 4 – This section deals with the operationalisation of the stepped care models and emphasises the need to incorporate psychological services into relevant settings. There should be agreed threshold criteria and referral pathways for access to HSC secondary care/specialist services which should have a single point of entry with appropriate triage and/or assessment to ensure that referrals are directed to the appropriate service/level of intervention. Examples of stepped care models for adult mental health psychological services, child and adolescent mental health and learning disability services are provided. These aim to highlight what types of interventions are delivered at the various steps and by whom.

SECTION 5 – This section deals with workforce issues and highlights the need for new ways of working and workforce development to ensure that psychological therapy services are successfully delivered. Staffing requirements are highlighted together with the need to have adequate training, accreditation and a supervision framework in place to promote safe and effective care.

SECTION 6 – This section focuses on implementation of the strategy and the need for further research. A Regional Psychological Therapies Group will take forward the recommendations, under the auspices of the HSC Bamford Taskforce which is jointly led by the HSC Board and Public Health Agency. Ongoing monitoring and evaluation of the strategy will be essential to take account of clinical and cost effectiveness, improved accessibility, workforce governance, service user and carer experience and satisfaction.

RECOMMENDATIONS

This Strategy makes the following recommendations:

- 1. The provision of psychological therapies should be a core component of mental health and learning disability services. Services should be delivered by staff with the skills and competence appropriate to the level of interventions required, and to national and regionally agreed standards and guidelines.**

- 2. Recognising the importance of psychological interventions, if a new care pathway or service framework is being developed, due consideration should be given to the inclusion of psychological therapies within the pathway and service standards.**

- 3. The public, service users and clinicians should have information on the range of psychological therapy services that are available and how to access them.**

- 4. In order to fully understand current service provision in primary and community settings, a detailed map of current capacity/demand and associated workforce skills is required in:-**
 - a) adult mental health, and learning disability services;**
 - b) child and adolescent mental health services; and**
 - c) child and adolescent learning disability services.**

- 5. A detailed map of the remaining specialist/secondary psychological therapy services is required, to ensure that those with more complex difficulties and/or severe and enduring mental health or learning disability needs also have access to appropriate specialist services. This mapping exercise will need to link into forensic mental health/learning disability services for both adults and young people, and physical, neurological disability and challenging behaviour services.**

- 6. The HSCB/PHA should develop an agreed service specification for the commissioning of psychological therapies, taking account of the service principles outlined in this document, and national standards and guidelines.**
- 7. Trusts should re-design mental health and learning disability services around a stepped care model with access to psychological therapy services at all levels.**
- 8. Each Trust should have a single point of access for HSC secondary care/specialist services informed by agreed threshold criteria and referral pathways, which should incorporate appropriate processes for triage and/or assessment to ensure that referrals are directed to the appropriate service/level of intervention.**
- 9. Professional and cross-professional workforce reviews, which are of strategic significance in improving access to psychological therapies, should be implemented.**
- 10. A consortium of stakeholders should be commissioned to agree a regional approach to training requirements, with particular reference to needs of therapists at the different levels within the stepped care model.**
- 11. A supervision framework should be developed, which sets out the core competences and accreditation required for supervisors at the different levels of intervention.**
- 12. Psychological therapy services should be subject to evaluation – to include therapeutic outcomes, safety and governance, cost effectiveness of service delivery and the views/experiences of service users and carers.**
- 13. In line with the Bamford Action Plan (2009) a prioritised plan for research on mental health and learning disability should be developed**

and should incorporate measurement of effectiveness of psychological interventions.

- 14. Under the auspices of the Bamford HSC Taskforce, a Regional Psychological Therapies Group should be established to implement this strategy and to advise the Department on the future development of psychological therapy services across the lifespan. Where appropriate, the Group should recognise the importance of psychological interventions for other long terms conditions. The Group should be representative of commissioners, service providers, carers and users.**

SECTION 1

Aims & Objectives of the Psychological Therapies Strategy

Strategic Context

The Impact and Cost of Mental Disability

AIMS AND OBJECTIVES OF THE STRATEGY

- 1.0 The Department of Health, Social Services and Public Safety (DHSSPS) has identified the development of psychological therapy services as an important element of its overall strategy to reform and modernise mental health and learning disability services.
- 1.1 This document provides a strategic framework for the development of these services, consistent with other strategies to improve health and well being, the management of long term conditions and the recommendations of the Bamford Review of Mental Health and Learning Disability (2007). In this context, the Strategy is part of the Bamford Action Plan produced by the DHSSPS in October 2009.
- 1.2 The aim is to provide a range of psychological interventions and services that are:
- Clinically effective;
 - Safe;
 - Cost effective;
 - Comprehensive;
 - Coordinated and user friendly and
 - Commissioned and delivered to a standard consistent with national and regionally agreed standards and guidelines.
- 1.3 The strategy has focused on the development of evidence-based psychological therapies and interventions, as defined in Section 2. However, it is recognised that a broad range of generic psychosocial interventions, delivered by health and social care professionals, make important contributions to secondary prevention, care and recovery in mental health services. These should be embraced and utilised, when translating the more specific recommendations of this strategy into operational frameworks.

- 1.4 The recommendations set out in this strategy will apply to psychological therapies provided across primary, secondary and community sectors to include Adult and Older People's Mental Health Services, Child and Adolescent Mental Health Services and Learning Disability Services. It is envisaged that they will link with other services such as Forensic Mental Health and Learning Disability Services and services for people with physical and neurological disabilities and challenging behaviour. The recommendations will apply to services provided by the statutory sector and to voluntary and independent sector services commissioned by the HSC.

STRATEGIC CONTEXT

- 1.5 The Bamford Review of Mental Health and Learning Disability (2007) noted the advances in the sophistication and range of psychological therapy services. It also highlighted that research shows that the use of certain therapies are effective in the treatment of particular conditions. However, it found that access to psychological interventions was extremely poor. A need for training across all mental health professional groups was identified to develop the skills of therapeutic relationship building. At the same time there was a need to use evidence based psychological therapies.
- 1.6 The Bamford findings reflect the impact of Troubles related trauma on both the adult and adolescent population in Northern Ireland and the ad hoc way in which psychological therapy services have developed.
- 1.7 Almost 40 years of civil unrest during the Troubles continues to impact on society, with services becoming more aware of the impact of trans-generational trauma on children and families. The psychological impact of the Troubles is difficult to estimate for many reasons; however, evidence suggests that significant numbers of people within the population have been psychologically affected by the conflict, with estimates of one in five people having suffered multiple experiences relating to the Troubles and one in ten have been bereaved as a result of the Troubles. Related to this, Bamford

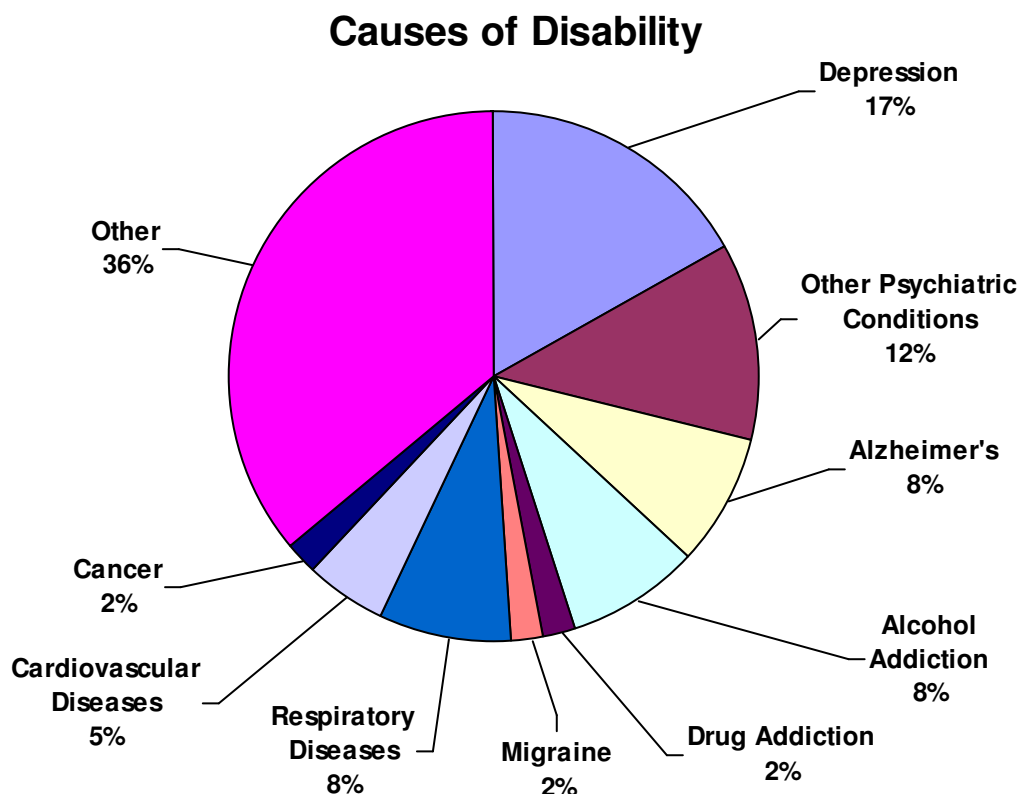
reported an estimated 25% increased psychological morbidity within Northern Ireland compared to neighbouring jurisdictions.

- 1.8 The Bamford Review highlighted that part of the problem has been that there is no overall framework that acknowledges the effectiveness of psychological interventions on health and wellbeing in Northern Ireland; describes the current service gaps; highlights the settings in which they should be available; and documents the training, competencies, supervision and accreditation which commissioners should take account of when commissioning services.
- 1.9 In response to the Bamford findings, this document aims to provide a template for moving forward on improving access to psychological interventions. The Strategy is underpinned by an additional investment over the Comprehensive Spending Review 2008-2011 (£4.4m recurrent from 1st April 2011). In addition, the Department has included in its Priorities for Action 2010/11 targets to reduce waiting times for psychological therapy to no longer than 13 weeks.

THE IMPACT AND COST OF MENTAL DISABILITY

- 1.10 The impact of disability on individuals, families and society can be profound. For individuals, the suffering and mental anguish arising from mental disability can be extreme. Professor Lord Layard in the *Depression Report* (2006) highlighted how crippling depression and anxiety can be on individuals and our society, and how psychological interventions are both clinically and cost-effective; thus requiring major investment. This is supported by the National Institute for Health and Clinical Excellence (NICE) which acknowledges the place of psychological interventions in a range of physical conditions in addition to the management and treatment of mental health including depression and chronic anxiety conditions.

Figure 1 - Causes of Disability



1.11 *Figure 1* above shows how important mental ill-health, in its broadest sense, is on disability – accounting for over 40% of all disability. Layard et al found that while depression and anxiety accounted for a third of all disability, they attracted only 2% of NHS expenditure.

1.12 Not only does mental ill- health impact on individuals, families and carers, but it also has economic consequences. The cost of mental ill health to the economy of Northern Ireland as a whole is huge. A 2003 study undertaken by the NI Association for Mental Health and the Sainsbury Centre for Mental Health '*Counting the Costs: The Economic and Social Costs of Mental Illness in Northern Ireland*' found that the cost of mental illness in NI in 2002/03 was £2.8bn. In the same year the total budget for DHSSPS was £2.4bn.

- 1.13 In addition, figures from the Department of Social Development show that Mental ill health remains the main cause of incapacity with nearly 44% of claimants having mental health or behavioural disorders*
- 1.14 Improving access to psychological therapies does not necessarily mean that the need for medication will reduce. However, for some service users it does provide an alternative to the need for reliance on medication.
- 1.15 The table below highlights the number of prescriptions and annual community prescription costs for antidepressants and anxiolytics in Northern Ireland for 2006-2008.

| Year | Number of Prescriptions | Ingredient Cost Before Discount |
|------|-------------------------|---------------------------------|
| 2006 | 2.04m | £22m |
| 2007 | 2.2m | £21m |
| 2008 | 2.24m | £20m |
| 2009 | 2.39m | £19.7m |

*Department for Social Development: Incapacity Benefit and Severe Disablement Allowance Summary Statistics February 2008

SECTION 2

Definition of Psychological Therapies

Scope of this Strategy

Psychological Interventions- What works? - Applying the Evidence Base

Current Service Provision of Psychological Therapies

DEFINITION OF PSYCHOLOGICAL THERAPIES

2.0 In this document the term psychological therapies means “an *interpersonal process designed to modify feelings, cognitions, attitudes and behaviour which have proved troublesome to the person (or society) seeking help from a trained professional (STRUPP)*”). They encompass a range of interventions, based on psychological theory and evidence, which help people to alter their thinking, behaviours and relationships in the present, and process trauma and disturbance from the past, in order to alleviate emotional distress and improve psychosocial functioning.

THE SCOPE OF THE STRATEGY

2.1 The main focus of this document is on psychological therapy services and interventions in the context of commissioning and provision of HSC services in primary, community and secondary care, and training, with particular reference to:-

- adult mental health services, including older adults;
- child and adolescent mental health services, and associated family services;
- learning disability services (adults and children and young people);
- forensic mental health and learning disability services; and
- services for people with physical and neurological disability, especially where it links to mental ill health, learning disability and challenging behaviour.

2.2 Psychological therapy provision is a multi-professional and multi-agency endeavour. Psychiatrists, psychotherapists, psychologists, counsellors, nurses, social workers, occupational therapists, arts therapists and many other groups are involved, all of whom need to communicate and co-ordinate effectively with one another. Therapy can also be provided by a range of practitioners in the voluntary and independent sectors.

- 2.3 Psychological therapies/interventions should be available to all age groups in a variety of settings and for a range of physical, emotional, psychological and psychiatric conditions. Their purpose is to provide effective treatment and promote individual, group and family wellbeing and resilience.
- 2.4 It is recognised that service providers should work in partnership with families and carers of service users, as they play an extremely important role in helping the recovery process and preventing relapse in certain conditions. The contemporary model of Family Work aims to educate families and carers about the presenting condition, its management and treatment and its impact on family functioning. This work aims to empower families in enhancing/developing coping strategies, family well-being, maintaining and extending social networks, managing/coping with a crisis and, where appropriate, recognising early signs of relapse.
- 2.5 The Bamford Review also recognised the importance of the recovery model for those with mental health conditions. Psychological therapies are an integral part of this recovery model and need to be integrated into individual care plans. In addition, it is recognised that psychological therapy intervention can play a significant part beyond the health and social care sector, for example, in schools and youth settings, and in the youth and adult justice systems. It is acknowledged that many services are delivered outside of the statutory system.
- 2.6 Outside of designated mental health services, psychological therapies have been shown to be beneficial in a range of other conditions, including chronic physical health conditions, long term neurological conditions including acquired brain injury, bereavement and terminal care. They can also assist and support families and carers. Recognising the breadth of conditions that can be assisted by psychological interventions, it is recommended that: during the course of development of a new care pathways and service frameworks, especially for life long physical health conditions, due consideration should be given to the place of psychological therapies within the pathway and service standards

- 2.7 The place of community, voluntary and independent sector is pivotal and, irrespective of which sector provides the service, standards for service delivery, training, accreditation and supervision should be comparable with relevant national standards and guidelines and local governance arrangements for the commissioning of services.

RECOMMENDATION 1

The provision of psychological therapies should be a core component of mental health and learning disability services. Services should be delivered by staff with the skills and competence appropriate to the level of interventions required, and to national and regionally agreed standards and guidelines.

RECOMMENDATION 2

Recognising the importance of psychological interventions, if a new care pathway or service framework is being developed, especially for other life-long physical health conditions, due consideration should be given to the inclusion of psychological therapies within the pathway and service standards.

PSYCHOLOGICAL INTERVENTIONS – WHAT WORKS? - APPLYING THE EVIDENCE BASE

- 2.8 The concept of “evidence base”, in relation to new treatments and interventions in health and social care, refers to the research to support the claimed benefits of a particular treatment, intervention or medication when used in the management of a particular condition.
- 2.9 This evidence- based approach seeks to embed research findings into the design, commissioning and practice of services acknowledging that findings may include different outcomes such as - effectiveness, acceptability, safety or quality and also different research methodology (e.g. randomised controlled trials, systematic reviews or qualitative research) all of which have their own validity.

- 2.10 It is fundamental that the evidence based approach adopted should be broad enough to accept the inevitable limitations in respect of the wide variety of individuals, types of intervention, conditions and settings to which it is applied. Nevertheless, there are several key sources for evidence based practice, e.g. locally endorsed guidelines from the National Institute for Health and Clinical Excellence (NICE) along with emergent and rapidly growing new evidence across the full range of psychological interventions.
- 2.11 A range of psychological therapies and interventions as applied to adults and older adults, child and learning disabled populations have an increasing evidence base as reflected in NICE and other national guidelines. These have been derived from four schools of psychological therapy (as outlined in **Appendix A** and defined in the National Skills for Health Initiative):
- Cognitive Behavioural Therapy;
 - Psychodynamic/Psychoanalytic Psychotherapy;
 - Systemic and Family Therapy;
 - Humanistic Psychotherapies.
- 2.12 National occupational standards, and in specific cases protocols, from these models of therapy have been developed for specific problems and contexts. Thus, a range of psychological interventions, derived from these therapy models, have an evidence base and have relevance for the multiple presentations which present to adult, older adults, child and adolescent, and learning disability services. Especially for the complex and co-morbid presentations, including individuals with severe mental illness, specialist training in appropriate therapeutic models will be required, together with the capacity to tailor and integrate interventions from a range of therapeutic perspectives.
- 2.13 There is now a strong evidence base for the use of psychological therapy services in the treatment of a wide range of conditions particularly for mental health. **Appendix B (1&2)** provides an overview of relevant National Institute

for Health and Clinical Excellence (NICE) guidance on psychotherapeutic interventions for common mental health disorder in children and adults.

These include:

- depression;
- bipolar disorders;
- generalised anxiety states and panic disorders;
- schizophrenia;
- post traumatic stress disorder;
- obsessive compulsive disorders;
- anorexia nervosa and bulimia nervosa;
- self harm; and
- personality disorders.

2.14 In order to make informed choices about the most appropriate therapy to access in relation to a particular need or specific health condition the public, service users and clinicians should have information on the range of psychological therapy services that are available and how to access them.

2.15 Individuals with established and enduring mental health conditions, including those who are inpatients, must also benefit from the provision of information.

RECOMMENDATION 3

The public, service users and clinicians should have information on the range of psychological therapy services that are available and how to access them.

CURRENT SERVICE PROVISION OF PSYCHOLOGICAL THERAPIES

2.16 Attempts to establish the number of professionals and range of therapies being delivered across Northern Ireland have been problematic. This is because staff can only be identified by job title/profession, for example, Psychiatrist, Clinical Psychologist, Social Worker etc., rather than the range of psychological services and therapies they provide. However, Northern Ireland data in 2008/2009 found that there were;-

- 158 clinical psychologists, 90 trainee clinical psychologists and psychology assistants;
- 103 established consultant psychiatrists posts in HSC services;
- over 60 other therapists specifically employed within Trusts to provide therapies for a range of conditions;
- 10 designated family therapy posts within CAMHS services, with half of these based in the Regional Family Trauma Centre; and
- 7 qualified Child and Adolescent Psychoanalytic Psychotherapists (CAPt) in NI, 3 of whom are employed in designated HSC child and adolescent posts in two Trusts.

2.17 In addition to above, there are other staff who provide psychological interventions but who do **not** have this specifically identified **in their job title or description** – for example, psychiatric nurses, social workers, occupational therapists, and a range of therapists. Such professionals will often have completed post- qualification training in, for example, cognitive behaviour therapy, interpersonal psychotherapy, schema therapy, narrative therapy, family therapy, art therapy, child psychoanalytic psychotherapy. It is likely that the therapeutic interventions provided by these professions will vary depending on the services in which they are employed.

2.18 In the context of mental health and learning disability services, there is also a range of HSC commissioned services from the voluntary and independent sectors where staffing levels and the range of psychological interventions and skills available are not well documented. Therefore, attempts to scope have also been difficult.

- 2.19 Until recently in general medical practice (GMS), there have been no formal therapy services directly available within practice. From 2009, the DHSSPS has provided the funding to introduce computerised cognitive behavioural therapy into every general practice in Northern Ireland. This “Beating the Blues” programme is endorsed by NICE and is primarily designed to treat mild to moderate depression. It is currently being rolled out in GMS and the expectation is that it will be available soon in every general practice in Northern Ireland. It will be available for access by patients and supported by therapists, as appropriate. In addition, a Directly Enhanced Service for depression has also been introduced into general practice. This will provide additional resources for GPs to access counselling services that meet defined standards and recognised accreditation.
- 2.20 All of the above information indicates that further detailed work is required to fully understand current service provision and its links to respective programmes of care, including primary and community care, and specialist secondary services.

RECOMMENDATION 4

In order to fully understand current service provision in primary and community settings, a detailed map is required of current capacity/demand, and associated workforce skills in:-

- a) adult mental health, and learning disability services;***
- b) child and adolescent mental health services; and***
- c) child and adolescent learning disability services***

RECOMMENDATION 5

A detailed map of the remaining specialist/secondary psychological therapy services is required, to ensure that those with more complex difficulties and/or severe and enduring mental health or learning disability needs also have access to appropriate specialist services. This mapping exercise will need to link into forensic mental health/ learning disability services for both adults and young people, and physical, neurological disability, and challenging behaviour services.

SECTION 3

Principles for Commissioning of Psychological Therapy Services

A Stepped Care Model for Mental Health and Learning Disability Services

Integrating Psychological Therapies into a Stepped Care Model

PRINCIPLES FOR COMMISSIONING OF PSYCHOLOGICAL THERAPY SERVICES

3.0 It is recognised that psychological therapies can be delivered in a range of settings and by staff with different professional backgrounds, for example, psychologists, nurses, occupational therapists, social workers, psychiatrists, counsellors, family therapists and arts therapists. Interventions can be provided by the statutory, voluntary, and independent sectors. But regardless of the profession, the background, the setting, or the sector in which it is delivered the service principles for commissioning and delivery of therapies should be broadly the same.

3.1 The key service principles which service commissioners and providers in the statutory, voluntary, and independent sectors should work to are outlined below. What is needed to underpin the delivery of effective and safe therapy services is:

- Access – to psychological therapies appropriate to age, diagnosis and severity of the condition. Services should be flexibly delivered and take account of local needs, complexity of conditions and available resources; services should follow a stepped care model.
- Information – information in an appropriate format on treatments available, how to access services and likely waiting times should be provided to service users and carers to inform decision making.
- Involvement in decision making – service users need to be involved in decision making about their care. To do this not only involves provision of information but also needs to be condition specific and relevant to the age of the individual.
- Safe and effective evidence based interventions – like any other treatment, psychological therapies can have the potential to do harm; hence there is a need to develop a number of service and quality standards and outcome measures to promote effective practice.

Ideally, such services should be capable of being bench-marked against other comparable services.

- Trained staff and appropriate supervision arrangements- there is a need for an agreed approach to effective selection criteria, recruitment, training and supervision arrangements to provide therapies at all steps of psychological interventions.
- Evaluation criteria – measurement of outcomes should be able to demonstrate, for example, access to services in primary, community and hospital settings, improved patient outcomes in terms of health and wellbeing; promotion of social inclusion, improvement in employment status and, service user/carer satisfaction and experience.

3.2 To ensure psychological therapy services are provided to the same standard across all service sectors throughout Northern Ireland it is recommended that the HSC should develop an agreed service specification for relevant therapies, taking account of the service principles contained in this Strategy.

RECOMMENDATION 6

The HSCB/PHA should develop an agreed service specification for the commissioning of psychological therapies, taking account of the six service principles outlined in this document, and national and regionally agreed standards and guidelines.

A STEPPED CARE MODEL FOR MENTAL HEALTH AND LEARNING DISABILITY SERVICES

3.3 From 2009 onwards, mental health and learning disability services will be structured around a stepped care model. This model provides a framework for the organisation and delivery of mental health and learning disability services with the aim of ensuring that individuals receive the level of required support and/or intervention appropriate to their need. The rationale for this model is to ensure that the best intervention is delivered in the right place, at the right time, by the right person to meet a person's assessed needs. Psychological therapy services should be an integral part of the stepped care

model for delivery of mental health and learning services. It is recommended that Trusts should re-design services around a stepped care model ensuring that psychological therapy services form an integral part.

RECOMMENDATION 7

Trusts should re-design mental health and learning disability services around a stepped care model with access to psychological therapy services at all levels.

INTEGRATING PSYCHOLOGICAL THERAPY SERVICES INTO A STEPPED CARE MODEL

3.4 Typically there are 4-5 steps in a stepped care model. It is organised around definitions of psychological need.

Step 1 – Recognition and assessment of an individual’s difficulties - this might require early recognition, watchful waiting and general advice;

Step 2 – Treatment for transient and mild disorders – this might require low intensity interventions such as psycho-education, guided self help, brief counselling and computerised cognitive behavioural therapy;

Step 3 – Treatment for moderate disorders – this might require access to specialist services such as cognitive behaviour therapy, interpersonal psychotherapy etc.; and

Step 4-5 Treatment for severe and complex disorders – this might require high level specialist services, capable of delivery of integrative and individually tailored psychological interventions.

3.5 The nature and intensity of therapy services will depend on individuals’ needs. At lower steps of the model, a range of “low intensity” therapists may be utilised to deliver circumscribed interventions (with an evidence base) which have been derived from the major models of therapy. These would address

common mild mental health difficulties with limited impact on functioning using, for example, supported self-help, anxiety, management strategies etc. Low intensity therapists are crucial to the implementation of the stepped care model and will, therefore, require careful supervision and their own training programmes to ensure patient safety and governance.

- 3.6 At the higher steps of care (sometimes referred to as high intensity workers) staff should have accredited and/or regulated training to a higher level. They would use standardised psychological therapies, delivered to protocol, to address those common moderate mental health problems that impact significantly on functioning.
- 3.7 High intensity specialists will be expected to have received accredited and/or regulated training in one or more of the major psychological therapies to deliver these therapies to individuals with moderate to severe mental health problems including, for example, Schizophrenia, Personality Disorder, Bi-Polar Disorder, Substance Misuse. Psychological services for those service users with complex and enduring mental health problems and high levels of co-morbidity, will require highly specialist individually tailored interventions informed by theoretical and therapeutic models. Such services will be delivered by highly specialist professionals, trained in a range of psychological and therapeutic models to formulate and manage complex problems.

SECTION 4

Operationalising a Stepped Care Model

A Stepped Care Model for Adult Mental Health Conditions

A Stepped Care Model for Children and Young People

A Stepped Care Model for People with a Learning Disability

OPERATIONALISING THE STEPPED CARE MODEL

4.0 The previous section highlighted the need for the integration of psychological therapies into mental health and learning disability services. It described a generic model of stepped care. Implicit in this is the recognition that a stepped care framework needs to link across services, for example, into forensic mental health and learning disability services as well as physical and neurological disability services, and across the life span of the individual taking account of the need for seamless service transitions.

A STEPPED CARE MODEL FOR ADULTS MENTAL HEALTH CONDITIONS

4.1 This Section specifically addresses how such a stepped care model should work within adult mental health services. It describes the how adults with mental health conditions requiring psychological interventions can access services appropriate to their needs.

4.2 Until recently, Mental Health Services had multi access points with regards to referrals for initial assessments and/or psychological treatments. This caused difficulties for referrers and services users and carers, and did not represent the best use of limited resources.



4.3 In order to address these difficulties a transparent, streamlined approach is currently being adopted to ensure timely access to appropriate specialist services delivered in HSC Trusts. Building on this, Trusts are introducing single points of access for specialist services (step 3) and associated threshold criteria and agreed referral pathways. Inevitably this process will require some flexibility to ensure that service users receive the services they require and that they can move between services, as necessary. Therefore, it is imperative that services communicate well within the stepped care model putting the needs of services user at the centre of care.

RECOMMENDATION 8

Each Trust should have a single point of access for HSC secondary care/specialist services informed by agreed threshold criteria and referral pathways, which should incorporate appropriate processes for triage and/or assessment to ensure that referrals are directed to the appropriate service/level of intervention.

- 4.4 Independent and voluntary sector organisations who have contracts with HSC organisations and primary care will also continue to provide a range of psychological therapy services as part of commissioned arrangements for primary care, community and specialist services. All such contracts will be expected to comply with regionally agreed principles and standards for service provision.
- 4.5 The diagram below shows the generic stepped care model for adult psychological therapies as part of mental health services. It includes the range of therapies that are delivered at the different levels of intensity and the training and supervision required at the different levels of intervention.

Stepped Care Model of Psychological Therapies (Adult Mental Health)

| Step | No. Pts. | Intensity | What Delivered? | Who Delivers / Training? |
|--|--|--|--|---|
| Step 1 Recognition and Assessment |  |  | <ul style="list-style-type: none"> • Early recognition/advice/support/watchful waiting | <ul style="list-style-type: none"> • Front line primary care staff <ul style="list-style-type: none"> – trained to monitor / screen for mental health difficulties – resourced with screening tool kits and liaison with single point of access centre. – Promote positive mental health and emotional wellbeing and use evidence based tool kits. |
| Step 2 Treatment for Mild Disorders | | | <ul style="list-style-type: none"> • Low intensity treatments (e.g. CCBT, brief behavioural and CBT, psycho education, guided self-help, group education, adjustment counselling, further assessment) | <ul style="list-style-type: none"> • Low intensity (LI) workers (Bands 4-5) – e.g. Assistant / Associate Psychologists, counsellors, mental health workers, OTs, nurses and SWs (Band 6 and above) • Leadership, governance and supervision provided by Band 7-8 Clinical Psychologists OR CBT therapists in ratio relationship to number of LI workers. |
| Step 3 Treatment for Moderate Disorders | | | <ul style="list-style-type: none"> • High intensity specific therapies - e.g. 10 + sessions of CBT or interpersonal; therapy for anxiety, depression, uncomplicated PTSD etc. • Circumscribed psychological therapies where there are evidenced based principles of treatment e.g. for agoraphobia, panic, phobias, adjustment to illness, recent onset non-organic presentations etc. • Supplemented by “single point of access” assessment service to direct to correct step as is appropriate level of intervention. | <ul style="list-style-type: none"> • High Intensity workers – e.g. Clinical Psychologists, CBT and IPT therapists with liaison from secondary care psychiatry when pharmacological adjuncts to therapy as required. • Capable of delivering CBT protocols for mood disorders, problem solving therapy, EMDR, exposure therapies etc. |
| Steps 4 – 5 Treatment for Severe / Complex Disorders | | | <ul style="list-style-type: none"> • Integrative or highly specialised therapies – e.g. co-morbid and complex presentations (e.g. mood, addictions, trauma, attachment disturbances, personality disorder; psychosis, conversion disorders, persistent self-harm, neurological). • Range of uni-modal, specialist therapies, plus capacity to integrate and fit therapeutic approach to patient where proceduralised pathways are absent or unlikely... | <ul style="list-style-type: none"> • Secondary care mental health teams comprised of Psychiatrists, Clinical Psychologists and other professions with specialist therapy training e.g. psychodynamic, CBT, systemic psychotherapy, Dialectical Behaviour Therapy, Cognitive Analytic Therapy etc. (all from the three main schools of therapy as specified in SFH); • Specialist psychotherapy services (e.g. for personality disorder, eating disorder, severe and complex presentations. • Psychosocial Interventions in severe mental illness including Psychosis, Schizophrenia and Bipolar disorder • Services will be supported by LI workers to deliver circumscribed elements of therapeutic programmes and psychological assessment. |






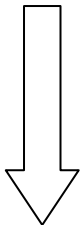
A STEPPED CARE MODEL FOR CHILDREN AND YOUNG PEOPLE

- 4.6 Psychological interventions can provide positive long lasting outcomes for children, young people and their families, with longer term cost savings for the HSC, and improved outcomes in education, social care and youth justice systems. Areas requiring psychological interventions include children and adolescents with physical and mental health conditions, children affected by trauma and bereavement, eating disorders, substance abuse, acquired brain injury and other neurological conditions, autism spectrum disorders, learning disabilities and children and adolescents in care, fostering and adoption services and forensic services.
- 4.7 There is now considerable empirical evidence for the effectiveness of psychological therapies derived from the 4 major schools (see section 2.11) in relation to the following presentations:
- disturbances of conduct, attention and mood,
 - psychosis,
 - deliberate self harm,
 - substance abuse,
 - eating disorders,
 - pervasive developmental disorders
 - long-term physical conditions
 - unexplained physical presentations
- 4.8 Although, still evolving, the evidence base currently allows professionals and commissioners to match the appropriate psychological therapy and level of intensity required to the presenting condition. For example parent training programmes have been shown to be effective in managing mild to moderate conduct disorders in children under the age of 8, whereas for adolescents presenting with severe and enduring disturbance of conduct multi-systemic therapy is evidenced as being most effective. In general, behavioural and cognitive psychological therapies have a strong evidence base in relation to mood and behaviour disturbances, attentional problems, pervasive

developmental difficulties and eating disorders, with systemic and family therapy gaining an increasing evidence base in relation to eating disorders, substance abuse and long-term conditions (*Evidenced- Based Psychotherapies in Child and Adolescent Mental Health Practice*, ACAMH 2007; *Evidenced-Based Approaches to Child and Adolescent Mental Health*, ACPP 2003; *Drawing on the Evidence*, CAMHs Evidence Based Practice Unit, 2006).

- 4.9 Evidence for the effectiveness of psychoanalytic psychotherapeutic interventions in children and adolescents is also growing (Kennedy 2004), with studies demonstrating its effectiveness in relation to an ever increasing range of presentations.
- 4.10 As noted above the research and evidence base continues to expand and the applicability of the various psychological therapies to specific conditions described above should not be seen be exhaustive.
- 4.11 Child and adolescent mental health services are currently provided within a stepped/tiered structure (see below) that mirrors the stepped care approach being promoted in adult services. It is important that the organisational structures within the two areas can work together to allow the seamless transition from child to adult services. It should be recognized that children often require intervention from a number of tiers/steps, sometimes at the same time, in order to achieve the most effective treatment and care plan.

A TIERED/STEPPED CARE MODEL OF DELIVERY OF PSYCHOLOGICAL THERAPIES TO CHILDREN AND YOUNG PEOPLE

| TIERED MODEL | STEPPED CARE MODEL/WHAT DELIVERED? | WHO DELIVERS? |
|--------------|---|--|
| TIER 1 | <ul style="list-style-type: none"> Children/young people/families present with psychological concerns Vulnerable children and families identified <div style="text-align: center;">  <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">STEP 1</div> </div> <ul style="list-style-type: none"> Advice/Support Screening/Initial Assessment Clear pathways of referral | <ul style="list-style-type: none"> General Practitioners Health Visitors Adoption/Fostering Services Midwives – acute and community |
| TIER 2 | <div style="text-align: center;">  <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">STEP 2</div> </div> <ul style="list-style-type: none"> Mild Disorders Low-medium Intensity Interventions Group Psycho-education Guided Self Help Parent Training Groups Behaviour Management Groups Counselling | <ul style="list-style-type: none"> Projects such as SURE START/ EXTERN Social Services |
| TIER 3 | <div style="text-align: center;">  <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">STEP 3</div> </div> <ul style="list-style-type: none"> Moderate Disorders High Intensity Interventions Specialist Therapy Input Specialist Assessments ADHD/ASD Clinics Specific evidence base therapies – CBT/EMDR Assessments of needs of children in care homes | <ul style="list-style-type: none"> Community Paediatricians Community Paediatric Nurses Family Centres PMHW School Counsellors Voluntary Organisations e.g.: PAPP/NSPCC/Barnardos/New Life Counselling/Contact Youth Social Services Behaviour Therapists Assistant/Associate Psychologists Educational Psychology Primary Care Workers |
| TIER 4 | <div style="text-align: center;">  <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">STEP 4</div> </div> <ul style="list-style-type: none"> Outpatient treatment for severe and complex mental health disorders Personality Disorders Services to Juvenile Justice Specialist Child Care Centre Specialist Services e.g.: eating disorders, drug & alcohol abuse Complex co-morbid disorders e.g.: attachment/ASD/ADHD | <ul style="list-style-type: none"> High Intensity Workers: Clinical Psychologists/Specialist PMHW/ CBT and IPT Therapists/Family Therapists/Child Psychotherapists/ Specialist SW/Specialist Community Paediatricians Tier 3 Liaison |
| TIER 4 | <div style="text-align: center;">  <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">STEP 5</div> </div> <ul style="list-style-type: none"> Inpatient treatment for severe and complex mental health disorders/personality disorders | <div style="text-align: center;">  </div> |

4.12 In keeping with Bamford's recommendations the following principles should inform service developments;-

- Children's services should provide for children and young people up to the age of eighteen;
- Early interventions for infants/children and their families are of strategic significance in terms of secondary prevention and such services should be promoted; and
- Historically, there has been a lack of service development within Tiers 1 and 2 of child and family services. Until this gap is addressed Tier 3 & 4 services will continue to be inappropriately utilized to cover this shortfall.

A STEPPED CARE MODEL FOR PEOPLE WITH A LEARNING DISABILITY

4.13 Learning disability is a life-long developmental disorder and categorised into 4 levels: mild, moderate, severe and profound learning disability. People with a learning disability have a high incidence of epilepsy, autistic spectrum disorder, sensory impairments and physical health conditions. They also have a higher incidence of mental health needs than the general population.

4.14 There is a significant and growing body of evidence that demonstrates the effectiveness of psychological therapies for people with a learning disability. This has demonstrated that such therapies are more effective and acceptable than pharmacological interventions for the management of a significant number of mental health difficulties.

4.15 However, simple adaptations to the implementation of traditional psychological therapies are often required when engaging with people with a learning disability. The degree of adaptation will be commensurate with the person's specific needs. For example, a person with mild learning disability

can participate in cognitive behaviour therapy with the adaptations noted above.

- 4.16 The current policy to support people with a learning disability in the community, rather than in a hospital setting, will shape the development of psychological therapy services and the training needs of staff delivering therapies. An adapted stepped care model will be required and an example is provided below.

AN EXAMPLE OF A STEPPED CARE APPROACH - LEARNING DISABILITY

Person with learning disability presenting to Learning Disability Service Diagnostic and Care Needs assessments completed

STEP 1 – Low Intensity Intervention

Referral to Day Support and/or Residential Support services

Service Inputs

- provide structure and meaningful activity (to enhance self esteem, self efficacy, etc)
- promote and monitor mental health and emotional well-being
- availability of staff to provide emotional support, problem solving approaches to difficult life events etc

Review Arrangements

- Annual review & as required

STEP 2 – Low-Medium Intensity Interventions - Community Learning Disability Teams

Community Learning Disability Teams - Multidisciplinary Team – including Psychiatry, Clinical Psychology (Band 7/8a), Social Work, Community Learning Disability Nursing; Allied Health professionals, etc

Service Inputs

- Monitor mental health & well-being
- Specific Interventions – for example
 - CNLD – assertive outreach for enduring mental illness
 - applied behavioural approaches
 - Social Work – psycho-education
 - counselling
 - problem solving approaches
 - Clinical psychology – targeted interventions (e.g. CBT; Applied Behavioural Analysis; Parent & Carer training,

Review Arrangements

- Monthly multidisciplinary Team review as required

STEP 3 – High Intensity Intervention

| | | |
|--|--|---|
| <p>Behaviour Support Service Peripetetic Multi-Disciplinary Team (Clinical Psychology, Behaviour Nurse Therapists, Speech & Language therapist etc)</p> <p>Target client group</p> <ul style="list-style-type: none"> - extreme/severe challenging behaviour - risk to self &/or others - subject to restrictive practices <p>Service Inputs</p> <ul style="list-style-type: none"> - Consultation Discharge - Consultation Assessment & Intervention Programme - Applied Behaviour Analysis <ul style="list-style-type: none"> - Assessment - Proactive strategies - Reactive strategies - Systemic interventions <p>Outcome Evaluations</p> <p>Pre & Post measures</p> <ul style="list-style-type: none"> - Frequency & intensity of challenging behaviour - Quality of life indicators - Review of service capacity to meet client's needs <p>Review arrangements</p> <ul style="list-style-type: none"> - weekly multidisciplinary team meetings | <p>Hear to Help Psychotherapy Service - Multidisciplinary service – has included Clinical Psychology, Cognitive Behaviour Therapist, Psychoanalytic Psychotherapist; Therapeutic Social Worker; Speech & Language Therapist</p> <p>Target Client Group</p> <ul style="list-style-type: none"> - Anxiety Disorders – PTSD, OCD, Phobias, etc - Depression, self harm, suicide - Traumatic life events e.g. childhood sexual abuse, victim of crime/exploitation - Complex bereavement reactions - Substance misuse - Offending behaviours incl sex offending/sexually harmful behaviours - Anger management <p>Service Inputs</p> <ul style="list-style-type: none"> - Individual psychotherapy (CBT, Integrative approaches, Psychodynamic Therapy, Counselling, etc) - Group Psychotherapy <p>Outcome Evaluation</p> <p>Pre & Post measures + critical points in therapy</p> <ul style="list-style-type: none"> - Emotional Problem Scale - Goals of therapy evaluation - APES – measure of insight into problems <p>Review arrangements</p> <ul style="list-style-type: none"> - Blocks of therapy negotiated and reviewed (e.g. 10 sessions & review) | <p>Consultant Psychiatry and Clinical Psychology Services</p> <ul style="list-style-type: none"> - Uni-professional service input <p>Consultant Psychiatrists</p> <p>Target Groups</p> <ul style="list-style-type: none"> - functional and enduring mental illness - organic disorders <p>Service Inputs</p> <ul style="list-style-type: none"> - Pharmacological interventions - Individual & family based therapy <p>Consultant Clinical Psychology</p> <p>Target groups</p> <ul style="list-style-type: none"> - complex and atypical mental health presentations - severe challenging behaviour - complex and dysfunctional social and support networks <p>Service Inputs</p> <ul style="list-style-type: none"> - multi modal behavioural interventions - systemic based interventions - cognitive, behavioural and integrative approaches |
|--|--|---|

STEP 4 – Specialist High Intensity Intervention

Step 4 – Specialist Inpatient Treatment – Referral to Muckamore Abbey Hospital

Target Group

- unstable mental health condition
- significant risk to self and/or others
- complex and unstable epilepsy
- medication review requiring inpatient care

SECTION 5

New Ways of Working – Workforce Development

Staffing Requirements

Training, Accreditation and Supervision

Links to Professional Regulatory Bodies

NEW WAYS OF WORKING – WORKFORCE DEVELOPMENT

- 5.0 Future development of psychological therapy services will require a competent workforce that has undergone required training in evidenced based therapies, augmented by robust supervision arrangements by appropriately trained and experienced professionals.
- 5.1 One of the key recommendations outlined in *Ten High Impact changes for Mental Health (2006)* is the “redesign and extension of roles in line with efficient service user and carer pathways designed to attract and retain an effective workforce”. Therefore the training and development of the psychological therapy workforce will need to take account of New Ways of Working (2007) (NWW) in both mental health and psychological therapy services.
- 5.2 A fundamental aspect of NWW is to create a shift in the culture and language in health care contexts so that psychological ways of understanding people’s distress become more common place amongst all professionals, and importantly that psychological intervention and therapeutic approaches are mainstreamed across primary community and secondary care services.
- 5.3 Key elements of workforce development include:-
- Up-skilling of the existing workforce with the requisite systematic and psychological therapeutic skills to maximise self help and recovery opportunities;
 - Adaption of multi-professional and multi-sector approaches
 - Appropriate skill mix aligned to stepped care model with robust clinical supervision arrangements;
 - Extended roles and the development of new practitioner therapist support roles;
 - Integrated care, co-working and consultancy approaches.
 - Partnership working through the sharing of skills and competencies across professional and practitioner boundaries; and

- New career pathways e.g. diploma/MSc training pathways for graduate assistant/ associate psychologists.

STAFFING REQUIREMENTS

- 5.4 New ways of working within the existing workforce is essential to ensure that a psychological therapies workforce is fit for purpose. However, the Bamford Review (2007) highlighted the relative underinvestment in psychological therapy services in Northern Ireland when morbidity and investment is compared to other jurisdictions.
- 5.5 Whilst the DHSSPS is not implementing the *Improving Access to Psychological Therapies (IAPT)* programme which is available in England, nonetheless the relevant documents produced by the Department of Health in England are useful tools to inform future staffing requirements and development. The following paragraphs highlight the need for additional resources to underpin the development of psychological therapy services in Northern Ireland. Figures specified below are consistent with estimates made by Bamford.
- 5.6 '*Improving Access to Psychological Therapy Services*' is designed to deliver NICE-compliant services to help people with depression and anxiety disorders. It estimates that for a population of 250,000 people with average levels of need some 40 trained therapists are needed. The programme recognises the need for a national training programme to provide the necessary number of trained therapists and enables the progressive expansion of local NICE - compliant services in primary care settings. The basic service model envisages a team of therapists taking referrals from GPs and delivering therapies at the required level in primary care or community settings.
- 5.7 Applying the IAPTS formula (40 therapists per 250,000) to a Northern Ireland population of 1.8m and using best estimates of current provision there is a need for an additional 180 practitioners for levels 1-3 (Primary and

Community service levels). For level 4 (specialist interventions) and level 5 (highly specialist interventions) it is estimated that a further 160 practitioners will be required.

TRAINING, ACCREDITATION AND SUPERVISION

- 5.8 Those working in psychological therapy services must have relevant training, accreditation and supervision to provide effective and safe services to standards required by relevant bodies.
- 5.9 Many professional staff, e.g. nurses, social workers, occupational therapists have already undergone training in psychological therapies. Others have obtained post-professional accreditation with recognized therapy bodies.
- 5.10 Work has already begun to address some of the training needs of a range of staff. For example, the University of Ulster has trained over 100 Health Service staff to certificate level in CBT. QUB has trained 25 staff to qualification level with a Masters qualification in Systemic Psychotherapy and more than 100 Health Service staff to Intermediate and Foundation levels and THORN training has been provided to a range of Health Service professionals, mainly nurses.
- 5.11 Child & Adolescent Psychoanalytic Psychotherapy (CAPt) is now an established clinical doctorate training programme, accredited by the Association of Child Psychotherapists (ACP), UK. The pre-clinical course has been available in NI from 2009.
- 5.12 Clinical Psychologists, whose training is commissioned from *The Queen's University Belfast*, constitute a substantial proportion of the psychological therapies workforce in Northern Ireland. In addition to training in theories and models of psychological illness and interventions, supervision and research skills, standards of proficiency and accreditation include competence in delivering CBT plus one other psychological therapy *across* the tiers and complexity of care.

5.13 Innovatively, the 2008 workforce plan for clinical psychology provides a template for *pre-qualification* training pathways at diploma/masters levels in order to populate an assistant and associate psychology workforce - at lower bands and intensity of intervention. This workforce plan is consistent with the stepped care model advocated in this strategy, and such new ways of working and training are encouraged across professional workforce reviews.

RECOMMENDATION 9

Professional and cross-professional workforce reviews, which are of strategic significance in improving access to psychological therapies, should be implemented.

5.14 The development of psychological therapy services will require a regional approach to training that is comprehensive and co-ordinated to ensure that practitioners have the necessary skills and competences to deliver the relevant therapy or interventions at the appropriate level in the stepped care model. Training approaches need to address the range of training needs from new therapists entering this field, existing healthcare professionals wishing to become skilled in a particular therapeutic intervention to those providing very specialist interventions.

5.15 It is recommended that; a consortium of stakeholders should be commissioned to agree a regional approach to training requirements, with particular reference to needs of therapists at the different levels within the stepped care model.

5.16 A complementary training programme for supervisors must also be implemented. It is recommended that: a supervision framework should be developed, which sets out the core competences and accreditation required for supervisors at the different levels of intervention.

RECOMMENDATION 10

A consortium of stakeholders should be commissioned to agree a regional approach to training requirements, with particular reference to the needs of therapists at the different levels within the stepped care model.

RECOMMENDATION 11

A supervision framework should be developed, which sets out the core competences and accreditation required for supervisors at the different levels of intervention.

LINKS TO PROFESSIONAL REGULATORY BODIES AND ASSOCIATED ISSUES

- 5.17 Psychological therapists are not equivalent across professional groups and training pathways. Traditionally psychological therapies have been delivered by chartered clinical and counselling psychologists, psychiatrists, psychotherapists and members of other professional groups (e.g. nurses, social workers, occupational therapists, arts psychotherapists) who have attained additional training in single modality psychological therapies, not part of their core professional training, accredited by relevant professional bodies. Psychiatrists and psychologists who have wished to develop further expertise in specific therapeutic modalities have also undertaken such additional training.
- 5.18 Whilst psychiatry will continue with statutory regulation by GMC and Royal College of Psychiatrists, applied psychologists (clinical, counselling, health, forensic, educational, occupational and sports and exercise) are subject to statutory regulation by the HPC as of 1st July, 2009, as well as professional accreditation by British Psychological Society for chartered status. It should be noted that arts psychotherapists are already regulated by the HPC. At the same time talks are ongoing to have non-medical psychotherapists regulated by the same body but the timescale for this is unclear at present.
- 5.19 With regard to services commissioned by the HSC from the voluntary and independent sectors, it is important that practitioners in these sectors are appropriately qualified/accredited and satisfy local service commissioning governance arrangements.

5.20 In relation to counselling services, the 2002 DHSSPS report *Counselling in Northern Ireland – Report of the Counselling Review* (commonly referred to as the ‘Park’ Report) identified a number of key issues in relation to local standards of counselling practice. These included, the need for statutory regulation; affiliation to a professional body; accreditation with a professional organisation; a rationalisation of training courses; undergoing regular supervision; using evidence based practice; befriending services should meet basic standards; and, those working with individuals affected by the Troubles should seek specialist training. The report’s recommendations should inform the governance arrangements for the commissioning of local counselling services.

SECTION 6

Implementing the Strategy

Monitoring and Evaluation of Services

Promotion of Research

Development of a Regional Psychological Therapies Group

IMPLEMENTING THE STRATEGY

- 6.0 The Implementation of this strategy will need to be coordinated on a regional basis linking with all health and social care services to ensure the integrity of service provision throughout Northern Ireland.
- 6.1 Over the Comprehensive Spending Review period (2008-2011), an additional investment (£4.4 m recurrent from 1st April 2011) in psychological therapies will provide opportunities for innovate change. However, the Bamford Vision recognised that additional investment would be required across mental health and learning disability services over a 10-15 year period to address historical underinvestment and increased need in the population of Northern Ireland. Ongoing monitoring and evaluation of psychological services is essential in order to inform further Comprehensive Spending Reviews.

MONITORING AND EVALUATION OF SERVICES

- 6.2 A service evaluation framework will be required to ensure timely implementation of the strategy and effective use of resources. The framework should evaluate services in terms of:
- Clinically effective evidence- based practice;
 - Outcomes (e.g. measures of symptom reduction, improved psychological well-being, therapeutic outcomes and indices of social inclusion), recognising the complexity of individual presentation;
 - Efficiency and cost effectiveness;
 - Accessibility targets (e.g. waiting times, meeting targeted population etc);
 - Governance of workforce (e.g. training and supervision policies);
 - Service user/carer experience and satisfaction.

RECOMMENDATION 12

Psychological therapy services should be subject to evaluation – to include therapeutic outcomes, safety and governance, cost effectiveness of service delivery and the views of service users and carers.

PROMOTION OF RESEARCH

6.3 Linked to evaluation is the recognition of the need for robust and scientific research to inform and expand the evidence base for effective psychological services and interventions. Therefore in line with the Bamford Action Plan 2009 a prioritized plan for research on mental health and learning disability should be developed and should incorporate measurement of effectiveness of psychological interventions.

RECOMMENDATION 13

In line with the Bamford Action Plan (2009) a prioritised plan for research on mental health and learning disability should be developed and should incorporate measurement of effectiveness of psychological interventions.

DEVELOPMENT OF A REGIONAL PSYCHOLOGICAL THERAPIES GROUP

6.4 The Department considers that the most effective way to implement this strategy is through the formation of a regional Psychological Therapies Group. This should be led by the HSC Board and Public Health Agency under the auspices of the Bamford HSC Taskforce. This Taskforce is designed to improve mental health and wellbeing, and enhance the emotional resilience of the population. It will oversee change in commissioning and service provision for mental health and learning disability services.

6.5 The Psychological Therapies Group will play a key role in delivering the Bamford Vision and will focus on;-

- Mapping of current psychological therapy service provision to fully understand current capacity and future demand;

- Ensuring that psychological therapy services are embedded in commissioning arrangements to national and regionally agreed standards and guidelines;
- Improving access to psychological therapy services;
- Integrating psychological therapies in a stepped care model of mental health and learning disability services across the lifespan, recognising the need to link with other physical and neurological disability services including challenging behaviour and forensic mental health and learning disability services;
- Coordinating the work of the Psychological Training Consortium to embrace new way of workings, and associated training and supervision frameworks;
- Monitoring and evaluation of implementation of this strategy to include;
 - Organisation and delivery of psychological therapy services;
 - Accessibility;
 - Clinical Outcomes
 - Cost effectiveness (acknowledging differing models and outcomes for people with complex and/chronic conditions);
 - Workforce governance (e.g. training and supervision);
 - Service user and carer experience and satisfaction; and
- Providing advice to the Department on the future development of psychological therapy services.

RECOMMENDATION 14

Under the auspices of the Bamford HSC Taskforce, a Regional Psychological Therapies Group should be established to implement this strategy and to advise the Department on the future development of psychological therapy services across the lifespan. Where appropriate, the Group should recognise the importance of psychological interventions for other long terms conditions. The Group should be representative of commissioners, service providers, carers and users.

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APPENDIX A

Cognitive Behavioural Therapy

Cognitive and behavioural psychotherapies are a range of therapies based on concepts and principles derived from psychological models of human emotion and behaviour. They include a wide range of treatment approaches for emotional disorders, along a continuum from structured individual psychotherapy to self-help material. The term 'Cognitive-Behavioural Therapy' (CBT) is variously used to refer to behaviour therapy, cognitive therapy, and to therapy based on the pragmatic combination of principles of behavioural and cognitive theories.

(taken from <http://www.babcp.com/about-cbt/> - British Association for Behavioural and Cognitive Psychotherapies)

Psychodynamic/Psychoanalytic Psychotherapy

The terms Psychoanalytic Psychotherapy and Psychodynamic Psychotherapy are used interchangeably. Psychoanalytic / psychodynamic psychotherapy can be used in a wide variety of conditions in which people have emotional or relationship difficulties and is not aimed at specific disorders.

(Taken from <http://www.psychotherapy.slam.nhs.uk/Default.aspx?tabid=520> - SLAM Psychological therapies)

Psychoanalytic relationships are generated by the desire to find meaning as well as relief from psychological suffering. In psychoanalytic psychotherapy particular attention is paid to analysing transference and resistance issues, so that the patient is helped to find a more creative relationship between conscious and unconscious processes and to discover their own personal truths.

(Taken from http://www.psychotherapy.org.uk/analytical_psychology.html - UK Council for Psychotherapy)

Systemic and Family Therapy

Systemic Family Therapy provides effective help for people with an extraordinarily wide range of difficulties. The range covers childhood conditions such as conduct and mood disorders, eating disorders, and drug misuse; and in adults, couple difficulties and severe psychiatric conditions such as schizophrenia. Throughout the life span, it is shown to be effective in treatment and management of depression and chronic physical illness, and the problems that can arise as families change their constitution or their way of life.

(Taken from <http://www.aft.org.uk/docs/evidencedocsept05creditedSS.doc> - The Association for Family Therapy)

Humanistic, Person-Centred/Experiential Therapy

Person-centred therapy, which is also known as client-centred, non-directive, or Rogerian therapy, is an approach to counselling and **psychotherapy** that places much of the responsibility for the treatment process on the client, with the therapist taking a nondirective role. Two primary goals of person-centred therapy are increased self-esteem and greater openness to experience. Some of the related changes that this form of therapy seeks to foster in clients include closer agreement between the client's idealized and actual selves; better self-understanding; lower levels of defensiveness, guilt, and insecurity; more positive

and comfortable relationships with others; and an increased capacity to experience and express feelings at the moment they occur.

(Taken from <http://www.minddisorders.com/Ob-Ps/Person-centered-therapy.html> -
Encyclopaedia of Mental Disorders

APPENDIX B

A summary of NICE guidance for psychological therapies by disorder and client age group

| | Depression | Bipolar Disorder | Panic & Generalised Anxiety | Schizophrenia | PTSD | Obsessive Compulsive & Body Dysmorphic Disorder | Anorexia Nervosa | Bulimia Nervosa | Self Harm | Personality Disorder |
|----------|--|--|-----------------------------|--|--|---|--|---|--|----------------------|
| Children | MILD Guided self help Nondirective supportive therapy Group CBT MOD-SEVERE CBT, IPT, Short term FT Systematic FT Child Psychotherapy | Primary intervention of Structured psychological therapy (With medication) Symptom focus Problem solving Social functioning education | No current nice guidance | No nice guidance for childhood onset schizophrenia | CBT 8-12+ sessions Involve families | CBT ERP Involve family Home Visits may be needed In extreme cases inpatient support may be needed | CAT CBT IPT Focal psychodynamic therapy Family interventions | CBT Other psychological treatments IPT DBT | Focus on underlying problems e.g. Depression/ Anxiety/ Personality disorder Developmental group psychotherapy | |

| | Depression | Bipolar disorder | Panic & Generalised Anxiety | Schizophrenia | PTSD | Obsessive Compulsive & Body Dysmorphic Disorder | Anorexia Nervosa | Bulimia Nervosa | Self Harm | Personality Disorder |
|---|---|--|---|--|--|---|--|---|--|--|
| Children | MILD guided self help Nondirective supportive therapy Group CBT MOD-SEVERE CBT, IPT, Short term FT Systematic FT Child Psychotherapy | Primary intervention of Structured psychological therapy (With medication) Symptom Focus Problem solving Social functioning education | No current nice guidance | No nice guidance for childhood onset schizophrenia | CBT 8-12+ sessions involve families | | | | Focus on underlying problems e.g. Depression/ Anxiety/ Personality Disorder Developmental Group psychotherapy | |
| Adults of working age | CBT & IPT 16-20 sessions Over 9 months Couple Therapy Psychodynamic Psychotherapy Counselling | Secondary structured psychological interventions Symptom focus Problem solving Social functioning education CBT post acute phase 16 sessions for mild to moderate | CBT (Home visits may be needed) Structured problem solving Counselling Also need to treat co-morbid problems | CBT Family interventions | CBT EMDR Psychodynamic Psychotherapy | CBT ERP involve family Home Visits may be needed In extreme Cases Inpatient support may be needed | CAT CBT IPT Focal psychodynamic Therapy Family interventions | CBT Other Psychological Treatments IPT DBT | Focus on underlying problems e.g. Depression/ Anxiety/ Personality disorder | DBT CAT Schema-focused CBT Dynamic Psychotherapy Therapeutic Community |
| Older adults | No specific nice guidance | Limited evidence as adult | No specific nice guidance | No nice guidance for late onset Schizophrenia | No specific nice guidance | No specific nice guidance | No specific nice guidance | No specific nice guidance | Extra emphasis on depression, ill health and risk | No specific nice guidance |
| <p><i>CAT – Cognitive Analytical Therapy</i> <i>EMDR – Eye movement Desensitization and Reprocessing</i> <i>Dynamic Psychotherapy</i> <i>Couple therapy</i> <i>Systemic FT</i></p> <p><i>CBT – Cognitive Behavioural Therapy</i> <i>DBT – Dialectical Behaviour Therapy</i> <i>Counselling</i> <i>Child Psychotherapy</i></p> <p><i>IPT – Interpersonal Therapy</i> <i>ERP – Exposure Response Prevention</i> <i>Therapeutic Community</i> <i>Structured Problem Solving</i></p> <p><i>FT – Family Therapy</i> <i>Schema – focused CBT</i> <i>Developmental group psychotherapy</i> <i>Short term FT</i></p> | | | | | | | | | | |

