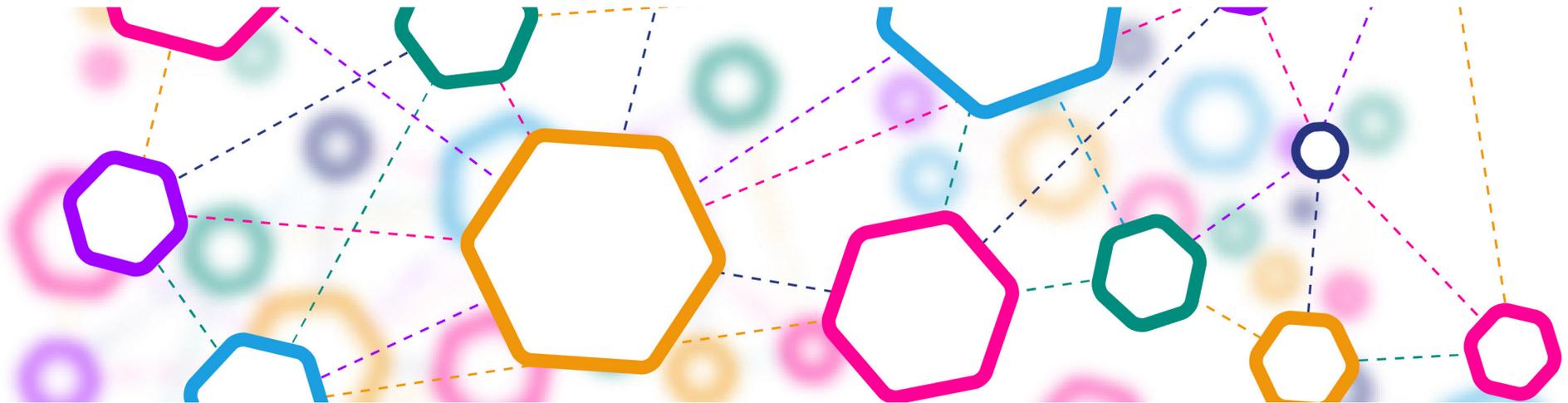

Matrics Cymru

Guidance for Delivering Evidence-Based Psychological Therapy in Wales



Written by the National Psychological Therapies Management Committee, supported by Public Health Wales

September 2017

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INTRODUCTION

The development of Matrics Cymru

Matrics Cymru is the result of collaborative working between service user and carer representatives of the National Mental Health Forum, Psychological Therapies Management Committees (PTMCs) of the seven health boards in Wales, Welsh Government, the National Psychological Therapies Management Committee (NPTMC) and Public Health Wales to help build effective, equitable and accessible psychological therapy services across Wales. Matrics Cymru is based significantly upon the work of the Scottish Matrix (NES 2015)¹. It incorporates learning from the Improving Access to Psychological Therapies (IAPT) programme in England² and standards from the Royal College of Psychiatrists/British Psychological Society collaboration in relation to service delivery.

Whilst the main focus of Matrics Cymru is on psychological therapy provision within mental health services, for adults, older adults, and people with a learning disability, many of the general principles also apply to the delivery of psychological therapy within physical health settings. The Scottish Psychological Therapy Matrix (NES 2015) includes evidence tables for psychological care and intervention in physical health care settings. In the context of legislation, to ensure equitable access to services, it is acknowledged that some service user groups require reasonable adjustments to be made to ensure the psychological needs of these groups are met appropriately.

1 [http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/the-matrix-\(2015\)-a-guide-to-delivering-evidence-based-psychological-therapies-in-scotland.aspx](http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/the-matrix-(2015)-a-guide-to-delivering-evidence-based-psychological-therapies-in-scotland.aspx)

2 <https://www.england.nhs.uk/mental-health/adults/iapt/>

Services for children and young people have decided that the service structure and the settings in which psychological interventions take place are sufficiently different from the other service user groups detailed above, that they need guidance developed specifically for these services. Relevant good practice guidance is set out in the document ‘What Good Looks Like’³. The qualifications and competences required to deliver individual therapy relevant when working with children and young people are set out in chapter 3.

Matrics Cymru is a structured guide to assist planning and delivering evidence-based psychological therapies within local authorities and health boards in Wales, including commissioned third sector⁴ and independent sector services⁵. It provides guidance to support greater quality and consistency in the delivery of psychological therapy across Wales. For the purposes of this document, psychological therapies are defined in the following way:

Psychological therapies are treatments and interventions that are derived from specific psychological theories and formulated into a model or treatment protocol. Psychological therapies are delivered in a structured way over a number of sessions by a suitably qualified practitioner, with informed consent from the service user or where a service user lacks capacity to consent to therapy, it may be contracted on their behalf after an assessment of what is in their best interests.

3 https://www.bps.org.uk/system/files/user-files/DCP%20Faculty%20for%20Children,%20Young%20People%20and%20their%20Families/public/cfcpr_3.pdf

4 The third sector is defined as organisations that are not statutory sector, are values-based and are either non-profit making, or re-invest profits in service delivery

5 Referred to under the generic term service(s) unless when reference is made specific to NHS health boards

Psychological therapies help people understand and make changes to their thinking, behaviour, feelings or relationships in order to relieve distress and to improve their functioning, wellbeing and quality of life and are mediated by the therapeutic relationship. The quality of the relationship between therapist and service user is an essential component in the delivery of effective psychological interventions. Please see appendix 1. Psychological therapies are sometimes referred to as ‘talking therapies’.

This definition is compatible with the Welsh Government Policy Implementation Guidance for Psychological Therapies (2012)⁶.

Matrics Cymru sets national standards across six key elements of service delivery to support education, training and workforce development alongside evidence tables which offer guidance on the safe and efficient delivery of effective, evidence-based care. It also provides guidance for capacity management, workforce re-design and advice on governance issues.

The questions being addressed by this document are:

- What services should be delivered?
- By whom?
- How should they be delivered on a whole service basis?

Following a range of national developments to improve access to and quality of psychological therapy delivered in Wales over the past decade, Psychological Therapies in Wales - Policy Implementation Guidance (PIG)

⁶ http://www.powysthb.wales.nhs.uk/sitesplus/documents/1145/Board_Item_2.5d_Appendix%204%20-%20Psychological%20Therapies%20in%20Wales%20Implementation%20Guidance%20%28002%29.pdf

and the Review of Psychological Therapies⁷, it was agreed that national standards and accompanying guidance should be developed for Wales alongside an agreed approach to national data collection.

Matrics Cymru is a technical guide and intended principally for professional and managerial use. However, it builds on the ethos of the Welsh Government Policy Implementation Guidance for Psychological Therapies and has been developed with active participation from service users and carers. The document emphasises the importance of applying the evidence base in the choice of therapy in terms of outcome measurement, but also emphasises the importance of the quality of the therapeutic relationship between service user and therapist and the way in which the organisation relates to the service user. The research into the therapeutic relationship is explored further in appendix 1, which also includes information from consultations with service users and carers, including the National Mental Health Forum. This appendix was written by a service user representative from the Forum.

Matrics Cymru is primarily designed to be a web based tool.

The development of Matrics Cymru has also involved the engagement of other stakeholders in Wales including those with responsibility for service delivery, third sector partners, professional bodies, training organisations and the executives of health boards.

⁷ <http://gov.wales/docs/dhss/publications/141024therapyen.pdf>

It is compatible with Welsh Government specific legislation and strategy, in particular, Parts 1 and 2 of the Mental Health (Wales) Measure 2010⁸ and Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales 2012⁹.

Matrices Cymru is not intended to replace local strategic planning processes or to stand alone. Responsibility for developing and implementing local strategies is vested in the Local Health Boards Psychological Therapies Management Committees. These will report to the National Psychological Therapies Management Committee which will in turn report to Welsh Government.

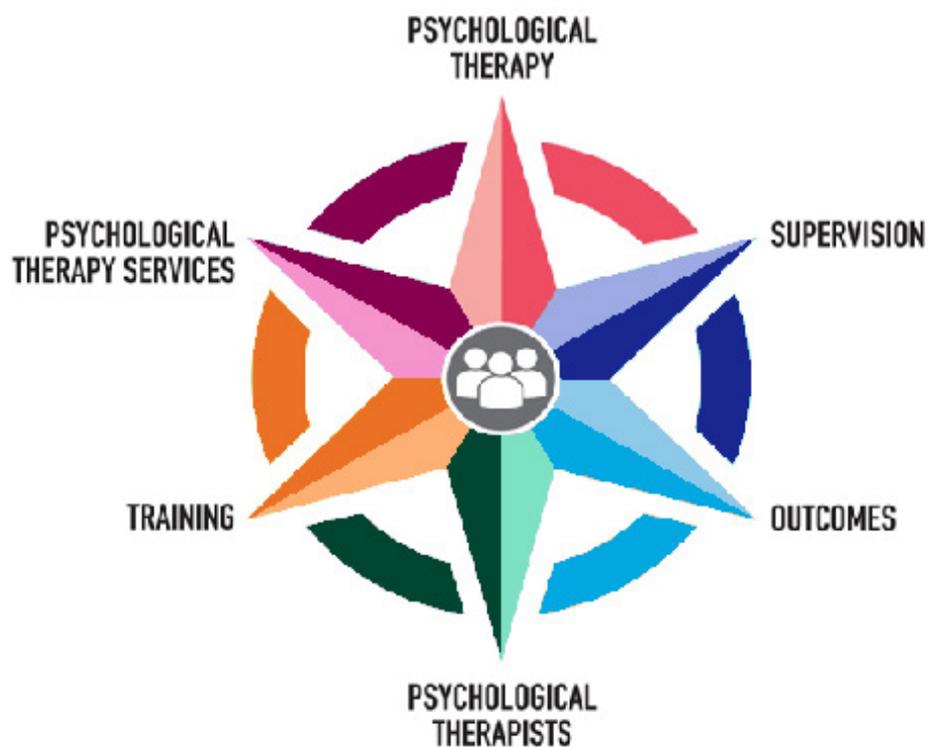
Throughout this document, the terms ‘service user’ and ‘client’ are used to support de-medicalising the language used to describe human distress and suffering. There is also an intended emphasis on holistic care and recovery in relation to the more complex end of the mental health and wellbeing spectrum. The increasing volume of psychotropic medication being prescribed is a concern within Welsh services, with some of the highest rates of anti-depressant prescribing in the UK in 2012. This can, in part, be attributed to a paucity of available and acceptable alternatives. It is also of concern that medication is often a cheaper yet less effective choice in the longer term.

Matrices Cymru defines standards for the following key elements of service delivery:

Psychological therapy services model	Standards to deliver and improve services on a measurable basis
Psychological therapy	Standards for services to understand and improve workforce management
Psychological therapists	The definition and competence at different levels of proficiency
Supervision	Standards to deliver and requirements to receive supervision
Training	Training standards for therapy and supervision provision
Audit and data collection	Data collection requirements
The evidence tables	Evidence for the application of psychological therapy for different conditions

8 <http://www.legislation.gov.uk/mwa/2010/7/contents/enacted>

9 <http://gov.wales/docs/dhss/publications/121031tmhfinalen.pdf>



The six key elements of service delivery for psychological therapy services

The main aims of Matrics Cymru

- To improve service user's experience of psychological therapy services
- To support health boards, local authorities and their partners; to develop universal approaches to service delivery; to enhance quality and to increase access to effective psychological therapy and interventions by offering clear and easily accessible guidance
- To recommend psychological therapy and intervention availability for specific service user groups based on evidence set out in the evidence tables. This enables health boards across Wales to clarify what core psychological therapy and interventions are recommended as a minimum
- To delineate structures for the delivery of psychological therapy and to define competency requirements across a range of complexity of presentation and intensity of intervention
- To recommend universal service improvement procedures, setting criteria for prudent and effective service delivery in order to build on the previous work of the Policy Implementation Guidance (2012)
- Matrics Cymru aspires to promote the delivery of efficient and effective psychological therapy and interventions, by seeking to minimise wasteful and harmful variations in practice through the clarification of training and practice standards and supervision requirements. This will, in part, also be achieved by workforce re-design to ensure that the workforce is delivering to capacity and at the right levels of competence

- Human and financial resource management will be central to the success of Matrics Cymru on a national basis. Emphasis on data collection will be a requirement to evaluate both output (productivity/capability/efficiency) and outcomes (quality/effectiveness/compatibility) and
- To enhance standards and standardise measurement and comparability of data, collected across all health boards and partner services with a focus on quality improvement and quality assurance.

Priority is given, in the first instance, to help services move towards delivering effective and accessible psychological care by:

- Meeting the psychological therapies waiting time targets which are consistent with targets set for other areas of mental and physical health
- Improving services for people with common and stable, severe mental health problems, in line with the requirements of Part 1 of the Mental Health (Wales) Measure 2010¹⁰
- Preventing service users developing chronic or intractable difficulties
- Improving services for service users with more complex and less stable presentations in line with requirements of Part 2 of the Mental Health (Wales) Measure 2010¹¹
- Building capacity in clinical priority areas, as identified by each health board

10 <http://www.legislation.gov.uk/mwa/2010/7/contents/enacted>

11 <http://www.rcpsych.ac.uk/pdf/Code%20of%20Practice.pdf>

The provision of psychological therapy does not prevent or preclude any assessment for secondary mental health or other services. Significant health gain and cost savings are likely to accrue from the expansion of psychological therapy within physical health services in line with the evidence base (see link to Psychological Therapies Matrix, Scotland)¹². It is well documented that people with physical health conditions, especially when long term, experience psychological distress and often have difficulty adhering to treatments. It has been estimated that 10% of suicides in the United Kingdom occur with people who have terminal or chronic health conditions¹³.

The King's Fund and Centre for Mental Health report, 'Long-term Conditions and Mental Health: The Cost of Co-morbidities' (2012)¹⁴, indicated that co-morbid mental health problems interacting with and exacerbating physical illness raises total health care costs by at least 45% for each person with a long-term condition and co-morbid mental health problem. It is therefore intended that Matrics Cymru will be used to inform the development of psychological therapy provision in physical health settings.

12 [http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/the-matrix-\(2015\)-a-guide-to-delivering-evidence-based-psychological-therapies-in-scotland.aspx](http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/the-matrix-(2015)-a-guide-to-delivering-evidence-based-psychological-therapies-in-scotland.aspx)

13 Bazalgette, L, Bradley, W & Ousbey, J (2011): The Truth about Suicide. Demos, London

14 https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf

Equality and diversity in Wales

Wales is a bilingual nation and ensuring access to psychological therapy in Welsh is therefore an important issue to be addressed in the delivery of services. The Welsh Language Act (1993)¹⁵ and the Welsh Language (Wales) Measure (2011)¹⁶ set standards for public bodies regarding the provision of services in the Welsh language. There will be a need to recruit and train Welsh speaking psychological therapists in order to make psychological therapy available in Welsh, if this is the preferred option of the service user. This is not only a legal requirement but the experience of therapy carried out in the preferred language (or even language of need) is richer and is likely to improve outcome. It is recognised that there are few fully bilingual therapists at present and health boards should include an audit of Welsh speaking therapists in their regular demand/capacity review and develop a plan to address any shortfall.

Wales has a diverse range of people and cultures. In the creation of services that are designed to meet the needs of the whole population, health board planners are required to adhere to the Equality Act 2010¹⁷ which specifies the protected characteristics; age, race, gender reassignment, disability, marriage and civil partnership, pregnancy and maternity, religion and belief, sex and sexual orientation. Welsh statutory services hold Public Service Equality Duty (PSED)¹⁸, which supports work

15 http://www.legislation.gov.uk/ukpga/1993/38/pdfs/ukpga_19930038_en.pdf

16 [http://www.comisiynyddygybraeg.cymru/English/Commissioner/Law/The%20Welsh%20Language%20\(Wales\)%20Measure%202011/Pages/The-Welsh-Language-\(Wales\)-Measure-2011.aspx](http://www.comisiynyddygybraeg.cymru/English/Commissioner/Law/The%20Welsh%20Language%20(Wales)%20Measure%202011/Pages/The-Welsh-Language-(Wales)-Measure-2011.aspx)

17 <http://www.legislation.gov.uk/ukpga/2010/15/contents>

18 <https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty-wales>

to eliminate unlawful discrimination, promote equality and foster good relations.

The PSED has raised the profile of the equality and diversity agenda, helping to embed a culture of fairness, dignity and respect and there is an imperative in Wales to cover the needs of the whole community at all levels of the service. It will be a challenge to provide equitable access to psychological therapies for many people with protected characteristics – however, working in partnership with the third sector, health boards should utilise the PSED in a spirit of equal access to devise ways to ensure access to services for all who need them, including delivery in other languages as required or via interpreters (see the British Psychological Society Guidance document) as predicted on a health board population basis.

SECTION 1:

Psychological therapy services model

Psychological therapy services should:

- Deliver evidence-based care via appropriately qualified staff
- Provide a choice of evidence-based therapies
- Operate within a framework of values-based practice
- Deliver recovery outcomes
- Help service users to achieve personally meaningful and enduring progress
- Engage with service users and carers where appropriate, at all stages of the process
- Evaluate and respond to feedback from service users about the quality of the therapeutic relationship and progress towards therapy goals at every stage of therapy
- Contribute to strengthening the evidence base

In practice, this means having psychological therapists in each service who are:

- Trained to recognised standards with the competences necessary to deliver psychological interventions effectively within the service context in which they work
- Delivering a therapy which has a strong evidence base, with respect to the service user's presenting difficulties
- Operating within a well-governed system which offers regular high quality, model-specific psychological therapies supervision, support and relevant Continuing Professional Development (CPD)
- Monitoring the quality of the therapeutic relationship recognising that this is an essential factor in achieving a successful therapy outcome
- Contributing to innovative and reflective practice

Stepped/Tiered care – matched care

There is an expectation that psychological therapy services will usually be delivered within a stepped/tiered care model. This applies equally to physical and mental health settings as well as to approaches to improve community wellbeing. The stepped care model for mental health is described in the Mental Health (Wales) Measure 2010 National Service Model for Local Primary Mental Health Support Services¹⁹.

19 <http://gov.wales/docs/dhss/publications/110914mhnatservicemodellen.pdf>

There will be some interventions and services that will cross different tiers of provision; the particular psychological therapy offered should be based upon service user need rather than the location of services.

Stepped/tiered care services adopt an incremental approach to service provision, best described as pyramidal in structure, with high volume, low intensity interventions being provided at the base of the pyramid to service users with the least complex difficulties. Subsequent steps are usually defined by increasing levels of case complexity and increasingly intensive forms of treatment.

An allocation process supporting informed choice of service users seeks to predict how service users will respond to the different levels of therapy available and to match service users with the least resource-intensive treatment likely to be effective. The aim is to match the level of intervention as far as possible to the level of service user need, taking into account such factors as risk, problem severity, chronicity, co-morbidity, social complexity, history of previous interventions and service user preference.

The needs of service users will be carefully assessed and met within the tier best suited to their presentation. This may not be the lowest step/tier in the pyramid and allocation to a tier is not diagnosis led. A robust referral and allocation process with clear criteria for allocation to different tiers of service will help to ensure that service users are offered interventions likely to match need. Service users should be supported to make informed choices regarding interventions through discussion and information about the therapy/therapy options which are appropriate and available. Where service users are unable to consent, as indicated by a mental capacity assessment, service users should be supported to make informed choices regarding interventions.

In all cases, the service user should be supported to have the greatest possible influence according to their capacity. Staff carrying out assessments will therefore need to be knowledgeable about the psychological therapies and interventions which would be suitable for each service user, in order to help them make an informed decision.

The foundation tier of the stepped/tiered care model for mental health conditions has an emphasis on community resilience, wellbeing and self-management for people with common mental health problems (such as low mood and anxiety) and on early identification/intervention for those troubled by mental health difficulties of a more complex nature. The relationship between the tiers in the model and the Mental Health (Wales) Measure 2010 are shown in figure 1. The Social Services and Wellbeing Act (Wales) 2014²⁰ also highlights the need to offer support in the community to promote wellbeing on a preventative basis. The evidence supports the development of Wales-wide, community based low intensity, high volume resources such as Stress Control, Mindfulness and Acceptance and Commitment Therapy (ACT) to address this. Both high volume interventions and low intensity psychological or psychosocial interventions should be highly valued as essential elements of services. They have the potential to deliver effective care to a significant number of service users, thereby ameliorating individual distress and reducing the pressure on primary care and higher tiers. Interventions offered at the foundation tier are sometimes delivered by third sector organisations.

For adults with additional learning needs or learning disabilities and other protected characteristics, reasonable adjustments must be made to enable them to access the above.

20 <http://www.senedd.assembly.wales/mgIssueHistoryHome.aspx?IId=5664>

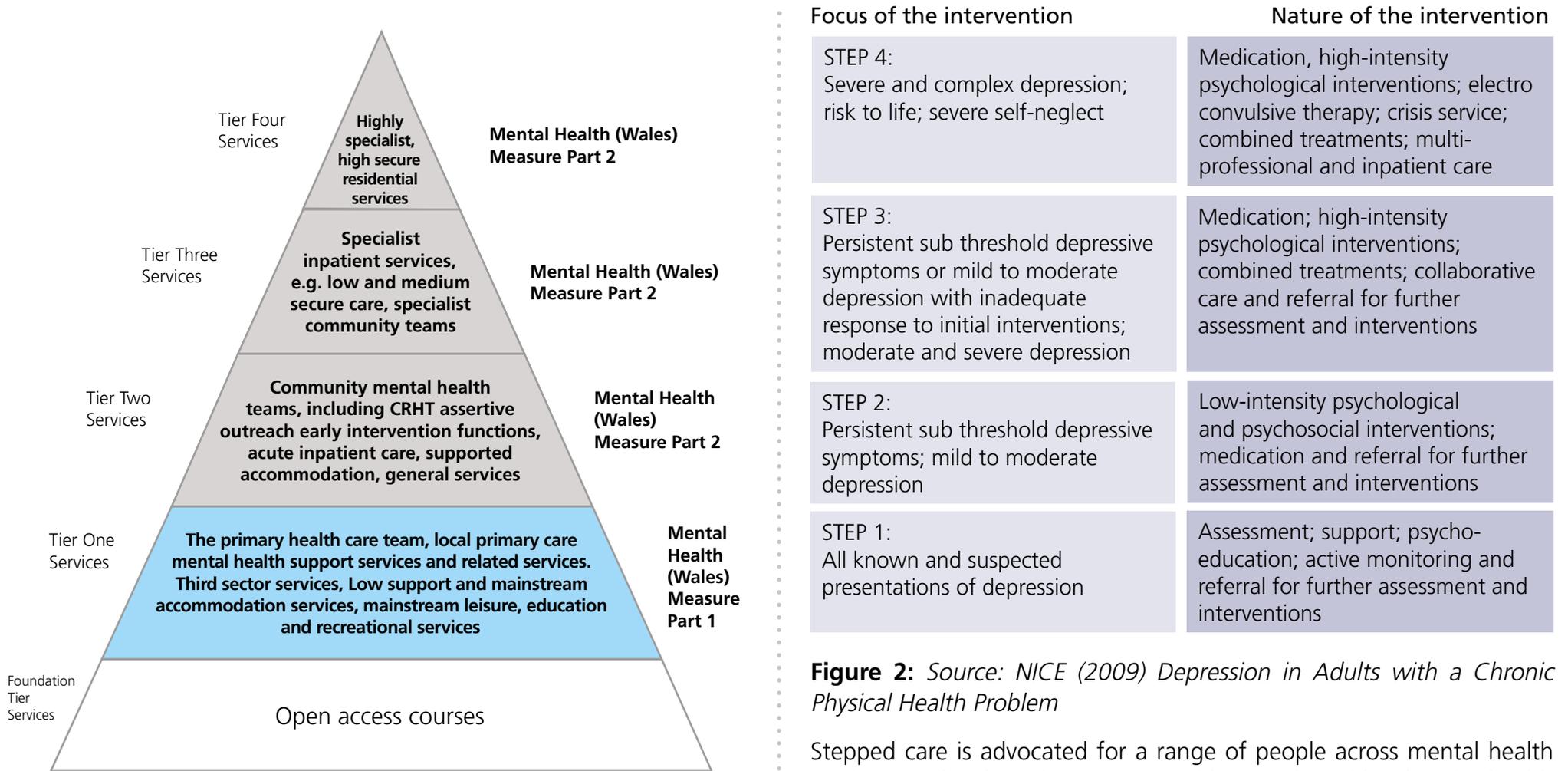


Figure 1: The stepped/tiered care model

Figure 2: Source: NICE (2009) *Depression in Adults with a Chronic Physical Health Problem*

Stepped care is advocated for a range of people across mental health services and when intervening with people with chronic health conditions who have psychological or mental health difficulties e.g. for depression and adults with a chronic physical health problem, NICE (2009) recommends a 4-step model (see Figure 2).

This model indicates the nature of the intervention for a particular level of severity of depression and identifies the areas of expertise required to provide intervention. Integration of mental health support within primary care and chronic disease management programmes is important if the needs of patients with long term conditions and psychological difficulties are to be addressed effectively^{21 22}.

The essential features of a stepped/tiered care system are:

- Matched/stepped care requires a range of interventions of differing intensity to be available
- The least intrusive treatment available that will provide significant health gain should be offered first and services should have pathways that guide clinicians to match clients to the least intensive interventions to meet need
- The system should be 'self-correcting' i.e. provide feedback and allow for the intensity of the interventions to be adjusted
- Clear understanding of the knowledge and competencies necessary for staff to operate safely and effectively at each tier of the system
- A range of systematic mechanisms must be in place to aid clinical decision making e.g. referral criteria, consensus on hierarchies of interventions, allocation guidelines including robust measures of complexity of presenting problems, risk and subjective and objective measures of service user outcome. This would include as a minimum:

21 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf

22 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf

- » Clearly defined inclusion criteria for each tier of service, well-defined pathways from one tier to the next and good communication between different tiers of the service
- » Well defined pathways to offer alternative evidence-based therapy and/or a different therapist where significant improvement has not been achieved within the appropriate tier of service. This will not necessarily require a step up or down to a different tier of service
- » Collection of valid and reliable outcome measures both to determine the appropriate pathway for individual service users and to monitor the effectiveness of the service

Evidence shows that the consideration of certain factors of match between the therapist, therapy and service user increases the likelihood of a positive outcome. The research to date suggests that a decision based on matching the therapist's directiveness with the service user's reactance and matching to client stage of change; coping style, culture, communication needs, learning style and preferences, is more likely to be successful²³.

Regular review of service user progress should be built into the system to compensate for any shortcomings in the assessment and allocation process or any change in presentation, so that individuals requiring a higher level of intervention, a different therapist, or an alternate therapy with an appropriate evidence base can be offered speedily and efficiently. To facilitate this process, progress including outcomes should be routinely and regularly recorded.

23 Norcross, John C, and Wampold, Bruce E. *Journal of Clinical Psychology Special Issue: ADAPTING PSYCHOTHERAPY TO THE INDIVIDUAL PATIENT*, Volume 67, Issue 2, pages 127– 132, February 2011

Where there is an alternative therapy with a robust evidence base for the treatment of the presenting problems, it may be appropriate to offer an alternative therapy or therapist, without the need to step up. There is evidence from the ongoing evaluation of the IAPT services in England and from research into monitoring therapeutic relationship that regular psychological therapy supervision informed by routine outcome measures and service user views of the therapy relationship, collected on a session by session basis, provides the level of information necessary to ensure timely adjustments to the service²⁴. Consideration should be given to the use of session by session service users rating scales.

Psychologically informed services

A psychologically informed generic policy framework should recognise that effective treatments rely on effective care relationships. The Psychological Therapies in Wales - Policy Implementation Guidance (2012) recognises the therapeutic relationship as central to recovery and also highlights the need to ensure service structures support their development.

Factors which facilitate a collaborative working relationship should be identified and monitored so both service users and therapists can work in partnership towards recovery and the therapeutic goals identified by the service user. Factors important to therapeutic relationship are explored in more detail in appendix 1.

Service design needs to reflect and foster psychologically minded services and should therefore offer evidence-based treatments within a setting designed to ensure a focus upon the nature and quality of relationships

with service users and between colleagues. It will also recognise the importance of environments which enhance quality of service user and staff experience and organisational behaviour which values staff in order for them to be able to value others. It is not just what is done, but the way in which it is done that will make the difference in achieving more effective outcomes from psychological interventions. This includes the therapeutic relationship, support between sessions, holistic care plans and the proactive, constructive management of conflict.

Whilst Matrics Cymru is specifically guidance for the delivery of psychological therapies, the efficacy of psychological therapy will be significantly enhanced if delivered within psychologically minded organisations.

Each health board should therefore develop a plan to embed psychologically informed care within their organisation in order to provide effective treatments through psychologically minded staff and systems. Some of the practical outcomes of adopting this approach are outlined in the Psychological Therapies Policy Implementation Guidance (PIG) and when developing a service delivery structure, it is essential to utilise the PIG alongside this document.

The Policy Implementation Guidance specifies fundamental psychological needs including the need to:

- Have secure, stable, enduring attachments to at least one significant other person
- Have attempts to communicate recognised empathically
- Belong to a family or other social group or system and to have a recognised, respected, valued identity and status within it

24 Lambert, M.J. and Shimokawa K Psychotherapy, Vol 48 (1) March 2011, 72-9

- Have secure, clear and consistent social boundaries
- Have a sense of hope, belief, value, meaning and purposeful occupation
- Develop an understanding and realistic sense of influence over ourselves and our environment

Additional needs identified within the psychological therapy evidence base and competency frameworks relating to individual therapy practice include being understood, being treated with dignity and minimising threats to personal freedom.

At the level of the individual service user within secondary mental health services, these needs should be acknowledged and met through the Care and Treatment Planning (CTP) process within Part 2 of the Mental Health (Wales) Measure 2010. CTP provides a framework which ensures a person's medical, social, psychological, cultural and spiritual needs are addressed through the intervention of a multidisciplinary team capable of meeting all of these facets of care and treatment, in a manner consistent with a holistic recovery approach. The CTP covers any or all of eight life areas which are: accommodation; education and training; finance and money; medical and other treatments; parenting or caring responsibilities; personal care and physical wellbeing; social; cultural and spiritual and work and occupation. This reflects a cultural shift within Welsh mental health systems toward bio-psycho-social and recovery approaches that foster wellbeing, with services oriented to help people address their unique individual problems. Within all mental health services a holistic, life history based approach to assessment and intervention should be taken, proportionate to the service context.

As specified within the PIG, all clinical staff working in NHS mental health services in Wales (and arguably across all health and social care systems) should have the basic level of knowledge and understanding necessary to communicate effectively with service users/carers and deliver holistic care, which takes account of people's psychological and emotional presentation and needs. Beyond that, staff from all disciplines have a role to play in the identification of psychological problems and many will be involved in the delivery of specific evidence-based psychological interventions and therapies at different tiers of the service. Within primary care and mental health services in particular, it will be necessary to maximise the contribution of all staff to the delivery of psychological therapies, in order to deliver a psychologically minded service in alignment with the requirements of the PIG.

The framework for the delivery of psychological therapies and for the provision of psychological therapy supervision is competence-based. Staff from any discipline, who can demonstrate the relevant competences, may be involved in delivery and supervision of psychological interventions and of related teaching and training.

The Levels of Psychological Care Model, originally developed in the NICE Guidance for Improving Supportive and Palliative Care for Adults with Cancer (2004) (adapted in Figure 3), is a useful guide to the level of expertise required to intervene at different levels of need.

Figure 3: Levels of psychological care

Level	Staff Group	Assessment	Intervention
1	All health & social care staff	Identify psychological needs	Information giving, empathic communication, psychological support
2	Health & social care professionals with additional expertise	Screen for psychological distress	Problem solving & informal counselling
3	Trained & accredited psychological professionals	Assess distress & devise basic formulation and intervention	Counselling & specific interventions (e.g. anxiety management, systematic desensitisation)
4	Highly specialist psychological professionals	Devise complex formulations & interventions	Multi-theoretical frameworks used to create and deliver unique interventions

Accountability

Services and staff are, first and foremost, accountable to their service users and their carers. There is therefore a need for excellent clinical governance, with registration of staff and robust, fair processes for service users’ and carers’ questions to be answered openly, transparently and in full. This should include access to a fair and impartial complaints process, a proactive and constructive approach to conflict resolution, unimpeded access to a second opinion, re-formulation and treatment reviews. It is essential that staff are fully up-to-date with and aware of these processes and also ensure that service users are given this information within the first few contacts with the service. Each health board will also have a robust mechanism for staff to raise concerns.

At a strategic level, there should be an identified health board lead for psychological therapies at executive director level. Direct accountability for psychological therapies at this level will ensure meaningful engagement with the local psychological therapies strategic planning mechanisms, facilitating negotiation around workforce re-design and the allocation of resources. The involvement of local service users and carers is crucial to ensure meaningful engagement.

Psychological therapy services should be strategically managed at national and health board level in a manner which creates confidence around accessibility, effectiveness, efficiency and service user safety. Effective strategic management should involve oversight and planning at a level above that of the delivery of individual treatment. There should be direct accountability for psychological therapies at health board level and an appropriate mechanism via PTMCs reporting to the NPTMC, to ensure nationally coherent and comprehensive planning across each health board area.

Co-production

A useful definition of co-production is:

‘Co-production enables citizens and professionals to share power and work together in equal partnership, to create opportunities for people to access support when they need it and to contribute to social change’.

At its most effective, co-production can result in the transformation of services and requires a relocation of power and control, through the development of new user-led mechanisms of planning, delivery, management and governance. It involves new structures of delivery to entrench co-production, rather than simply ad hoc opportunities for collaboration. Co-production differs from consultation in demanding more active involvement and decision-making by the person using a service. It is an approach which affirms and supports an active and productive role for people who use services and the value of collaborative relationships in delivering outcomes negotiated with the person using the service²⁵. It brings professionals and the people who use services together to identify and manage new and existing risks. ‘The service user has to trust professional advice and support, but the professional has to be prepared to trust the decisions and behaviours of service users and the communities in which they live rather than dictate them’²⁶.

The principles of “working in partnership towards recovery” within secondary mental health services are enshrined in the Code of Practice

25 Co-production and Personalisation in Social Care Changing Relationships in the Provision of Social Care (49): 9–18. Barnes M. et al. (2008) Designing citizen-centred governance, York: Joseph Rowntree Foundation

26 Hunter, S. and Ritchie, P. (2007b) ‘Introduction: With, Not To: Models of Co-Production in Social Welfare

to Part 2 and 3 of the Mental Health (Wales) Measure 2010²⁷.

In co-produced services there is a stronger emphasis on relationships than in traditional service delivery systems, making staff continuity important. If staff turnover is high and users have to redevelop relationships over and over again, they are likely to grow tired and ‘stop co-producing their service’²⁸. Staff also need training to develop more interpersonal, facilitative skills rather than just having a rigid, delivery focus. Staff morale is as important as client morale. In practice, a co-productive organisation needs to facilitate the same level of staff participation in developing services that they are asking of their service users²⁹.

Co-productive initiatives may sideline groups that have been generally marginalised and underserved, such as people living in poverty, the homeless, black and minority ethnic people, lesbian and gay people, older people, people with cognitive and communication difficulties and those living in residential settings^{30 31 32}.

27 <http://www.rcpsych.ac.uk/pdf/Code%20of%20Practice.pdf>

28 SCIE Research briefing 31: Co-production: an emerging evidence base for adult social care transformation By Dr Catherine Needham, Queen Mary University of London and Sarah Carr, Social Care Institute for Excellence. Published March 2009

29 Bovaird, T. (2007a) ‘Beyond engagement and participation: user and community co-production of public services’, *Public Administration Review*, vol 67, no 5, pp 846–860

30 Wilson, G. (1996) ‘Quality through co-production’, *Care Plan*, Vol 3, no 1, pp 13–15.

31 Boyle, D. et al. (2006a) *Hidden work: co-production by people outside paid employment*, York: Joseph Rowntree Foundation.

32 *Shaping Our Lives*, National Centre for Independent Living and University of Leeds Centre for Disability Studies (2007) SCIE people management knowledge review 17: developing social care, service users driving culture change, London: SCIE.

Co-production ‘does not dispense with the need for promoting equality, enforcing standards or improving delivery. However, it offers a different way to think about the relationship between the state, service providers and service users’³³.

Psychological Therapies Management Committees (PTMC)

The functions that each health board’s PTMC will need to exercise are as follows:

- Oversee the workforce re-design programme
- The implementation of the National Psychological Therapy Plan
- Data collection and analysis
- Prepare reports for health board committees and NPTMC
- Develop and oversee a training strategy
- Oversee provision of training and supervision
- Support service managers in setting up systems to ensure clinical governance and manage supply and demand
- Oversee the management and monitoring of all psychological therapy capacity
- Promote service/practice-based research to advance the evidence base in collaboration with academic institutions, service users and carers

Services should involve staff in developing the processes around the monitoring and delivery of the national access targets, in order to harness local expertise, generate creative solutions and maximise subsequent engagement. Engagement of service users and carers is essential to inform models of service delivery and the range of services required.

It is recognised that there is a considerable gap in many areas between what is currently available and the level of service required to meet the needs of the Welsh population and the aspirations of the Welsh Government. Matrices Cymru recognises that the skill set of the workforce needs developing, including a need to establish suitable training schemes, in order to achieve the full range of potential therapies and treatment across all levels of delivery. Where there is such a discrepancy however, up-skilling of staff alone will not be enough to produce the necessary increase in capacity. Organisational change and workforce re-design will be essential and some re-configuration of resources may well be required. Oversight of this process is the responsibility of the local PTMCs.



33 Carr, S. (2004) SCIE position paper 3: has service user participation made a difference to social care services? London: SCIE.

Workforce re-design should include:

- Training and support for service managers in stepped care/systems analysis/data reporting/caseload management
- Planning the sustainable development of the psychological therapy services to meet required targets and commitments, in line with Welsh Government priorities
- Auditing availability of appropriately trained psychological therapy practitioners and supervisors
- A language audit of trained psychological therapy practitioners and supervisors to establish the availability of Welsh speaking staff (and any other language spoken), to identify gaps in services and where training is necessary
- Prioritising and commissioning training based on service need, available evidence of effectiveness of treatment approaches for particular service user groups, cost-effectiveness and issues of equity and accessibility
- Facilitating and contributing to local service re-design to support the implementation of the strategic plan
- Ensure links to work on the implementation of the PIG and Matrics Cymru in local areas and work of the local CAMHS network leads for psychological therapy
- Putting in place appropriate governance to ensure safe service delivery, including ensuring necessary clinical supervision and CPD both for those in training and those practicing in the service
- Promoting service-based research and audit to advance the evidence base and audit effectiveness of local delivery models, including

appropriate activity and outcome measures. This includes acting to amend practice and systems based on the result of audit cycles

- Facilitating the implementation of properly funded research trials to evaluate new, innovative therapeutic approaches and to further explore how the components of therapy practice, either common to all therapies or specific to particular models, contribute positively or negatively to outcomes
- Utilise workforce re-design in order to release and reorganise capacity within available resources

In this process, there should be an emphasis on ensuring systems that make best use of current resources where increasing access is not only about training increased numbers of staff to deliver high quality care, it is also about delivering this care in the most efficient way possible in order to produce the maximum impact within the resource available.

Predicting the right amount of therapy to meet Welsh population needs is not an exact science as calculating the level of need is confounded by an array of factors such as population size, deprivation and prevalence rates (some of which may well be hidden). Overall prevalence is to some extent determined by socioeconomic factors such as social deprivation.

Whilst the full range of tiers is required within any psychological therapy service, the proportions of care delivered within each may vary according to the context. In IAPT services in England, covering populations with mild to moderate difficulties, a ratio of 60% high intensity psychological therapists to 40% low intensity workers is emerging as the optimal staffing configuration. Services focusing on more complex client groups who are more likely to be seen in secondary care, would require a higher proportion of high intensity and highly specialist therapists.

Careful thought needs to be given to this aspect of service design, in order to balance the availability of support at each level with the aspiration to maximise access to the service on a whole system basis.

Matrics Cymru presents the evidence base for the effectiveness of treatments, but there is also a need for services to apply the evidence base in relation to systems improvement methodology. This will aid health boards in designing efficient and effective processes and systems.

Improving Quality Together (IQT)³⁴ is the national quality improvement learning programme for all NHS Wales' staff and contractors, which builds upon recognised local, national and international expertise. The IQT skills are based on the Model for Improvement, looking at:

- Setting aims
- Measures
- Understanding a system
- Identifying changes
- Testing those changes
- Spreading improvements

There is now considerable experience within the Welsh NHS on using systems improvement methodology and most health boards have centralised improvement teams who can work with specific services on organisational priorities.

Additionally, there are a range of individuals working in mental health services with the knowledge and experience of using service improvement methodologies based on the 1000 Lives Improvement programme:

<http://www.1000livesplus.wales.nhs.uk/home>

A standardised methodology for assessing demand and capacity to deliver psychological therapy should be adopted by each local PTMC. Useful documents in this respect can be found at the links below:

<http://www.qihub.scot.nhs.uk/media/169335/demand-booklet.pdf>

Demographics, projected population figures and official statistics for each health board can be obtained via the StatsWales site:

<https://statswales.wales.gov.uk/Catalogue>

Service delivery

When considering access to psychological therapy, it is important to bear in mind that access is not simply related to service capacity. We know that there are groups within the community who do not access services in proportion to the level of mental health problems and distress they experience. Social deprivation, life circumstances, ethnicity, levels of ability, gender and age for example, can all influence people's knowledge about and decision as to whether or not to make contact with mental health services.

34 <http://www.iqt.wales.nhs.uk/home>

Emerging evidence from IAPT in England suggests that having a direct access option within the service which is not filtered through the GP increases uptake by disadvantaged groups³⁵. Services should not assume that they are equally acceptable and accessible to all. Health boards have a responsibility under equality legislation to identify groups experiencing difficulty with access to services and to make appropriate adjustments to improve access.

Workforce management

Matrics Cymru sets out a range of formally accepted UK definitions and standards. In conjunction with the local PTMC, service managers need to understand both the available workforce and the skills and knowledge required to meet local needs and national priorities in order to:

- Identify current workforce involved in the delivery of psychological therapy
- Identify knowledge, skills and supervision requirements of workforce
- Plan effectively for the future workforce supply
- Ensure the delivery of effective training and supervision strategy
- Ensure adherence to data collection requirements to further drive up service quality, clinical performance and productivity
- Develop a case for expansion (or workforce re-design) based on reliable service demand aligned to accurate workforce capacity data

³⁵ The English Department of Health has been so convinced by the evidence accumulating through the ongoing evaluation, that all IAPT services have now been directed to create 'direct access' options.

To ensure consistency of psychological therapy services across Wales, the standards developed for the Accreditation Programme for Psychological Therapies Services (APPTS) will be adopted. The APPTS programme is run by a central team at the Centre for Quality Improvement (CCQI) at the Royal College of Psychiatrists, in partnership with the British Psychological Society. Individual health boards can choose to seek accreditation via the APPTS scheme but this is not a requirement.

The core standards for APPTS are organised according to the Care Quality Commission (2013) requirements that services are:

- Safe
- Effective
- Caring
- Responsive to people's needs
- Well-led

The CCQI Quality Standards (unmodified for Wales) can be found here:

<http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/psychologicaltherapiessvc.aspx>

The core standards have been developed to apply to a wide range of psychological therapies services, including services provided by the NHS, the voluntary and the private sector.

A template of key development questions for services can be found in Section 6.

SECTION 2:

Psychological therapy practice

There is recognition that the term psychological therapy is used to describe a wide range of practice and that there is often a degree of confusion over its meaning.

Psychological therapies are treatments and interventions that are derived from specific psychological theories and formulated into a model or treatment protocol. Psychological therapies are delivered in a structured way over a number of sessions by a suitably qualified practitioner, with informed consent from the service user or where a service user lacks capacity to consent to therapy, it may be contracted on their behalf after an assessment of what is in their best interests. Psychological therapies help people understand and make changes to their thinking, behaviour, feelings or relationships in order to relieve distress and to improve their functioning, wellbeing and quality of life and are mediated by the therapy relationships. The quality of the relationship between therapist and service user is an essential component in the delivery of effective psychological interventions. Please see appendix 1. Psychological therapies are sometimes referred to as 'talking therapies'.

Therapy goals are based on the areas of life that the service user identifies as a priority for change and are most likely to lead to recovery. They are developed during the formulation process.

Psychological therapies are recognised as effective treatment options for a wide range of mental health needs, with an increasing evidence base demonstrating both clinical effectiveness and economic benefit. The National Institute for Health and Clinical Excellence (NICE) recommends that psychological therapy be made available on the NHS as a first-line intervention for a number of conditions.

It is now accepted that many people who present to health services can achieve good outcomes from evidence-based psychological interventions (such as large scale psycho-educational groups) that are less resource-intensive and delivered at lower tiers of the system, freeing up capacity at the higher tiers of service to provide effective treatment for those with more complex difficulties.

The Welsh Government's intention is that services covered by Part 1 of the Mental Health (Wales) Measure 2010 (e.g. Local Primary Mental Health Support Services delivered at Tier 1) meet the needs of individuals who are experiencing mild to moderate and/or stable severe and enduring mental health problems, whilst those service users with unstable severe and enduring presentations will receive care and treatment in specialist services under a statutory Care and Treatment Plan, as required within Part 2 of the Mental Health (Wales) Measure 2010 (Tier 2 and above).

Table 1 indicates the range of interventions used at different steps/tiers of the service and the parts of the Mental Health (Wales) Measure 2010 that they are likely to be appropriate for. This can be mapped to the levels of intensity field in the evidence tables. Individual health boards will have designated and agreed schemes for provision of psychological therapy and interventions within Part 1 of the Mental Health (Wales) Measure 2010.

Table 1

High volume, low intensity interventions
<p>Tier 0:</p> <p>Information</p> <p>Use of information and evidence-based health technologies is the least resource intensive level of intervention suitable for direct access by the general population, as it does not involve one-to-one contact with mental health staff and does not require GP referral. It could include psycho-educational information available on mental health issues in general, on common mental health problems and on different treatment approaches.</p> <p>Direct access evidence-based self-help</p> <ul style="list-style-type: none"> • Book Prescription Wales¹ • Computerised CBT packages (CCBT) • High volume, low intensity psycho-educational/self referral courses (stress control/acceptance and commitment therapy/mindfulness/positive psychology). These can be accessed without referral into Part 1 mental health services <p>The design of materials should be appropriate for dissemination throughout community resources including GP surgeries or other health and social care agencies, library/reading schemes, relevant television programming, large-scale psycho-educational groups and high quality psychological therapy websites.</p> <hr/> <p>¹ http://www.nhsdirect.wales.nhs.uk/lifestylewellbeing/bookprescriptionwales</p>

Low intensity interventions following identification of mild to moderate mental health distress

Tier 1: Part 1, Mental Health (Wales) Measure 2010

- Psychologically informed solution focused interventions to increase activity and social engagement
- Guided self-help for specific mental health related distress
- Supported Computerised CBT (CCBT) packages
- Telephone CBT (TCBT)
- Structured psycho-educational groups with an evidence base for a variety of common mental health problems/distress e.g. anxiety management/sleep/depression
- Structured exercise (exercise referral scheme²)

The interventions are aimed at mild/moderate mental health problems with little complexity, are time-limited and usually last between 2 and 6 sessions.

² <http://wlga.wales/national-exercise-referral-scheme-ners>

High intensity interventions/Psychological therapy

These comprise evidence-based interventions developed from psychological theory and practice i.e. standardised psychological therapies (CBT, IPT etc.) delivered to protocol. The therapies are aimed at moderate/severe common mental health problems with significant complexity and effect on functioning and usually last up to 16 sessions.

Some therapy will be delivered individually, but there may also be structured groups for specific problem areas, such as obsessive compulsive disorder, eating disorders, or emotional regulation. The provision of higher intensity psychological therapy may sit within both Part 1 and Part 2 services, as designated by health board schemes in respect of the Mental Health (Wales) Measure 2010 (the Measure). The criteria set by the Measure indicate those with unstable and severe presentations will receive psychological therapy services as part of a Care and Treatment Plan in specialist services under Part 2 of the Measure. Those service users with stable and severe presentations may also benefit from specialist psychological therapy services provided through a Part 1 scheme i.e. receiving care in a Part 2 provision (such as a CMHT) should not prevent a person from accessing relevant psychological therapy from a Part 1 service.

High intensity specialist psychological therapy

Tier 1-2:

These are standardised high intensity psychological therapies developed and modified for specific client groups. They are often delivered at the same level as high intensity therapy, but in a specialist context. Specialist therapy is aimed at moderate/severe mental health problems with significant complexity and effect on functioning (e.g. substance misuse, eating disorders, bi-polar disorder) and normally last between 16 and 20 sessions. In some cases therapy can be longer than this, due to the complex and often intractable nature of difficulty experienced by people who require this level of psychological therapy. Specialist psychological therapy services are most commonly accessed through mental health service pathways and may sit within Part 1 or Part 2 services, as designated by health board schemes in respect of the Mental Health (Wales)

Measure 2010. The criteria set by the Measure indicate those with unstable and severe presentations will receive psychological therapy services as part of a care and treatment plan in specialist services, in line with the requirements of Part 2 of the Measure. Those service users with stable and severe presentations may benefit from specialist psychological therapy services provided through a Part 1 scheme.

Tier 2/3/4, Part 2 Mental Health (Wales) Measure 2010

Highly specialist psychological therapy and interventions

These are highly specialist, individually tailored interventions based on case formulations drawn from a range of psychological models and are provided for service users with highly complex and/or enduring problems - they normally last 16 sessions or more. These services are usually delivered through secondary, tertiary and specialist services within Part 2, as designated by health board schemes in respect of the Mental Health (Wales) Measure 2010.

Determining competence for the delivery of psychological therapy

Over the past 10 years, there have been significant developments in defining competencies for the delivery of psychological therapies.

Commissioned by Skills for Health with the research led by Roth and Pilling¹ at University College London (UCL), significant progress has been made in developing UK-wide competences in relation to the four main schools of psychotherapy. The research determined four generic competences needed to relate to people and to carry out any form of psychological intervention as follows:

- Knowledge
- Assessment
- Building a therapeutic alliance
- Supervision

¹ See for example Roth, A.D. and Pilling, S (2008): Using an evidence-based methodology to identify the competences required to deliver effective cognitive and behavioural therapy for depression and anxiety disorders. *Behavioural and Cognitive Psychotherapy* 36:129-47.

Table 2

Generic competences in psychological therapy: The competences needed to relate to people and to carry out any form of psychological intervention (Roth and Pilling 2008)

Knowledge:	Knowledge and understanding of mental health problems; knowledge of and ability to operate within professional and ethical guidelines and knowledge of a model of therapy; the ability to understand and employ the model in practice form the basic underpinning to any intervention. Being able to draw on and apply this knowledge is critical to effective therapy.
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	The ability to operate within professional and ethical guidelines encompasses a large set of competences, many of which have already been identified and published elsewhere (e.g. profession-specific standards, or national standards such as the Ten Essential Shared Capabilities (Hope 2004) and the suites of National Occupational Standards relevant to mental health (available on the Skills for Health website at www.skillsforhealth.org.uk). Embedded in these frameworks is the notion of 'cultural competence', or the ability to work with individuals from a diverse range of backgrounds, a skill which is important to highlight because it can directly influence the perceived relevance and hence the likely efficacy of an intervention.
Assessment:	The ability to make a generic assessment is crucial if the therapist is to begin to understand the difficulties that concern the client. This is a different activity to the focused assessment described in the problem-specific competence lists. In contrast, a generic assessment is intended to gain an overview of the client's history, their perspectives, their needs and their resources, their motivation for a psychological intervention and (based on the foregoing) a discussion of treatment options. Assessment also includes an appraisal of any risk to the client or to others.

	This can be a challenging task, especially if the person undertaking the assessment is a junior or relatively inexperienced member of staff. Bearing this in mind, the ability of workers to know the limits of their competence and when to make use of support and supervision is crucial.
Building a therapeutic alliance:	This comprises four competences and is concerned with the capacity to build and to maintain a therapeutic relationship. Successfully engaging the client and building a positive therapeutic alliance is associated with better outcomes across all therapies. Just as important, is the capacity to manage the end of treatment, which can be a difficult time for clients and for therapists, as disengaging from therapy is often as significant as engaging with it; this process is an integral part of the 'management' of the therapeutic relationship.
Supervision:	Making use of supervision is a generic skill that is pertinent to all practitioners at all levels of seniority because clinical work is demanding and usually requires complex decision-making. Supervision allows practitioners to keep their work on track and to maintain good practice. Being an effective supervisee is an active process, requiring a capacity to be reflective and open to criticism, willing to learn and willing to consider (and remedy) any gaps in competence which supervision reveals.

The ability to monitor relationships, identify and repair any ruptures is also associated with better outcomes. These competences are common to all who provide psychological therapy and interventions and should be integral to high quality training, which should inform ongoing CPD.

The scope of the competence framework

Staff to whom the framework applies: The competence framework is designed to be relevant to staff who deliver psychological therapy in a range of clinical settings. It defines clinical knowledge and skills relevant to a range of professions such as low intensity, applied psychologists, psychiatrists, psychotherapists, art therapists, family therapists, nurses, occupational therapists and social workers.

Areas of clinical work covered by the framework: The competence framework is focused primarily on clinical work, which excludes service management and development skills. Audit and research skills are not specified in depth, though the ability to make use of measures (and to monitor outcomes) is identified as a core clinical skill, as is the ability to make informed use of the evidence base relating to therapeutic models and practice. Within Wales and as set out by Matrics Cymru, it will be a requirement that all staff who provide psychological interventions and therapy will participate in data collection and audit, productivity/resource management and include nationally agreed outcome measurement within the range of measures they use to assess whether the goals mutually agreed for therapy have been achieved.

Role of supervision in supporting the implementation of the framework: Supervision plays a critical role in supporting competent practice and the ability to make use of supervision is included in the framework.

Competences associated with the delivery of supervision are detailed in a separate framework². Supervision is discussed in more detail in Section 4.

Factors such as the strength of the therapy relationship, expectations of the service user and factors e.g. environment in which therapy delivered, also contribute to therapy outcome. Parameters of the therapeutic relationship such as successfully managed counter-transference, goal consensus and empathy have been identified as significant in delivering good therapy outcomes. Training to address ruptures in the therapeutic relationship will improve both the therapy experience and the outcome. These important factors are explored in more detail in appendix 1.

Modalities of psychological therapy

The traditional modalities of therapy most commonly provided within the NHS across the UK are:

- Cognitive and behavioural therapies
- Systemic psychotherapy
- Brief psychoanalytic/psychodynamic psychotherapy
- Humanistic/person centred/experiential therapy

In addition to these traditional modalities, there is a range of newer evidence-based therapies available, some of which are hybrid versions of the main modalities including:

- Dialectical Behaviour Therapy (DBT)

- Mentalisation Based Therapy (MBT)
- Cognitive Analytical Therapy (CAT)
- Interpersonal Therapy (IPT)
- Acceptance and Commitment Therapy (ACT)
- Eye Movement and Desensitisation Therapy (EMDR)
- Solution Focused Therapy (SFT)

It is a key intention of the Matrics Cymru to ensure access to Level A evidence-based therapies appropriate to presenting problem across mental health services and that a choice of at least one alternative approach is available, where indicated by the evidence.

The outcomes from well-designed research trials predict an initial response rate of around 60% for most evidence-based therapies, leaving 40% of service users who may well respond better to an alternative evidence-based approach. The aim should be to match people with the therapy and therapist most likely to be effective. Where a therapy has been concluded but has not led to significant health gain, a different therapy or a different therapist may still produce benefits for the service user and should be considered after discussion of the factors that could be changed to better address the presenting difficulties.

Service users and carers should be informed of the available options and fully engaged in the process of decision making around any planned interventions. There are significant numbers of service users experiencing more than one problem, often with very complex presentations, who do not fit neatly into traditional diagnostic categories.

² For example: www.ucl.ac.uk/clinical-psychology/CORE/supervision_framework.htm

It is important that a range of therapeutic approaches is available for this group and there is evidence that experienced and highly skilled therapists, who are able to work flexibly using a range of models, are more successful in engaging these people in psychological therapy.

There is a significant body of evidence for the causal impact of adversity and trauma across all mental health problems³. People who experience four or more adverse events in childhood have been found to be five times more likely to suffer from low mental wellbeing of various kinds. It is therefore important that systems as a whole are based on an awareness of the prevalence and impact of adversities and offer interventions aimed directly at processing the emotional effects of adversities. The effects of complex trauma resulting from adverse experiences including neglect, abuse of all types, bullying etc. are pervasive and if unresolved, negatively impact on the mental health of the individual across the lifespan and these effects are also likely to impact on the wellbeing of their families. Many types of adverse childhood experience interfere with the person's ability to form secure attachments.

Services need to be configured in such a way as to foster the development of healthy attachment relationships. This may be overlooked in crisis response models of care where the service user may be continually coping with changes in the team of mental health professional they see.

Formulation of the individual's presenting difficulties by a skilled and qualified practitioner, alongside service user choice, will guide the type of therapies provided. A formulation is a hypothesis about the reasons for a person's difficulties, which links psychological theory with practice and guides the intervention.

³ The Welsh Adverse Childhood Experiences Study, Bellis et al, Centre for Public Health –Liverpool John Moores University (2016) <http://www.cph.org.uk/wp-content/uploads/2016/01/ACE-Report-FINAL-E.pdf>

In other words, it draws on the evidence in order to develop a collaborative individual understanding and plan, which includes the personal meaning of life events, traumas and adversities. Formulation and/or case conceptualisation is a core skill in psychological therapy delivery. Robust and holistic multi-disciplinary formulation may be required to understand the function/s of a person's presentation, particularly if a person presents psychological distress through behaviours that challenge or if they communicate non-verbally.

The competence frameworks for each therapy modality were commissioned by Care Services Improvement Partnership (CSIP), Skills for Health and NHS Education for Scotland (NES)⁴. Competence frameworks should be accessed via the University College London (UCL) CORE homepage at:

<http://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks>

CORE competence frameworks for specific therapy modalities and clinical supervision are being periodically added and include:

- [Cognitive and Behavioural Therapy](#)
- [Psychoanalytic/Psychodynamic Therapy](#)
- [Systemic Therapy](#)

⁴ For the purposes of the National Occupational Standard project these competences are referred to as Statements of Evidence. They are developed by a team at UCL, a process which is overseen by an Expert Reference Group constituted of researchers and trainers selected for their expertise in the relevant therapy modality. Competences are identified using an evidence-based methodology (described in detail in the documentation which accompanies each framework). These are clustered according to a 'map' of the activities through which therapists carry out the therapy. This process is subject to careful review from the Expert Reference Group. When completed, this work is published by the Department of Health and made available through the UCL website.

- [Humanistic Therapy](#)
- [Interpersonal Psychotherapy](#)
- [Dynamic Interpersonal Therapy](#)
- [Counselling for Depression](#)
- [Couples Therapy for Depression](#)
- [Supervision of Psychological Therapies](#)

For the four core modalities, there are national occupational standards for psychological therapies which should be used to ensure best practice and commissioning training:

<http://www.bps.org.uk/consultation-papers/national-occupational-standards-psychological-therapies>

Curricula and standards for psychological wellbeing practitioners in England:

https://www.ucl.ac.uk/pals/study/masters/TPPPSYSLCB01/recruitment_files/BPS-standards-for-accreditation

Additionally there are competence frameworks for CAMHS, psychosis and bi-polar disorder, personality disorder and persistent physical health problems at:

- Psychological interventions in child and adolescent mental health services
- Psychological interventions with people with psychosis and bipolar disorder
- Psychological interventions with people with personality disorder
- Psychological interventions with people with persistent physical health problems (long term conditions/medically unexplained symptoms)

SECTION 3:

Psychological therapists

This section explores:

- The definition of a psychological therapist
- Required standards for psychological therapists
- Levels of interventions required for efficient and effective service

Governments across the UK have experienced difficulty in defining what formal psychological therapy is and who is qualified to deliver at different levels. This situation has been clarified through an extensive piece of work by The Centre for Workforce Intelligence (CfWI) (2012) which provides the following definition¹. As advised by the NPTMC, the Welsh Government agrees that Wales will adopt this definition.

Psychological therapist

1: To have completed one year of recognised full-time (or equivalent part-time) psychotherapy or counselling training leading to a qualification, certification or accreditation recognised by a relevant professional or regulatory body listed below:

Professional bodies

- Association for Cognitive Analytic Therapy

¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/507554/CfWI_Physiological_Therapies_Workforce_in-depth_review.pdf

- British Association of Art Therapists
- British Association for Behavioural and Cognitive Psychotherapies
- British Association for Counselling and Psychotherapy
- British Analytical Council
- British Psychological Society
- British Association of Dramatherapists
- British Association of Music Therapy
- British Society of Couple Psychotherapists and Counsellors
- Royal College of Psychiatrists
- United Kingdom Council for Psychotherapy²

Regulatory bodies

- Health and Care Professionals Council – responsible for regulating art therapists/music therapists/drama therapists/clinical and counselling psychologists
- General Medical Council
- Nursing and Midwifery Council

2. To have achieved a competency level that fulfils the requirements of the regulatory, accrediting or professional body

² The UKCP includes those professional bodies that are organisational members of UKCP and accredit psychological therapists to the required standard. See <https://www.psychotherapy.org.uk/join/our-organisational-members-and-trainings/> for a full list of UKCP organisational members. For a full list of UKCP accrediting organisations: <https://www.psychotherapy.org.uk/join/our-organisational-members-and-trainings/accrediting-organisations/> For a full list of UKCP training organisations: <https://www.psychotherapy.org.uk/join/our-organisational-members-and-trainings/training-organisations-2/>

3. To be a member of a relevant professional or regulatory body and continue to fulfil any accreditation or membership criteria, including meeting requirements for:

- Continuing professional and personal development
- Regular supervision
- Codes of practice

4. To have gained the supervised therapy experience required by the regulatory or professional body encompassing assessment, formulation, engagement, developing the therapeutic relationship, using relevant therapeutic interventions, working collaboratively with clients and working to end therapy

The Centre for Workforce Intelligence (CfWI) also offers Good Practice recommendations:

The required standards above apply to all types of psychological therapy and the following may not apply to all types of therapy, but are recommended as good practice:

1. The ability to provide long and short term therapy, as appropriate to the therapy modality and client needs
2. Competence to work with clients of moderate severity, significant complexity and impaired functioning
3. The collection of outcome data and client feedback, the use of this in supervision and in service audit and evaluation
4. To be working at Step 3 or above in NICE guidelines stepped care model or equivalent

N.B.: For some therapy models, experience of personal therapy is an additional requirement or recommendation.

It is recognised that the psychological therapies workforce includes staff from a range of different professional backgrounds and training routes. All members of staff who provide formal psychological therapy as part of their role in services will comply with the Matrics Cymru standards (including trainees, voluntary or honorary members of staff). Where the term 'psychological therapist' is explicitly used in Matrics Cymru, it is with reference to the Centre for Workforce (2013) definition and standards stated above.

Exclusions: The definition specifically excludes those working solely using short term low intensity interventions, who would more correctly be defined as working at practitioner level rather than therapist level and those who may have attended shorter courses in counselling or a psychological therapy. Therapeutic interventions from appropriately supervised therapy practitioners with lower levels of experience and training can still be of great value. Such practitioners currently provide the majority of psychotherapeutic interventions in the NHS and are likely to continue to do so.

There has been concern about the unregulated nature of psychological therapy. Several issues have arisen in relation to this issue across the UK, especially with respect to public protection and the nature of who is qualified to deliver psychological therapy. Formal yet voluntary registers have been developed across the UK and Scotland has created its own register³.

³ http://www.cosca.org.uk/new_documents.php?headingno=18&heading=Accreditation%20for%20Counsellors%20/%20Psychotherapists

In England, *Scheme One* of the revisions to the Health and Social Care Act⁴ has led to the introduction of an Accredited Voluntary Register (AVR) scheme, which has been developed and is maintained by the Professional Standards Authority for Health and Social Care (the Authority). This is a form of quality assurance and the UK Government intends that as the scheme progresses, NHS employers and commissioners will insist on practitioners either being subject to statutory regulation through registration with the Health and Care Professions Council, or that they are on an AVR. The Authority is promoting the AVR scheme and encouraging its use as a standard in national NHS guidance on the provision of services.

It is recommended that psychological therapists in Wales meet the Centre for Workforce Intelligence criteria and are on a register of a regulatory body, e.g. HCPC or use the AVR scheme.

It is expected that all staff groups coming into contact with people with mental health issues, in the context of physical health conditions, will be skilled at providing psychological care as indicated by Levels of Psychological Care Model (NICE 2004) (see figure 3) and as advocated by the King's Fund and Centre For Mental Health (2012). This would involve being able to identify psychological needs and providing general psychological support and information by using empathic communication. This is consistent with well functioning psychologically minded organisations. Professional staff should know their limitations and when to refer on for a more specialist psychological assessment.

At the higher tiers of the matched/stepped care system, staff may be accredited to a specialist level in one or more of the major therapeutic approaches.

Further down the pyramid, they may simply be required to use circumscribed elements of any particular approach under appropriate supervision. The skills and competences required to deliver these interventions effectively are acquired through training and maintained through clinical supervision, CPD and practice which includes feedback from service users provided through a range of mechanisms.

It is recognised that the outline in Table 3 below does not adequately reflect the complexity of the delivery of psychological therapies and that individuals may have pursued idiosyncratic training pathways which have equipped them with high-level competences, even though they have not completed doctoral level training. It is the responsibility of the health boards to ensure that their staff have the necessary competences to take on a particular role. They may wish to use their PTMC as a reference group in this respect.

Table 3 shows the minimum training required for the delivery of different levels of psychological interventions:

4 http://www.legislation.gov.uk/uksi/2015/64/pdfs/ukxi_20150064_en.pdf

Table 3

Intensity of intervention	Client group / level of severity	Treatment delivered	Competence / training routes
<p>Low intensity:</p>	<p>Common mental health problems – stress/anxiety/depression</p> <p>Severity: Mild/moderate, with little complexity and limited effect on functioning</p>	<p>Low intensity evidence-based interventions e.g.</p> <ul style="list-style-type: none"> • Supported self-help • Solution-focused/problem solving • Structured anxiety/depression management groups • Self-help coaching • Telephone CBT (TCBT) <p>High volume courses:</p> <p>For example:</p> <ul style="list-style-type: none"> • Mindfulness • Acceptance and commitment • Stress control 	<p>Level of competence: Must meet the ‘Skills for Health’ low intensity competences and the standards referenced within the Matrics Cymru</p> <p>Staff with additional training plus intensive, ongoing clinical supervision</p>
<p>High intensity:</p>	<p>Common mental health problems or those whose difficulties are beneath the threshold of secondary care</p> <p>Severity: Moderate/severe with significant complexity and effect on functioning</p>	<p>Standardised psychological therapy delivered to ‘protocol’</p> <p>Treatment duration as specified in NICE guidelines (usually up to 16 sessions)</p> <p>Specialised supervision</p>	<p>Level of competence: As a minimum training that meets the Centre for Workforce Intelligence (CWFI) definition for a psychological therapist</p> <p>Must meet the ‘Skills for Health’ high intensity competence</p>

<p>High intensity specialist:</p>	<p>Moderate/severe mental health problems with significant effect on functioning</p> <p>Specialist areas</p> <p>For example:</p> <p>Schizophrenia, Personality disorder, Bi-polar disorder, eating disorders, substance misuse etc.</p> <p>Severity: Moderate/severe with significant complexity and effect on functioning</p>	<p>Standardised psychological therapy delivered to 'protocol'</p> <p>Treatment duration as specified in NICE guidelines (usually up to 16 sessions)</p> <p>Specialised supervision</p>	<p>Level of competence: Must meet the 'Skills for Health' high intensity competence</p> <p>Diploma level therapy training, plus further training in application of advanced therapy techniques to specialist area</p> <p>Further knowledge and skills may be acquired through formal training or through specialist supervision</p>
<p>Highly specialist:</p>	<p>Complex, enduring mental health problems with a high likelihood of co-morbidity and beyond the scope of standardised treatments</p> <p>Severity: Highly complex</p>	<p>Highly specialist, individually tailored interventions, drawing creatively on the theoretical knowledge base of the discipline of Doctoral Level Psychology and Consultants in Medical Psychotherapy</p> <p>Normally lasting 16 sessions and above</p> <p>As per NICE guidelines</p> <p>Specialist supervision at all levels</p> <p>Providing advice, consultation and training to multi-disciplinary colleagues</p>	<p>Level of competence: Specialist knowledge of a range of theoretical and therapeutic models. Ability to formulate complex problems using a range of psychological models, taking into account historical, developmental, systemic and neuropsychological processes. This will include:</p> <ul style="list-style-type: none"> • Doctorate in Clinical or Counselling Psychology, Consultant Medical Psychotherapist, individual clinicians with highly developed special skills and expertise, normally including involvement in research and equivalence to doctoral qualification. Identified by health board PTMC as having the requisite knowledge and skills. Qualifications and practice consistent with National Standards

Providers of psychological interventions

Allied Health Professionals (AHPs)⁵

AHPs are a varied group which includes occupational therapists, physiotherapists, speech and language therapists and dietitians. Health boards should ensure the delivery of evidence-based psychological interventions by appropriately trained AHPs to support rehabilitation, self-management and recovery approaches as part of local delivery strategies.

The challenge for services is to utilise the AHP staffing resources at their disposal, to deliver a range of evidence-based psychological interventions and maximise AHPs potential to promote better outcomes for service users and carers. The challenge for AHPs is to clearly articulate their contribution to delivering psychological interventions and actively engage in PTMCs and strategy groups. Working in partnership with local PTMCs, AHPs can integrate recognised psychological approaches into their core practice and contribute significantly to the national psychological therapies agenda, by enabling service users and carers to have a choice of evidence-based non-pharmacological therapies. Appropriately trained and supervised AHPs can deliver a range of the evidence-based interventions under a robust clinical supervision structure.

Applied psychology

Historically, the bulk of psychological interventions delivered within the NHS were traditionally carried out by applied psychologists (primarily clinical and counselling psychologists) from within psychology services and departments.

⁵ AHPs working in mental health include occupational therapists, arts therapists, physiotherapists and speech and language therapists

However, in recent years the emphasis has been on expanding capacity through skill mix so that psychologists have increasingly been involved in the development and maintenance of psychological competence in the existing multi-professional workforce. A broader skill mix has evolved within psychology and psychological therapies services themselves with the addition of assistant psychologists, cognitive behaviour therapists and other professional therapists. In addition, there has been an increase in the number of staff from other disciplines trained in particular psychotherapeutic approaches. This extension of the skill mix and the demand for greater access to psychological interventions, has led to an increase in the requests for applied psychologists and other qualified professionals to provide training and supervision.

Art therapists

This is an umbrella term for four distinct professions: Art Psychotherapy, Music Therapy, Drama Therapy (all registered with HCPC) and Dance Movement Psychotherapy. All use verbal and non-verbal approaches, working in partnership with service users and their support services to alleviate emotional distress and effect change. Although there are shared theoretical underpinnings and practices, each profession has its own training of minimum two years Masters post-graduate route following BA Graduate in relevant art medium, or related discipline. Arts therapists in Wales are employed in a variety of in-patient and community settings, including: adult mental health, learning disabilities, education, CAMHS, palliative care, older adults, forensics, substance abuse, stroke rehabilitation. They also lead in arts in health and wellbeing projects. They offer single or joint modality assessment and therapy; individual and/or group assessments and therapy; advice and consultation, supervision, staff training, formulation and MDT decisions about most appropriate care.

Carers

Carers or other members of the service user's community can be an essential resource in the assessment of individuals, especially where persistent and pervasive patterns of distress are suspected. Where a service user identifies a person, or people whom they trust to give valid information on their wellbeing and difficulties, these people are in a position to give valuable information about how the individual has behaved through their life course and in contexts outside of the mental health service. The nature of the mental health service and the assessment process can induce behaviours which are not typical for the individual being assessed. A lack of external evidence may even impede an accurate assessment. If seeking external evidence is practical, this needs to be done with the informed consent of the service user and with the usual regard for confidentiality.

Many carers simply do not know what to do for the best or how to support recovery and many ask for support so that they too can be helpful. There are some therapies in which carers are recognised as co-therapists in the delivery of the interventions but in all therapies and interventions, providing carers with knowledge of psychologically supportive ideas will have a beneficial impact on the wellbeing of both service user and carer. With service user permission and collaboration, carers can assist with the generalisation and application of therapeutic progress, if given the right information and amount of support to do so, enabling gains and new understandings to transfer from the therapy room into the real world setting.

Counsellors

Counsellors need to be registered with a relevant professional body, to meet the standard set by CfWI definition of a Psychological Therapist and are normally qualified to Post-graduate Diploma or Masters Degree level

in Counselling, Integrative Counselling or CBT. Those working within the NHS and statutory sectors will be working towards accreditation or accredited with the appropriate professional body which ensures that counsellors comply with standards for supervision, ethics and training. Although initial core training modalities can range from humanistic, person-centred interventions through to more specific complex problem focused treatments, there may be agreed service specifications regarding delivery of high intensity interventions in statutory services in Wales in which counsellors with appropriate training and supervision deliver specific interventions. Within primary care, counsellors deliver low intensity and high intensity interventions providing brief, structured interventions drawing on either a single theoretical model (e.g. CBT) or more commonly, a pluralistic theoretical model (e.g. Systemic) to address specific problems.

Nursing

As the largest profession in the NHS, the input of mental health nurses is critical in enabling health boards to deliver good psychologically-based care and to meet the increasing demand for psychological therapies. The Chief Nursing Officer Review of Mental Health Nursing (MHN) (2006)⁶ specified that the Mental Health Nurse role in delivering psychological therapies must be progressed using a stepped approach to competence development. At that time it was estimated that over 5,000 mental health nurses in England were qualified to provide psychosocial interventions for people with psychosis. Significant numbers were trained in a range of different approaches, for example, Psychosocial Intervention (PSI) models like Thorn and Meriden/Behavioural Family Therapy (BFT).

⁶ From Values to Action: The Chief Nursing Officer's Review of Mental Health Nursing (2006)

However, it has proven difficult at times for mental health nurses to use their new skills in practice⁷.

Whilst not a core component of their primary training, this role now requires the provision of accredited training, ongoing psychological therapies supervision for nurses practicing psychological therapies and proactive activity management, to ensure nurses have protected time to deliver psychological interventions and therapies in practice.

Primary care staff

The majority of psychological distress and mental health problems are dealt within the primary care setting. With reference to psychological interventions, GPs, practice nurses and other primary care staff who are working closely with clients and families in the general health context have a key role in identifying psychological problems, offering advice, delivering low intensity interventions as appropriate and referring clients on to mental health services where this is indicated. Within some GP practices, staff may be trained to deliver psycho-educational packages and guided self-help interventions. Since the enactment of Part 1 of the Mental Health (Wales) Measure 2010, all health boards in Wales now have a Local Primary Care Mental Health Support Service with a range of functions which include assessment, signposting and interventions within a psychosocial model.

As a consequence, mental health expertise and resources are now available much closer to primary care practice and there is an expectation that earlier availability in the service user journey will reduce the impact of psychological distress, especially for people with mild to moderate common mental health problems and for those with more severe but stable conditions.

⁷ <http://www.meridenfamilyprogramme.com/download/research-and-resources/Trainers%2520Audit.pdf>

Psychiatry

All psychiatrists working in mental health have mandatory training in the different forms of psychological therapy, in order to become Members of the Royal College⁸ and may deliver low intensity psychological interventions, as well as supporting the psychological wellbeing of people in mental health settings. Psychiatrists from a range of specialties may have additional training in psychological interventions and therapies which are relevant to their areas of work.

A smaller number of psychiatrists will have completed a three year higher specialist training in psychotherapy⁹, which includes intensive training in one psychotherapeutic modality (CBT, Psychodynamic or Systemic Therapy) and working knowledge training in the other two approaches. They are then able to work as 'consultant medical psychotherapists'. As such they are able to train and supervise specialty registrars in psychotherapy and staff from other disciplines.

Psychotherapy trainee placements

Honorary psychotherapists who are completing formal psychotherapy training regardless of their initial training, require supervised practice placements which meet the criteria for their training. Those health boards and third sector organisations in Wales who offer placement opportunities to psychotherapy trainees should have codes of practice in relation to this group of staff¹⁰.

⁸ <http://www.rcpsych.ac.uk/workinpsychiatry/faculties/medicalpsychotherapy/trainingandcpd.aspx>

⁹ <http://www.rcpsych.ac.uk/workinpsychiatry/faculties/medicalpsychotherapy/trainingandcpd.aspx>

¹⁰ <http://www.nhs.uk/working-in-the-nhs/joining-the-nhs/volunteering-in-the-nhs/>

The third sector

Across Wales, there are many examples of third sector provision of therapy which are commissioned by Service Level Agreements (SLA) or are independently funded. Health boards must ensure psychological therapists within services commissioned by the statutory sector meet the standards set out in the Matrics Cymru. These services contribute significantly to the mixed economy and choice agenda often providing therapies in non-stigmatising settings and often accessible via self referral. It is necessary for statutory and non-statutory services to work in partnership to avoid duplication or gaps in provision.

SECTION 4:

Psychological therapy supervision

Supervision is a key element of clinical governance for staff delivering psychological therapies, alongside CPD and life-long learning to ensure safe, accountable practice and high quality clinical and professional services.

Supervision is identified within a range of documents in relation to the governance of professional practice, for instance, the Care Quality Commission's Essential Standards of Quality and Safety (2010)¹ and the Health and Care Professions Council's Standards of Practice 2c.2 (HCPC 2016)².

The Department of Health (1993) defines supervision as, 'A formal process for professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety in complex situations. It is central to the process of learning and scope of the expansion of practice and should be seen as a means of encouraging self-assessment, analytical and reflective skill'. Psychological therapies supervision reduces potentially harmful variations in practice and ensures the safe, effective and efficient delivery of psychological therapy.

1 https://services.cqc.org.uk/sites/default/files/gac_-_dec_2011_update.pdf

2 <http://www.hcpc-uk.org/aboutregistration/standards/standardsofconductperformanceandethics/>

It should be noted that psychological therapies differ significantly from physical interventions in a number of respects. The vehicle for delivery is a complex interpersonal interaction and treatment sessions often take place over extended periods of time, usually on a one-to-one basis with no direct observation.

The best available evidence suggests regular psychological therapies supervision should cover all active cases and focus on adherence to model, progress in treatment and elements of the therapeutic relationship. It should be informed by the service user's routine outcome measures. It is important to distinguish between managerial supervision which may cover a range of clinical, administrative and performance issues and psychological therapies supervision as defined above. Psychological therapies supervision focuses on the delivery of a particular therapy in a specific context. It is essential to the provision of effective psychological therapies services, both during training and to ensure the safety and quality of subsequent practice. It is a requirement of all the professional bodies accrediting psychological therapists specified. The effectiveness of supervision can be enhanced through the use of audio and audiovisual recording of sessions and is essential for some groups e.g. music therapy trainees.

Psychological therapies supervision:

- Ensures that the supervisee practices in a manner which conforms to ethical and professional standards
- Ensures delivery in line with the evidence base
- Promotes fidelity to the therapeutic model
- Provides support and advice in dealing with individual cases where the therapy may be stuck, or where there are elements of risk

- Acts as a vehicle for training and skills development in practice
- Can improve treatment effectiveness when it is outcome focused (and incorporates discussion of outcome measures within sessions)

There are a number of ways to offer supervision with some modalities requiring individual supervision, whilst others benefit from shared supervision or case discussion. For instance, systemic/family therapy models allow for consultation via a team and DBT provides weekly team consultation. If staff are trained in and offering multi-modality psychological therapies, then they will also require multi-modality supervision in accordance with standard requirements.

It is best practice not to use the client's name in routine supervision, especially where this takes place in groups.

Trainees may have to comply with more frequent and intensive levels of supervision to adhere to accrediting organisation requirements. Honorary psychotherapists who are completing a formal psychotherapy training (to include psychotherapists, counsellors, CBT therapists, counselling psychologists, health psychologists and art/music/drama therapists) require supervised practice placements which meet the criteria for their training. Those health boards and third sector organisations in Wales who offer placement opportunities to psychotherapy trainees should have codes of practice in relation to this group of staff³.

Service managers must ensure the availability of adequately trained supervisors offering an appropriate range of modality specific supervision, with the capacity for regular supervision of both trainees and qualified staff.

³ <http://www.nhscareers.nhs.uk/working-in-the-nhs/joining-the-nhs/volunteering-in-the-nhs/>

This may be via re-design of the workforce rather than an increase in resources so that experienced and trained staff are released to provide supervision for less qualified staff. They may also wish to invest in video conferencing or other IT assisted facilities to improve access to specialist supervision⁴. Shared supervision resources across localities, national networks or health boards may be an appropriate way to support provision, particularly in specialist areas.

The NPTMC has a central role in workforce re-design and in monitoring quality standards for supervision.

There is a particular knowledge and skill set necessary for the delivery of good quality psychological therapies supervision and being a competent therapist does not in itself equip a practitioner to be a competent supervisor. As in the practice of psychological therapy itself, the quality of the relationship between the supervisor and supervisee is an influential factor in ensuring successful outcomes from supervision. The standards used for supervision in Wales will be those identified in the University College London competence framework which were commissioned by Care Services Improvement Partnership (CSIP), Skills for Health and NHS Education for Scotland) (NES)⁵.

⁴ Many health boards utilise SKYPE supervision from a National Eating Disorder Specialist on a regular basis – it is conducted on a group basis and professional observers are enabled to take advantage of this supervision

⁵ For the purposes of the National Occupational Standard project, these competences are referred to as Statements of Evidence. They are developed by a team at UCL, a process which is overseen by an Expert Reference Group constituted of researchers and trainers selected for their expertise in the relevant therapy modality. Competences are identified using an evidence-based methodology (described in detail in the documentation which accompanies each framework). These are clustered according to a 'map' of the activities through which therapists carry out the therapy. This process is subject to careful review from the Expert Reference Group. When completed, this work is published by the Department of Health and made available through the UCL website

These can be accessed via the link below:

http://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks/Supervision_of_Psychological_Therapies

The standards were developed from the work of Roth and Pilling to:

- Describe the competences which will be needed to supervise high and low intensity CBT derived interventions
- Develop a supervision framework applicable to other modalities, included in the range of therapeutic approaches for which competence frameworks are being developed e.g. psychoanalytic/psychodynamic, systemic and humanistic/person-centred/experiential)

All staff delivering psychological therapies supervision should:

- Be a qualified psychological therapist, with a working knowledge and experience of the interventions in which they are providing supervision. A qualified high intensity CBT therapist, for example, would normally be expected to have two or three years of experience of delivering the therapy under supervision before putting themselves forward for supervisor training

and

- Have training which equips them with the supervision competences set out in the UCL competence framework

SECTION 5:

Training

Training and skills development are key to:

- The delivery of psychological therapy and supervision
- Increasing the capacity of the current and any new workforce to deliver effective interventions at both the required quality and volume

Values base and recovery focus

All staff working in mental health services will be operating from the values base as described in the 10 Essential Shared Capabilities. The 10 Essential Shared Capabilities were originally developed and published by a partnership involving the Department of Health, the Sainsbury Centre for Mental Health, the National Institute for Mental Health in England and the NHS University in 2004. It is important to note that these organisations worked closely with service users and carers to ensure that they reflected their priorities. It is intended that they will enable service users and carers to have increased awareness of what to expect from staff and services.

The 10 essential shared capabilities

1. Working in partnership
2. Respecting diversity
3. Practising ethically
4. Challenging inequality

5. Promoting recovery
6. Identifying people's needs and strengths
7. Providing service user-centred care
8. Making a difference
9. Promoting safety and positive risk taking
10. Personal development and learning

Over time there may be other values based standards that will require the training of staff.

In addition to training in values based care and recovery, all mental health staff should have a basic level of psychological 'awareness' and 'literacy'. This should include:

- Training in a psychological model within which they can construct a basic psychological formulation of service user's difficulties
- Training in listening and communication skills
- Training in basic counselling skills
- Training in self-awareness and the role of the therapeutic relationship

Psychological therapy services also need to ensure they comply with the terms of the Welsh Language Act 1993⁶ and the Welsh Language Measure (2011).

6 <http://www.legislation.gov.uk/ukpga/1993/38/contents>

Psychological interventions and therapy

Psychological therapies interventions can be subdivided in line with the tiers in a stepped care model as below:

- Low intensity treatments
- High intensity therapy
- High intensity specialist therapy
- Highly specialist therapy and interventions

The mapping of levels of training against the tiers of the matched/stepped-care system is shown in Section 3, Table 3, “Minimum training to deliver different levels of therapy in Wales”. Competence to practice within a specific psychological therapy model e.g. CBT, systemic therapy should also be consulted (see Page 36 and 37).

In June 2017, there were no All Wales training schemes that deliver training for the 10 essential shared capabilities, or for the workforce delivering low intensity interventions. It is therefore important that local training schemes are structured around the relevant competence frameworks identified in Matrics Cymru and that those delivering the training have the appropriate level of expertise.

The standard of competence required to deliver high intensity specialist psychological therapy has been set intentionally high at Diploma level, in order to ensure fidelity to the evidence base. However, it is recognised that some staff currently delivering high intensity psychological therapy will require additional training to meet this standard.

In addition to direct practice-based training, staff will also need training in accountability processes and procedures, including legal obligations, how to manage complaints, second opinions and investigation of errors or potential errors.

The effectiveness of therapy, supervision and the state of the therapy relationship are profoundly affected by the accuracy and reliability of record keeping. Partial and inaccurate records can mean lost opportunities, missed risks, misunderstandings and misrepresentations of the service user. Staff need to know how to check the accuracy of their records with service users, use electronic recording devices to improve accuracy and what they can or cannot change in records and the process they need to follow to change it. It is essential that any opinion is identified as an opinion and all the facts leading to that opinion are given, so that subsequent clinicians can assess the situation for themselves and errors can be better identified and addressed.

Local PTMCs should develop and oversee a training strategy for each health board area. The NPTMC should carry out an option appraisal for developing All Wales training in these areas.

SECTION 6:

Audit and data collection

Data to be collected nationally

The data collection system is focused on mental health services and on people who present for psychological interventions. As a consequence, the waiting time measures will primarily focus on therapies delivered in Part 1 of the Mental Health (Wales) Measure 2010 and as part of a Care and Treatment Plan (Part 2 of the Mental Health (Wales) Measure 2010) in the higher tiers of service.

This is not to suggest that other higher volume, low intensity interventions are unimportant. The evidence is that a substantial proportion of those with mild/moderate mental health difficulties can be treated effectively at this level, reducing demand for service at higher tiers. Indeed it is envisaged that health boards will only be able to meet access targets if they provide a substantial volume of high quality low intensity interventions as part of an integrated service. Welsh Government has stated a commitment to continue to shift services away from hospital based care towards community focused care services and wellbeing (to include self management and resilience building).

In order to monitor progress on waiting times in keeping with the Mental Health (Wales) Measure 2010, access targets and access targets for treatment in physical health settings, key information will be collected for every service user in keeping with Welsh Government protocol. This will include as a minimum:

- Date of receipt of the referral

- Date of start of initial assessment for suitability for psychological therapy
- Date psychological therapy commenced

Waiting times should be measured and adjusted for client unavailability due to ill health or life circumstances and based on when the service offered the appointment, in line with waiting time protocol. Changes in waiting time targets may inadvertently impact on other areas of service. Services should identify the impact of service re-design, to ensure that service users are not adversely affected for other elements of care.

Waiting time for psychological therapy should be collected for all patient groups across the lifespan and for the purposes of data collection, the definition of psychological therapy will be that set out in Matrics Cymru. There are also situations in which psychological therapy is delivered through family members, carers and health or care staff, who are being trained or supported to deliver a particular psychological intervention. This may happen where adult clients have given permission to include carers and/or friends in their therapy process, but is almost certain to happen in, for example, services for people with learning disabilities or dementia. In these circumstances the therapist may be involved in face to-face sessions with third parties as described. Although the named patient may not be present, the usual regard for confidentiality issues must be maintained and these interventions should be counted.

Many interventions delivered in primary care will not meet the criteria to be counted as a psychological therapy, but will deliver appropriate psychological support to many people with mild/moderate levels of psychological distress and with successful outcomes.

Monitoring and reporting of waiting time for these interventions/ treatments delivered by services within Part 1 of the Mental Health (Wales) Measure 2010, including LPMHSS, memory assessment services and counselling services are already reported by health boards. It is recommended however, that the waiting time for psychological and psychosocial interventions is captured separately from medical, occupational or employment support. Examples of what should and should not be counted are given in appendix 2.

Key demographic information will also be collated to include Equality Impact Assessment data in an effort to understand service provision deficit and to enable targeting resources to under-represented groups or those with protected characteristics. This includes services in the Welsh language.

Balancing measures

The setting of a target for any part of the system can have repercussions for other areas of service. It is expected that health boards will collect data locally on a number of additional balancing measures. This will help to ensure that the drive to achieve targets does not impact negatively on other parts of the system, or on the quality of service user care. The monitoring of any target should also include a balancing measure, capturing the percentage of people assessed as not suitable for psychological therapy and those who drop out once accepted.

Outcome measures

Service user outcomes are an essential measure and need to be monitored closely, to ensure that progress is being made towards achieving the goals agreed by the service user and therapist at the beginning of therapy. Routine measurement of significant aspects of the therapeutic relationship should also be made.

The introduction of the Mental Health Data Set and the Welsh Community Care Information System will include outcome measures from a service user perspective and standardised outcome measures.

In the field of psychological therapy there has long been a drive to “bridge the gap” between practice and research¹. This has led to a recognition that both Evidence-Based Practice (EBP) and Practice-Based Evidence (PBE) are necessary to deliver high quality interventions which can be delivered in routine clinical settings.

Evidence-Based Practice (EBP) draws on information gathered from Randomised Controlled Trials (RCTs), enabling a comparison between the outcomes of different types of therapy and often includes a control group that has not been offered therapy. Systematic reviews and meta-analysis draw together large numbers of primary research studies to provide an overview of the evidence for specific interventions e.g. NICE guidance or a Cochrane Review.

The commitment to deliver evidence-based practice has a number of implications for any service. The evidence base is derived from the results of key therapeutic research trials and in order to effectively deliver an ‘evidence-based’ therapy, services must be able to ensure that practitioners are replicating the conditions operating within those trials as closely as possible.

1 Barkham, M & Mellor-Clark, J. (2003). ‘Bridging Evidence-Based Practice and Practice-Based Evidence: Developing a Rigorous and Relevant Knowledge for the Psychological Therapies’. *Clinical Psychology and Psychotherapy*. (2003), 10, 319-327.

The Practice-Based Evidence [PBE²] approach includes a wider base of evidence from “real-world” (typically, NHS) settings rather than from RCTs. This method enables services to drive up quality standards through benchmarking and case tracking with reference to service led criteria, including clinical outcomes and is effective in improving practice. Recent evidence from the Practice Research Network (PRN) for IAPT³ shows that the most effective IAPT services in England routinely employ these methods to enable clinicians to monitor, reflect and improve their practice. This approach to improving services emphasises the value of data quality, which can be reduced by incomplete data and lack of assurance regarding treatment fidelity. The methods of PBE need to be seen as complimentary to evidence-based practice.

In order for a health board to be able to determine whether a psychological therapy is being delivered in line with the evidence base, they will require information to be collected to establish that interventions are delivered:

- By appropriately trained staff
- To individuals or groups on a face-to-face basis⁴
- In dedicated/focused sessions within protected time with recommended levels of psychological therapies supervision and accurate session recording

2 Barkham, M. and Margison, F. , ‘Practice-based evidence as a complement to evidence-based practice: From dichotomy to chiasmus’, in Freeman, C. & Power, M. (ed), Handbook of evidence-based psychotherapies: A guide for research and practice (Chichester: John Wiley & Sons, Ltd. 2007)

3 Clarke et al NSP Conference 2016

4 ‘Face-to-face’ will include interventions delivered by telephone or direct video link and in the foreseeable future by video link and other web based systems

Where there is a limited evidence base either through EBP or PBE, a psychological therapy may be delivered in order to meet the needs of a particular service user. It is recognised that the current evidence tables do not cover all problem areas and it is assumed that health boards will take advice from local/national specialists/experts on the status of current evidence and best practice where national guidance is not available.

Data will need to be collected nationally on all psychological therapies being delivered to people with mental health difficulties within Part 1 and Part 2 of the Mental Health (Wales) Measure 2010. Information about the level of variance (i.e. how often therapies are delivered outside the evidence base) will provide an overview, both locally and nationally.

Matrics Cymru evidence tables

The Matrics Cymru evidence tables, taken together with the advice on service structure, standards and governance set out in Matrics Cymru, form a template against which service planners and managers in health boards can map their current services. The evidence tables, can be downloaded here:

<http://www.1000livesplus.wales.nhs.uk/opendoc/308332>

How to use the Matrics Cymru evidence tables

Effectiveness and cost-effectiveness

The evidence base for any intervention, as currently defined in SIGN and NICE guidelines, will generally tell us one of three things:

- That there is evidence in the literature for the effectiveness of that intervention and if this is the case, the intervention will then be ranked on the quality of the available evidence

- That there is no clear evidence in the literature for the effectiveness of that intervention. It is recognised that the absence of robust evidence for any particular approach does not prove that the approach is ineffective and it may be that the evidence has not yet been collected. However, in an environment where resources are limited, it is prudent to focus on where we can have the greatest confidence in the maximum return for our investment
- That there is evidence in the literature that the particular intervention is ineffective, or indeed harmful

In the first and last cases the implications are clear:

- Health boards should provide interventions for which there is good evidence of effectiveness
- Where an intervention has been proven ineffective or harmful, it should not be provided
- Where little or no evidence has been collected, there needs to be some flexibility of approach. In a number of areas, for example, there are longstanding services which are recognised as being of benefit to clients in spite of the lack of a tradition of high-quality EBP research. There is no suggestion that these services should be dismantled, but it is crucial that health boards begin to collect their own good quality evidence [PBE] around the effectiveness of such services. Not only is this essential for good governance, but it will contribute to the wider evidence base and help ensure that investments are effective in the longer term

When using the tables as an aid to strategic planning, it is important to start off by scoping local expertise and building on the experience already available.

However, services need to be able to demonstrate that they are working towards providing evidence-based services in a developmental way.

Where two or more treatment options are comparable in terms of effectiveness, then issues of cost-effectiveness should be considered. Factors which need to be taken into account include:

- The cost of treatment in terms of therapist time and other resources, taking account of models of service delivery and service user turnover
- The investment required in training staff to deliver the intervention, taking into account levels of skills/knowledge already available within the system
- The sustainability of training to maintain service in the long term
- The efficiency of training (i.e. what percentage of time the trained staff are able to deliver the intervention within the service)
- The capacity of the system
- Issues of client choice

Which therapies - the evidence base

Across the UK, the strategic focus has been on CBT in the first instance because it is the therapeutic modality which currently has the widest evidence base and is most cited in the literature.

A strong CBT foundation will put health boards in a good position, both to provide many of the high intensity interventions necessary and to deliver psychological interventions at the low intensity level appropriate for mild/moderate mental health problems and with maximum likely impact on the reduction of anti-depressant prescribing.

Most of the evidence-based low intensity options, including self-help, problem-solving and computerised or online packages are derived from CBT principles.

It is not expected that health boards will provide all of the therapeutic approaches recommended in the tables for any particular service user group.

The psychological therapies they choose to provide will be guided by:

- The services they already have
- The expertise available locally
- The advice of the national and the local PTMCs
- Current and future Wales national policy/strategic requirements

It is important that service users and carers (where appropriate), are engaged meaningfully in this decision-making process and that individual service user preference is given due consideration.

It is also crucial that the field of psychological therapy continues to evolve and therapeutic advances or innovative service developments should not be stifled by the rigid application of current guidelines. Trials of new therapies or of new applications of existing therapies and new paradigm research trials will generally be organised by national research networks and the local PTMCs can contribute to this process by facilitating access to service user data (adhering to formal research ethical requirements).

PTMCs can also encourage service innovation, based on the evidence as it currently stands and support the robust evaluation of new projects. However, the interests of service users must remain paramount and appropriate research protocols must be adopted wherever innovative approaches are being trailed.

Key development questions for services template

The template below is presented as a series of key questions which cover the monitoring and delivery of psychological therapy services and broader issues to improve quality, access to psychological interventions and therapy.

Effective governance

- Is there an identified health board lead (usually the Chair of the PTMC) for delivery of the Policy Implementation Guidance and the National Psychological Therapies Plan at Executive Director level and an identified project lead for the implementation of the Policy Implementation Guidance and National Plan?
- Are there project governance approaches in place to manage local implementation (e.g. project initiation plans, communications strategies)?
- Is there a mechanism whereby information on the progress towards meeting the Policy Implementation Guidance can be fed back at health board PTMC level?
- Does the PTMC take an organisational overview of achieving Matrics Cymru standards?
- Has there been an audit of staff delivering psychological therapies, their level of training and the availability of psychological therapies supervision?
- Is there a mechanism for ensuring that all staff have relevant qualifications for delivering psychological therapies and appropriate levels of supervision and membership of relevant bodies for clinical governance?

- Are there robust and fair processes for accountability to service users and carers, including a culture of openness and transparency, evidenced by a willingness to answer service user and carer questions fully, openly and transparently, proactive and constructive responses to conflict and complaints, access to second opinions and mechanisms for error investigation and decision reviews, such as re-formulation and additional assessments?

Effective data capture systems

- Have all services delivering psychological therapies been identified and are arrangements in place to collect data from these services?
- Have service users' communication needs been taken into account in data capture, to ensure people at all levels of ability have opportunity to contribute to the evidence base?
- If service users do not have the capacity to consent, have individuals involved in their care been given the opportunity to contribute to the outcome data and evidence base?
- Are there effective data capture systems in place to monitor waiting times?
- Is there dedicated IT support to configure data collection and analysis?
- Is there a plan to engage staff in developing the processes around the monitoring of the Matrics Cymru standards, implementation of the National Plan and delivery of the Policy Implementation Guidance and to offer them the necessary information, training and support to collect the data routinely?

- Is the client information system easy to use in clinical practice, based on electronic recording of data and can it feed meaningful and clinically relevant information back to staff to inform both direct client care, service audit and re-design?

Service design

- Is there a multi-disciplinary, multi-agency psychological therapies strategic planning group with the authority and remit to oversee the re-design of services/workforce?
- Will there be investment at system level to foster change and have links been made with health board's generic improvement structures (especially in relation to psychological therapies in physical health)?
- Is there a mechanism for involving service users, carers and other key stakeholders in workforce/service re-design?
- In order to ensure the sustainability of a matched/stepped care approach and maximum service impact with existing resources, is there a process for developing and refining matched/stepped care systems which have clear access thresholds and criteria for allocation to different levels of treatment, self-correcting mechanisms and can demonstrate effective delivery through clinical outcomes?
- Are there systems in place to effectively manage demand, capacity and queues (waiting lists)?

Measurement of outcomes and productivity/ resource capability

- Is there routine monitoring of outcomes using reliable and validated outcome measures¹?
- Are outcome measures being collated, analysed, reported and used to drive clinical and service improvement via the PTMC and NPTMC?

1 Work is currently being undertaken to agree these nationally

Training and supervision of staff

- Is there a mechanism for ensuring that all staff have relevant qualifications for delivering psychological therapies and appropriate levels of supervision and membership of relevant bodies for clinical governance?
- Is there a process for determining what training or CPD will be necessary to enable staff to deliver optimal psychological care and therapy at each tier of the service?
- Is there an educational infrastructure and funding to support training?
- Will the re-designed services/workforce be structured in such a way as to support and enable trained staff to deliver psychological therapies safely and effectively (especially supervision, mentoring and in house training)?
- Is there access to and protected time for regular supervision and CPD appropriate to level of service delivery?

- Do staff have protected time in which to make use of their skills?
- Are there systems in place to effectively manage demand, capacity and queues (waiting lists)?

Service availability/access

- Are there psychological interventions and therapies services in place to meet the needs of the main client populations, diagnostic groups and the needs of clients in key Government priority areas?
- Are there plans to ensure delivery across areas of greater demand (e.g. using the Welsh Index of Multiple Deprivation¹)?
- What are the gaps in service availability?
- What are the priorities for development and re-design?
- In any particular service, what percentage of the potential client population is accessing the service?
- How will increased access be demonstrated for the spectrum of service users, including 'hard to reach' groups?

1 <http://gov.wales/docs/statistics/2015/150812-wimd-2014-revised-en.pdf>

APPENDIX 1:

Service user perspective on therapeutic relationships

According to an American Psychological Association (APA) Presidential Task Force, in 2005 on Evidence Based Practice (APA 2006 p 273), evidence-based practice is defined as the 'Integration of the best available research with clinical expertise and patient characteristics, culture and preferences'.

The later APA Task Force on Evidence-Based Therapy Relationships, chaired by John C. Norcross in 2011 (Norcross and Wampold 2011) states (see link: <http://societyforpsychotherapy.org/evidence-based-therapy-relationships/>)

"Efforts to promulgate best practices or Evidence-Based Practices (EBPs) without including the relationship are seriously incomplete and potentially misleading" and "the therapy relationship acts in concert with treatment methods, patient characteristics and practitioner qualities in determining effectiveness; a comprehensive understanding of effective (and ineffective) psychotherapy will consider all of these determinants and their optimal combinations".

Although APAs work looks at client culture and treatment preferences as aspects of 'match' between therapist and client, it does not look at client culture and preferences in the respect of what they value and prefer in a therapy relationship. However, service users do have strong preferences for the sort of service they want to receive. Norcross et al (2011) do conclude that "the patient, the therapist and the research all need to be in alignment or 'on the same page'".

This would imply that what matters to the client or recipient, with regard to quality of psychotherapy, forms a part of evidence-based practice.

Extensive research has not yet been done into what service users or clients feel are the important characteristics of successful, or unsuccessful therapy relationships. However, material from focus groups, discussions at consultation events/conferences and review of on-line discussions reveal key issues that are very much reflected in on-going research about the factors within the therapeutic relationship that have the greatest predictive value on outcomes.

They also show where future work might build on assessment of the most effective and most risky relationship characteristics, through the co-production of evaluative research which better reflects the things that service users have raised as important. It is already clear from research that service user or client evaluations of the therapeutic relationship, were more reliable in predicting therapy success than the therapist's evaluation or that of an independent researcher observing the process (Horvath et al 2011).

Service users specifically seek a respect for their autonomy and hence the option to make an informed choice of which treatments they take, which they refuse, who they work with and for how long. Seligman (1995) states that those whose length of therapy or choice of therapist was limited by costs, or 'managed care', did worse.

To support informed choice, service users seek information about risks and possible outcomes of therapy, as well as how treatment will feel. Feeling safe is also frequently cited as most important, safe and competent staff, transparent and accountable decision-making and effective monitoring, quality assurance, safety protocols, complaints processes and management when things go wrong.

As part of transparency, service users seek to be fully informed about diagnosis and treatment. They want acceptable, individually adapted treatments which take account of their needs and preferences.

For service users, the importance of relationship in therapy is a no brainer. Therefore, there were few surprises in the research, which confirms the significant effect of relationship on outcomes and dropout rates.

Others hedge their bets by saying that relationship is at least as important as technique, but Lambert's figures (Lambert and Barley 2001) would suggest that in fact it is twice as important in predicting success as technique.

Non-relationship client factors (including presence of support between sessions) 40%

Relationship 30%

Techniques 15%

Expectancy 15%

Norcross (2011), on the basis of a number of meta-analyses, attributes the following effect sizes to major factors which predict success of therapy. The larger the numbers, the bigger the positive impact the factor has on outcomes.

/*Counter-transference management: 0.56 (Hayes et al 2011)

Rupture repair after training: 0.39 (Safran et al 2011)

Goal consensus: 0.34 (Tryon and Winograd 2011)

Collaboration: 0.33 (Tryon and Winograd 2011)

Empathy: 0.30 (Elliott et al 2011)

Alliance: 0.27 (Horvath et al 2011)

Positive regard: 0.27 (greater with people from ethnic minorities) (Farber and Doolin 2011)

Collecting client feedback: 0.23-0.33 (Lambert and Shimokawa 2011) (Shimokawa, Lambert and Smart 2010)

Congruence (perceived honesty of therapist): 0.24 (Kolden, Klein et al 2011)

Rupture repair before training: 0.24 (Safran et al 2011)

Counter-transference unmanaged: -0.16 (Hayes, Gelso and Hummel 2011)

Adapting therapy to individual client characteristics (Norcross and Wampold 2011)

Match therapist directiveness to client reactance: 0.35 (Beutler, Harwood and Michelson 2011)

Match to client stage of change: 0.33 (Norcross, Krebs and Prochaska 2011)

Match to client coping style: 0.26 (Beutler, Harwood and Kimpala 2011)

Match to client culture: 0.22 (Smith, Domenech and Bernal 2011)

Match to client preferences: 0.15 (Swift, Callahan and Vollmer 2011)

Religion and spirituality: no difference in mental health outcomes, but 0.16 for spiritual outcomes (Worthington, Hook and Davis 2011)

An older piece of work (Norcross 2002) also looked at other factors including transference. Transference is often seen as the central technical intervention in therapy. However, the results were not as strong as some might hope. In fact, for service users who struggled with relationships, higher rates of transference interpretations led to poorer outcomes. For other people, a focus only on making transference interpretations for central aspects of interpersonal dynamics led to better outcomes. However, the effect size is not given and in the later publications, this factor is not included due to lack of sufficient research.

For service users, the use of transference interpretations in therapy is controversial. On the one hand, interpretations can feel aggressive and hurtful to the point of abusive in some cases and on the other, it can feel as if the therapist is hiding behind 'transference' to justify, or avoid facing, the negative effects they have on others. The further problem of this approach is that it is sometimes manipulated by the therapist rather than transparent and overt and can therefore undermine trust in and respect for the therapist, when the client finds out (which they often do).

For these reasons, further research into the effect of using transference interpretations, which take on board the feelings of service users would be helpful, as it is important to understand the risks of this approach and whether its application can be more transparent, collaborative and positive.

The parameters described above by Norcross et al (2011), however, are all complex constructs, made up of clusters of more simple relationship characteristics, with arguably some overlap. Support, for instance, was integral to several of the factors explored, including positive regard and affirmation; alliance and collaboration.

Many of the parameters explored owed more to the history of various forms of therapy, such as Carl Rogers' view of unconditional positive regard, than to client identified helpful characteristics of therapists.

Monitoring the therapy relationship through client feedback

The use of client feedback on the quality of therapy is discussed by Lambert and Shimokawa (2010), whose meta-analysis identified an effect sizes between 0.23 and 0.33. In addition, rates of clients worsening in therapy were cut in half.

They refer to the clinicians' 'limited ability to accurately detect client worsening in therapy', which together with the conclusion that service user assessments of the quality of the therapeutic relationship are more predictive of success than the therapist's or an external observer's, expose an evidence base for monitoring patient experience of therapy. Add to this the large positive effect of rupture repair on outcomes, which may be identified earlier using client feedback and the value of this approach becomes significant.

However, Lambert and Shimokawa, also caution the use of feedback where there are incentives for clients to understate or overstate their problems. This will be the case where therapy is delivered in an environment where there is no choice of therapy model or therapist; where people are often dropped from therapy if they are considered to not be responding and sent away with the message that they are either not suitable or not ready for therapy; where other services have been provided, only if therapy is maintained or for patients on a Community Treatment Order, where re-admission is a consequence of not engaging in therapy.

To feel safe to be open about the quality of the relationship and the rate of progress or worsening, the following conditions are needed.

1. At all following stages, the client's communication preferences will be taken into account. If the client is unable to consent in a direct psychological talking therapy, but are in receipt of a psychological intervention (directly or indirectly) then it is essential to take into account verbal and non-verbal communications regarding their wishes and fears in relation to the therapeutic relationship
2. There is a choice of different therapy models and information and advice to guide that choice
3. At assessment, clients are informed that a good relationship with the therapist is necessary for effective therapy and that if the therapy relationship is not working, letting the therapist or other staff know of the problems will not result in exclusion from therapy treatment, but to a process to either repair the relationship or assign a new therapist, with the full consent and involvement of the client
4. At assessment, clients are informed of the importance of letting the therapist and other staff know if the therapy is not helping, so that there can be problem solving to improve therapy, or to step up treatment, or move to a different model. Again, service users must be reassured that the service will not be withdrawn, but the offer will be changed
5. Service users' need to be reassured that they will not be blamed if the relationship is not working, or if they are not improving. For this to be credible, such blame has to stop, so that no client is ever refused or excluded from therapy just because a particular therapy with a particular practitioner has not worked. The Scottish Matrix points out that 40% of clients do better with a different therapy. Additional supportive services, especially for those who do not have support in the community, must never be dependent on therapy

being continued. In fact, the research shows that support between sessions has a significant positive effect on outcomes (Lambert and Barley 2001)

6. Any pressure to undertake therapy is likely to have a negative effect on honest appraisal of relationship/progress and also a negative effect on outcomes

You may like to visit www.psychcentral.com '10 reasons why therapy may not be working' and follow the service user responses, to get some insight into why service users' feel therapy fails. This is an American site and the context in which evidence is presented will sometimes relate to American organisations and health care systems. Much of the content relates to common factors in therapy; however, variations in systems and registration from state to state enables an insight into how systems and registration affect practice and therapy success, therefore the site is still relevant to psychotherapy wherever it is practiced.

The necessity of a good relationship underpins four critical aspects of therapy:

1. Client's perception of safety in the relationship
2. Ability of client to disclose sensitive information to the therapist
3. A positive therapeutic relationship as a context and foundation for change
4. Continuation or dropout rate

Clearly the first of these has a significant impact on the other three and is the most commonly cited characteristic of therapists wanted by clients.

These aspects of therapy require a number of attitudes, skills and characteristics of the therapist, as well as a sufficiency of information given to the service user to ensure best use of the therapeutic opportunity.

If the relationship is not right, therapy is, at best, unlikely to produce positive results and at worst can cause significant harm. Service users are unwilling to engage within an unhealthy relationship and bad experiences also reduce willingness to engage with other health staff, other therapists or other models.

I will unwrap the relationship issues in each of these aspects of therapy.

1) Client perception of safety in the relationship

Safety is affected by the client's confidence in the therapist's behaviour/abilities and their ability to trust the therapist to be able to handle anything they say, any way they feel, any thoughts they have and experiences they relate in a constructive and helpful way.

Below are some of the things that affect confidence and trust in the therapist, in terms of positive and negative therapist behaviours:

Positive therapist factors

- Therapist insight into therapist's own internal unresolved conflicts (counter-transference) and ability to manage them to prevent acting them out in therapy, to ensure they don't have a negative effect on therapy
- Humility
- Flexibility

- Manage power difference sensitively

Positive regard and affirmation

- Genuine enjoyment of client's company
- Trusts client

Therapist's response style to client disclosure and feelings

- Non-judgemental attitude
- Accept client and respect client despite faults
- Believe client
- Make an effort to understand client
- Concern for client's welfare
- Warmth
- Support and encouragement
- Optimism
- Positive attributional style to explain client's behaviour

Rupture repair

- Ability to recognise and repair ruptures in the relationship
- Therapist able to acknowledge own contributions to any ruptures
- Respond to ruptures in a non-defensive manner
- Not blame client for ruptures

- Recognise when a relationship cannot be healed and refer client to another therapist and/or therapy
- Respond positively to client concerns

Therapist behaviours which undermine client's ability to feel safe

- Coercive approach
- Controlling
- Make threats to continuation of therapy, in order to enforce client compliance and/or protect self and/or colleagues from inconvenience or challenge
- Apply derogatory terms to clients
- Impose own views or own agenda
- Believe they are mind readers
- Emphasise power difference, to disempower and/or oppress client
- Devalue or disrespect service user
- Create negative comparisons between self and service user e.g. see self as the rescuer, or hero of a client the therapist sees as 'deficient, weak or defective'
- Arrogant at service user's expense
- Refusing to accept or believe client's account of their own experiences, life history, sense of self i.e. "you're imagining that"
- Inflexible, failure to adapt therapy to client needs and preferences
- Dishonesty

- Dislike of, or lack of respect for client
- Negative attributions for client behaviours, feelings and thoughts
- Refusal to change opinions about client problems in the face of client objections (failed therapeutic alliance)/foresight bias
- Refusal to negotiate tasks (failed therapeutic alliance)
- Blocking client access to other health services or other health professionals
- Refusing client requests to be seen by a different therapist or to have a different kind of therapy
- Blocking access to a second opinion, external review of therapy, or psychological assessment for detailed formulation, where expected progress is not being made
- Breaking the law e.g. threatening the withdrawal of service if a client complains
- Inappropriate boundary breaches
- Assuming own reaction to the client is the responsibility of the client, when client's reaction to the therapist is 'transference' and therefore not the responsibility of the therapist
- Automatically blaming the client for relationship ruptures and refusing to accept any personal responsibility
- Goading client to 'create negative transference' or to reveal symptoms

- Assume client will 'benefit' from knowing how the therapist feels with the client, assuming that their feelings reflect how people in general feel in response to the client
- Assuming that how they feel when working with the client (counter-transference) reflects how the client feels in any way at that time, whilst not checking how the client actually feels, by asking them
- Refusing to believe clients view of self

Factors that influence client's ability to trust clinician

- Confidentiality of material discussed
- Honesty and sensitivity of therapist

Therapeutic relationship effects on trust

- Ensure the development of a mutual agreement on the aims and purpose of therapy/on a formulation – before doing anything else
- Ensure full and genuine agreement on tasks before starting work
- Offer any suggestions kindly, sensitively and without negativity
- Answer client questions fully, openly, transparently and honestly

Non-relationship factors affecting trust

- Accuracy, reliability and completeness of records
- Credibility/accountability of clinician
 - » Training quality
 - » Ability

- » Registration
- » Reputation with other service users
- » Success rate
- » Dropout rate
 - » Information for client about ethical and conduct codes required of therapist, what behaviour to expect from them and how to raise concerns, through NHS and through regulator
 - » Service user does not have faith in the method, feels it is the wrong approach for them, or feels coerced to take part in the process

Safety and trust are also influenced by the client's confidence in the **system's ability:**

- To provide choice and respect client preferences
- To pick up and resolve problems occurring in therapy
- To deal sensitively with complaints
- To identify where therapy is not working and make other therapy arrangements
- Have specific clear processes for clients to raise concerns about the therapy relationship or the suitability of the model
- Have a policy which supports additional assessment or psychological review and formulation where client is not progressing as expected

- Have a clear policy to step up therapy if it is not working, to try a different therapy if current method is not working and to change the therapist if the relationship is not working
- Have a policy which supports access to a second opinion when requested by the client in order to bring new insights to therapy, to provide peer scrutiny and challenge to the therapist, to answer client's questions if the therapist and service can't, or to resolve a difference of opinion between therapist and client about the formulation or tasks required

The research shows that factors associated with the client and their support makes the largest contribution to therapy success.

Lambert and Barley (2001), talk about extra-therapeutic factors. A closer read of their paper shows that the 40% figure given in their pie chart for these factors actually relates to the percentage of clients who get better without therapy. They refer to various client traits that may increase or decrease the likelihood of good outcomes in therapy. This may indicate a tendency for therapists to explain failure by reference to client factors, rather than attributing therapy success to client factors.

The fact is that the therapist aids a client to achieve good outcomes, but it is the client that makes the changes and therefore client factors must be critical to success. Research into this area, to increase the client's ability to heal, is likely to yield the most impact on therapy outcomes.

The limited information that is available and common sense would suggest that the following actions and interventions could help clients to feel safe in therapy.

Therefore, to feel safe, the client needs to:

- Have support from people between therapy sessions from family,

friends, support groups, help-lines or other professionals

- Be careful to keep disclosure in sessions to a level at which the associated emotions are manageable
- Develop skills to increase ability to cope with difficult emotions
- Put together a crisis plan in case needed
- Put together a store of activities, objects, books, DVDs etc., that provide comfort, distraction, encouragement, self-affirmation, additional coping skills, self-management and self-acceptance and/or acceptance of their personal situation
- Identify resources to improve resilience e.g. stress management course, expert patient programme, on-line support
- Learn as much as possible about component parts of formulation (diagnosis) and about other people's coping strategies, where they share the same kind of problems
- Learn about the model of therapy, any risks and how those risks can be managed
- Let therapist and/or service know of any concerns about relationship, including relationship ruptures
- Be willing to give the therapist an opportunity to work to repair any rupture
- Be open about any concerns regarding progress or worsening
- Be assertive about preferences

2) Ability to disclose sensitive information

The client needs to feel

As above,

- Safe with the therapist
- That they will cope with distress that emerges in therapy
- That any distress will be contained and held by the therapist
- That they will be supported with their distress
- That there is support between sessions

Also that:

- The therapist is well attuned to them
- The therapist 'gets it'
- The therapist cares about their welfare
- The therapist is non-judgemental
- The therapist is a culturally appropriate person to talk to and more likely to understand e.g. same culture, same ethnicity, same language, same gender, same orientation, same level of education, same generation, etc. e.g. a woman might find it hard to disclose any sexual abuse to a man
- The therapist is competent

3) A positive therapeutic relationship as a context and foundation for change

Research into the social development of the infant and neurobiology demonstrates the relationship parameters which are necessary to create plasticity of the brain and therefore enable change.

4) Relationship as a context and prerequisite for healing

- High level of attunement to client:
 - » Accurate mirroring
 - » Acceptance
 - » Understanding
 - » Closeness
 - » Indistinct boundaries (depending on development level of client)
- Contain client distress safely
- Support clients whilst they are distressed
- Be reliably compassionate and kind
- Be reassuring
- Be a guardian of hope for client
- Help client develop a language for emotions
- Celebrate progress
- Positive affirmations
- Supporting individual differentiation of client and development of self-agency

5) Continuation or dropout

It is self-evident that you are more likely to continue in therapy if you feel, for instance, that the therapist likes and cares about you, if you feel they 'get it' and you feel that the method being used is acceptable and tailored to your needs.

Drop out is more likely if you have, for instance; felt coerced or pressurised to attend therapy; if you have no support between sessions; if you don't feel involved in decisions about goals or tasks; if your preferences have been ignored; if you have felt over-powered by the therapist; the therapist has hurt or harmed you; if you don't feel safe; if you are not confident about the therapist's competence; if you don't feel heard or understood; if your questions are not answered; if you don't feel you are making progress or if you are feeling worse; you feel judged or there is some problem with the personal characteristics of the therapist which makes disclosure too difficult e.g. a woman may not be able to open up to a male therapist about sexual abuse.

More work needs to be done to: identify reasons for premature dropout from therapy; explore the risks of harm to service users and how to manage or prevent those risks. Some research places emphasis on the external assessment of the relationship rather than asking clients directly why they left. Too much of the research is therapist led rather than reflecting the research questions and evaluations of the client.

Within the scope of the Matrics Cymru and the Psychological Therapies in Wales Policy Implementation Guidance, we have the opportunity to generate evidence through practice to inform the next Matrics Cymru up-date. Co-producing evaluation and therapy monitoring tools with clients has great potential for identifying further relationship factors which improve or imperil therapy outcomes.

It has been shown (Flückiger, Holtforth et al 2013) that the quality of the relationship and progress as appraised by the client, in early sessions, are highly predictive of the final outcome. Therefore, it would seem wise to have a discussion between the service user and a therapist other than the one they are seeing, to discuss the quality of the relationship and early progress after 2 to 4 sessions and where the relationship is not working, or progress is not being made, to change to a different therapist at this early stage.

Conclusion

Relationship is crucial to therapy. Upon it hinges whether a client chooses to stay in or leave therapy, whether they are able to disclose sensitive issues to the therapist and whether they are able to be open both about their relationship with the therapist and whether they are making progress or getting worse.

Relationship is implicit in most models of therapy and the evidence from research to date does show significant difference in outcome as a result of key relationship factors. Some maintain that the power of the relationship is even more important than the technique.

For service users, therapist match is essential. The two most critical factors they raise are 1) a therapist who 'gets it' and 2) feeling safe.

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to the individual patient: Religion and spirituality.’ J Clin Psych: 67(2),
204-214, Feb 2011

APPENDIX 2:

Waiting time for psychological therapy

The Welsh Government has issued clear waiting time targets for the delivery of psychological therapies in services, which are delivered in Part 1 and Part 2 of the Mental Health (Wales) Measure 2010. Waiting times are periodically revised, but are usually compatible with waiting time targets for the delivery of interventions for physical health conditions. Waiting time for psychological therapy should be measured using the designated Welsh Government protocol.

Appendix 2 provides guidance on which interventions would be considered to be psychological therapies for the purpose of workforce planning and services delivery. This guidance does not supplant or supersede the definitions that will be provided by the Welsh Government for the purposes of data collection.

For the purposes of this document, psychological therapies are defined in the following way:

Psychological therapies are treatments and interventions that are derived from specific psychological theories and formulated into a model or treatment protocol. Psychological therapies are delivered in a structured way over a number of sessions by a suitably qualified practitioner, with informed consent from the service user or, where a service user lacks capacity to consent to therapy it may be contracted on their behalf after an assessment of what is in their best interests.

Psychological therapies help people understand and make changes to their thinking, behaviour, feelings or relationships in order to relieve distress and to improve their functioning, wellbeing and quality of life and are mediated by the therapeutic relationship. The quality of the relationship between therapist and service user is an essential component in the delivery of effective psychological interventions. Please see appendix 1. Psychological therapies are sometimes referred to as 'talking therapies'.

All staff contacts, where the primary purpose is to deliver a psychological therapy which fulfils this definition, should be counted. If the answer to the following questions is 'yes' then the intervention should meet the definition and be included in the waiting time target.

1. Can you identify a psychological model that underpins the intervention, e.g. Cognitive Behavioural Therapy (CBT)?
2. Is there a psychological formulation of the problems that the service user wishes to address which has led to the recommendation for the intervention?
3. Is the therapy provided over a series of structured sessions set out in a therapy contract?
4. Is the intervention delivered by a practitioner trained to provide therapy in the model agreed with the service user?

It is not always easy to decide whether a particular intervention provided by a member of staff with several roles fulfils the criteria to be counted as a psychological therapy. Examples are given below:

These examples would qualify as psychological therapies.

- 1: Staff delivering CBT-based guided self-help to protocol, or standardised small-scale anxiety management groups.**

For example:

The work of a practitioner employed in the Local Primary Mental Health Support Service (LPMHSS) who is facilitating an emotional regulation group for service users who have been offered and accepted this therapeutic intervention following assessment by LPMHSS would be counted, but if the same practitioner were delivering a large-scale psycho-educational group such as Stress Control or Activate your Life to a drop-in audience this would not be included.

A Community Psychiatric Nurse (CPN) using CBT informed practice (or a particular CBT technique outside of a standardised treatment package); while on a routine home visit to a patient would not count this under the target. Whereas, the same CPN delivering a specific CBT-based intervention (e.g. guided self-help) to a recognised protocol in the course of a series of home visits, would count this under the target.

2: All contacts where staff are delivering high intensity therapy, high intensity specialist or highly specialist therapy for mental health problems including people diagnosed with dementia who have a learning difficulty, or to people suffering from mental health problems where this is co-morbid with physical health problems and substance misuse.

For example:

Where a diabetic patient is receiving a cognitive behavioural intervention focused on improving control of diabetic symptoms, this would not be counted. However, if the same patient were receiving a psychological therapy for depression, which may be related to the physical condition, this would be counted under the target.

A psychological therapist working with carers or support staff to establish and oversee the delivery of an evidence-based intervention for anxiety to a person with a learning disability would count, even though the therapist might not be working 'face-to-face' with the service user.

An Occupational Therapist carrying out an assessment of a service user's capacity to dress themselves would not count this as a psychological therapy however, if the same Occupational Therapist were delivering any part of a DBT intervention, this intervention would be counted.

The work of a Psychological Therapist working with carers or support staff co-producing a plan to deliver an evidence-based psychological therapy for a person demonstrating behaviour that challenges in the context of dementia would be counted, even though the Therapist might not be working 'face to face' with the service user themselves.

A Nurse facilitating a post diagnostic group for people recently diagnosed with dementia would count this as a psychological therapy if the group was delivered using a specified psychological therapy model, but the same nurse co-coordinating a carer support group with psycho-educational content would not fulfil the criteria.

What should not be counted?

Open access, large scale psycho-educational groups should not be counted, although some measure of volume of care should be in place.

Computerised CBT accessed via an open access site at home or a local library.

All staff should be delivering psychologically-informed care, which may involve formulating a service user's difficulties in psychological terms. Although this is an essential element of holistic care, the formulation process itself should not be counted.

Where assessments are purely investigative or diagnostic, or for the purpose of general care planning and do not involve or lead on to the delivery of psychological therapy (as defined), they should not be counted.