

16 Gumley AI, Schwannauer M. Staying well after psychosis: a cognitive interpersonal approach to recovery and relapse prevention. Chichester: Wiley; 2006.

17 Pasquini P, Liotti G, Mazzotti E, Fassone G, Picardi A and The Italian Group for the Study of Dissociation. Risk factors in the early family life of patients suffering from dissociative disorders. *Acta Psychiatrica Scandinavica*. 2002;105:110-16.

18 Morgan C, Kirkbride J, Leff J et al. Parental separation, loss and psychosis in different ethnic groups: a case-control study. *Psychological Medicine*. 2007;37:495-503.

19 Read J, van Os J, Morrison AP, Ross CA, Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica*. 2005;112(5):330-50.

20 Liotti G, Gumley AI. An attachment perspective on schizophrenia: disorganized attachment, dissociative processes, and compromised mentalisation. In: Moskowitz A, Dorahy M, Schaefer I (eds). *Dissociation and psychosis: converging perspectives on a complex relationship*. Wiley; 2008.

21 Read J, Gumley A. Can attachment theory help explain the relationship between childhood adversity and psychosis? *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis*. 2008;2:1-35.

22 Tait L, Birchwood M, Trower P. Predicting engagement with services for psychosis: insight, symptoms and recovery style. *British Journal of Psychiatry*. 2003;182:123-8.

23 Tait L, Birchwood M, Trower P. Adapting to the challenge of psychosis: personal resilience and the use of sealing-over (avoidant) coping strategies. *British Journal of Psychiatry*. 2004;185(5):410-15.

24 Dozier M Attachment organisation and the treatment use for adults with serious psychopathological disorders. *Development and Psychopathology*. 1990;2(1):47-60.

25 Dozier M, Lomax L Clinicians as caregivers: role of attachment organization in treatment. *Journal of Consulting and Clinical Psychology*. 1994;62:793-800.

26 Dozier M, Lee SW. Discrepancies between self and other report of psychiatric symptomatology: effects of dismissing attachment strategies. *Development and Psychopathology*. 1995;7(1):217-26.

Topics in training

Thinking of applying for the IAPT high or low-intensity training? **Sara Perren** has some advice



The aim of the Improving Access to Psychological Therapies programme (IAPT) is to ensure that anyone suffering from depression or

anxiety can access a National Institute for Health and Clinical Excellence (NICE) recommended evidence-based talking therapy wherever in England they live. When London School of Economics Professor, Richard Layard, first noted that the Government was failing in its obligation to provide NICE compliant treatments in mental health¹, he stressed the strong evidence base for cognitive behaviour therapy (CBT) for the treatment of both anxiety and depression. He pointed out the shortage of qualified CBT therapists, recommending that the Government urgently remedy a situation in which it was doing little to meet its own targets in mental health.

In November 2007 the Government announced funding rising to £173 million over three years to ensure that IAPT services were available to 50 per cent of the population by 2011. Thirty-two primary care trusts (PCTs) were commissioned to provide IAPT services in 2008/09; a list of these IAPT sites and corresponding training providers can be found on the NHS IAPT website².

A large portion of the money pledged is being used to train therapists in CBT. CBT is emphasised because this is the only therapy recommended by NICE for anxiety disorders³. The evidence base for CBT is strong for depression too, so while counselling, couples therapy, interpersonal therapy (IPT) and behavioural activation are also recommended by NICE for the treatment of mild-to-moderate depression⁴, the IAPT monies are not being used to train people in these therapies because there are already sufficient people trained to deliver them.

The IAPT model is based on a stepped-care approach first outlined in the NICE guideline on depression^{4,5}. IAPT services offer low-intensity interventions at step 2 (mild depression/anxiety) and high-intensity interventions at step 3 (moderate-severe depression/anxiety). Low-intensity therapists often work by telephone and email, offering guided self-help, computerised CBT and bibliotherapy. High-intensity therapists offer time-limited psychotherapy, usually CBT.

IAPT services are recruiting people to full-time training posts in either low- or high-intensity CBT. Recruitment for both training posts and qualified positions is via the NHS jobs website⁶. (Go to the site and type 'IAPT' in the keywords search box.) All of the high-intensity and many of the low-intensity trainings are university based. The syllabuses can be found on the website⁷. Training is one day a week for a year for low-intensity, and two days a week for high-intensity posts. High-intensity trainees are paid on Agenda for Change band 6 while training and band 7 once qualified, while low-intensity trainees are paid on band 4 during training, moving to band 5.

Counsellors are identified in the IAPT commissioning toolkit as a group of people well suited to undertake the IAPT training at both low- and high-intensity levels⁸. Some counsellors feel they are already offering high-intensity interventions, and would regard becoming a low-intensity therapist as a backwards step. However, low-intensity training could be appropriate for a newly qualified person looking for a clearly defined career path into the profession, or be ideal for a therapist who enjoys brief cognitively focused interactions with people. If you do not have a degree and are unable to assemble the knowledge, skills and aptitude portfolio required to make you eligible to apply for high-intensity training, doing a low-intensity training could be one route

IAPT offers an opportunity to undertake a funded training, leading to a career with a structure that permits the achievement of responsibility and seniority

into eventually training as a high-intensity therapist. Recruiting panels seem to vary in their attitude to counsellors. Some accept the IAPT commissioning toolkit's⁸ stipulation that a BACP accredited counsellor fulfils the criteria for high-intensity training; others regard counselling as fundamentally a low-intensity intervention that should be reserved to treat people at the mild end of the depression spectrum, and therefore would look to recruit counsellors to low-intensity training posts. Currently it would seem that there are more counsellors doing low-intensity than high-intensity trainings.

So what would attract counsellors to do high-intensity training? Some counsellors in the NHS feel that there is little in the way of career progression. The opportunities for taking on management, supervisory or training roles may be limited. IAPT offers an opportunity to undertake a funded training, leading to a career with a structure that permits the achievement of responsibility and seniority. Also, counsellors' pay is low compared with some other mental health professions offering the equivalent of high-intensity interventions. A glance at the NHS IAPT jobs page reveals that counsellors recruited into IAPT services are attracting Agenda for Change band 5 and 6 salaries, while newly qualified high-intensity therapists start at band 7. Counsellors who do not undertake high-intensity training may find themselves working alongside high-intensity workers whose starting salary is better than that of an experienced lead counsellor.

All this sounds fairly compelling, so

why would counsellors not undertake these trainings? To start with, all current training opportunities are in CBT. You may not want to become a CBT therapist. It may not be a model that suits your skills and personality. You may not believe that the evidence base for CBT is persuasive; you may be convinced that your therapy model is more effective and empowering and just want to be able to practise it in peace. You may want to put your energy into researching the evidence base for your core model, or into campaigning for counselling to be recognised as an equivalent high-intensity intervention within IAPT, attracting the same salary and opportunities. You may want to wait for the other evidence-based interventions to be commissioned and apply for those posts as they occur. You may not be in a position to apply for a full-time training post.

While there seems to be no difficulty in counsellors being recruited to low-intensity training posts, it is more difficult to ascertain the extent to which counsellors are getting high-intensity training posts. This seems to be a mixed story – different experiences in different regions. Some counsellors report being turned down for high-intensity training for which they feel themselves well qualified. Some employers and training providers report feeling somewhat suspicious of counsellors, who they feel are wedded to a different model, do not want to be CBT therapists and are only applying because they fear their jobs are at risk. However, some counsellors have been recruited to these training posts and recently began their training alongside other professionals in the field.

It is difficult at present to get figures on who is being trained – those on high-intensity trainings seem to range from newly qualified clinical psychologists to occupational therapists, nurses, counsellors, social workers and graduate mental health workers. In different sites the ratio of the different professionals differs, depending presumably on the recruitment pool. In all cases, if you do not have a degree you have to assemble an aptitude, skills and attainment portfolio to prove your ability to do the training. Low-intensity trainees do not have to be graduates,

though some areas are only recruiting graduates in the first wave.

In some areas employers are putting funded alternative CBT training in place – either to enable people to gain the initial CBT training they need to apply for high-intensity IAPT training, or to enable counsellors who cannot apply for a full training the opportunity to train in CBT as part of their involvement in an IAPT service. We do not know what IAPT services will look like in a few years' time. For the moment the emphasis is on training CBT therapists. The training posts offer suitably qualified counsellors who are interested in a shift in career direction the opportunity to do a fully funded further training. It won't be for everyone, but for some counsellors it is an option worth considering. ■

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References

- 1 London School of Economics Centre for Economic Performance's Mental Health Policy Group. The depression report: a new deal for depression and anxiety disorders. London: London School of Economics; 2005. Available via: www.ufpmentalhealth.com/downloadfiles/layard_depression_report.pdf Accessed: 12/8/08.
- 2 www.iapt.nhs.uk/about/new-improving-access-to-psychological-therapy-sites-2008
- 3 National Institute for Health and Clinical Excellence. Clinical guideline 22: Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. London: NICE; 2004.
- 4 National Institute for Health and Clinical Excellence. Clinical guideline 23: Depression: management of depression in primary and secondary care. London: NICE; 2004.
- 5 www.iapt.nhs.uk/services
- 6 www.jobs.nhs.uk
- 7 www.iapt.nhs.uk/2008/02/curricula-for-high-intensity-therapist-and-low-intensity-therapy-workers/
- 8 www.iapt.nhs.uk/2008/04/improving-access-to-psychological-therapies-iapt-commissioning-toolkit/