



# In the spirit of IAPT: the development of mental health services in Lancashire

Lancashire Care NHS Foundation Trust has been making psychological care everybody's business over the past three years. It's been good news for counsellors associated with the service, according to **Zubeida Ali** and colleagues

Established in 2002, Lancashire Care NHS Foundation Trust (LCFT), in the North West of England, is a leading provider of mental health services. It was awarded Foundation Trust status in December 2007, and has since continued to use the financial freedom to invest in higher quality services to just over 1.3 million people in Lancashire. In becoming a foundation trust, LCFT has a public membership of over 8000 and members have opportunities to be involved in improving and planning services for the local population in a more meaningful way. For ease of management, the area covered by LCFT is divided into three geographical localities – North, Central and East Lancashire, cross-cut by functional networks providing services dedicated to working age adults, older adults, forensic care, substance misuse and early intervention in psychosis, and child and adolescent mental health.

## Trust-wide developments

A number of recent ambitious developments in the adult services network and other developments within individual localities have influenced LCFT's delivery of services. In 2001, a formal consultation for the establishment of a new mental health trust in Lancashire suggested that the proposed care trust<sup>1,2</sup> would be a new type of mental health organisation

that would, 'Create a culture in which social, psychological and medical models of mental health and illness are equally valued'.

Overall, the aim was to meet the needs and aspirations of service users to have a wider choice of treatments in a timely way, especially with regard to appropriate psychological therapy across the adult services network. From this, the agenda *Making Psychological Care Everybody's Business* (MPCEB)<sup>3</sup> was born. MPCEB began as an exercise in restructuring in June 2007, with a three-month consultation and subsequent HR processes taking about a year. (The ongoing development of non-psychological services staff will take at least two to three years.) Achieving the MPCEB agenda has implications for the development of psychological skills and competencies across the workforce. The eventual aim is that staff from all professional backgrounds with psychological skills will have the opportunity to use and develop these competencies with appropriate supervision. For this, services and teams are required to provide effective psychological care in addition to waiting time and waiting list management.

To be effective, clinical and operational governance arrangements for the provision of psychological therapies needed to be developed. However, all this posed a number of

challenges, and several proposals were considered to manage them. Broadly, these proposals centred on a model of service delivery for psychological care and psychological therapies, ensuring that the range of therapies provided were evidence-based and compliant with National Institute for Health and Clinical Excellence (NICE) guidance, while maintaining a wide range of mainstream psychological therapies not yet assessed by NICE. Organisational and managerial arrangements also needed to be aligned to support the delivery of agreed services, and to manage the significant implications for the workforce.

The aspirations of the MPCEB agenda have been that service users will benefit from more timely access to psychological assessments, formulations and interventions via a stepped-care model. Moreover, the levels of knowledge, skill and expertise among staff will be supported and enhanced, and all staff will have opportunities to provide psychological care and/or psychological therapy at a level of complexity consistent with their knowledge, skills and competence.

Paramount to the success of these developments has been the appointment of psychological leads, and their involvement in planning and informing decision-making processes

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and good working relationships with colleagues responsible for local management and service planning. Structurally this has resulted in the creation of an Adult Network Psychological Services Lead, three Locality Professional Leads for Psychological Services (in North, Central and East Lancashire) covering both community and inpatient services, and an Adult Network Professional Lead for Counselling, posts which were filled from the existing workforce.

The first successes of these initiatives have been the recognition and valuing of skills within existing services, and the ability of LCFT to work collaboratively with commissioners. LCFT has seized the opportunity to develop innovative ways of working in order to offer a choice of NICE-approved psychological therapies as well as maintaining psychological therapies not yet assessed by NICE (see 'Locality-specific developments', below). All this has also made it logical for commissioners to seek LCFT's support in addressing new mental health targets for psychological therapies when commissioning services, and to work closely with LCFT as an ally and collaborator.

### Locality-specific developments

When East Lancashire became a wave 2 Improving Access to Psychological Therapies (IAPT) programme

development site<sup>4</sup> in 2008, thinking around innovative ways of working within primary care had already borne fruit. This had come with the award of a tender in August 2007 to provide new primary mental healthcare services from Blackburn with Darwen PCT to a consortium consisting of LCFT, the provider arm of the PCT and Blackburn with Darwen Borough Council. The winning bid was based upon a 'therapies plus' model developed by two of the authors (David Hodgetts and John Keaveny) in their previous East Lancashire-specific employment. The strong underlying rationale was that therapy is not the only (and often not the most effective or desirable) response to a person's mental health difficulties.

Since its take-up, the IAPT programme has been developed alongside existing services in LCFT to their mutual benefit, and ensured that counsellors and other practitioners already in post continued to offer a variety of models of practice. This step was underpinned by the recognition that cognitive behaviour therapy (CBT) would not be appropriate for all patients, since this one style does not meet the needs of all. The trust has also recognised that while IAPT operates at the level of primary mental health care, it does not represent the totality of potential provision at this level. LCFT already employed a wealth of skilled practitioners who, while not

fitting the IAPT staff criteria for high-intensity therapists or psychological wellbeing practitioners (formerly low-intensity therapists), nonetheless had much to contribute to the provision of primary care/community-facing mental healthcare provision. These included nurses, occupational therapists, clinical psychologists and, of course, counsellors.

The past year (2008/09) has been a time of rapid expansion and rising demand for mental healthcare services, which has required consolidating our achievements and working towards meeting the needs of the local community. Results from the IAPT demonstration sites<sup>5</sup> highlighted the need for services to engage more closely with the communities they serve. In East Lancashire, managers and clinicians within the trust have worked hard to improve the experience and pathways into services for a range of people who have traditionally found services hard to reach. Central to this has been that managers and leaders not only generate ideas, but also incubate and facilitate innovation by professionals. Counsellors have a long and valued relationship with GPs, having traditionally been based in primary care. This has enabled LCFT to build on their good work, and this in turn has helped LCFT to further the development of good working relationships with these stakeholders. With regard to meeting the needs of

the community, initiatives focused on self-referral and services linking in with broader community provision are in their genesis, but aim to address this fundamental issue, which is reflected in the service user's experience of many mental health services.

### The development of counselling in LCFT

Before counsellors were employed by LCFT, they were mostly self-employed, providing a service to GPs in the area on an ad hoc basis and thus mirroring a pattern across primary care services throughout the NHS.

In 1998 a counselling service co-ordinator was employed by Communicare NHS Trust in the locality of East Lancashire, to implement, deliver and develop counselling within the structures of the organisation, and this was one of the many posts inherited by LCFT. Within the provision for East Lancashire, the referral route for counselling for patients with mild-to-moderate mental health issues for brief, time-limited counselling (up to 10 sessions), was via their GP. Counsellors worked hard to develop good working relationships with these GPs as this was essential and necessary for ensuring that the work being directed to counsellors was appropriate, especially at a time when counselling was the only mental health provision in primary care in the region. The available primary care services for people with mental health problems at that time varied between non-existent and a very limited amount of counselling, which was available via community mental health teams (CMHT), consisting of specialist psychological practitioners and community psychiatric nurses with counselling skills. Any referrals deemed inappropriate for the primary care counsellors were usually directed to these teams, based in secondary care services, which was less than ideal – and this was the driver for the eventual re-organisation of primary care mental health provision in LCFT.

### The impact on counsellors

The MPCEB agenda and the appointment of a professional lead for counselling have provided LCFT counsellors with a voice in the development of services – and hence

the opportunity to develop innovative ways of working and influence the development of genuinely integrated primary mental health care. Anecdotal evidence has suggested that counselling services have been de-commissioned around the country in order to increase CBT provision within the context of IAPT. This has not been mirrored here in LCFT, which has been good news for both the counsellors and the local communities. The creation of the Professional Lead for Counselling post arose in part from the recognition by the Adult Network Professional Lead for Psychological Services of the issue that counselling tended to get a poor deal when managed by other psychological professions. This was initially addressed by creating a counselling manager post in 2007 within the East Lancashire Psychological Services Department of LCFT. Since the advent of MPCEB, psychological services departments within the three geographical localities have been devolved, and psychological therapists (including counsellors) integrated into mental health teams.

Counsellors have shown that they have an important part to play in these recent developments, integrating with other professional disciplines and members of the primary care team – though there is always scope for greater involvement. The opportunities created by this integration have helped to increase communication between counsellors and other members of the primary care mental health teams and further support the management of clients with mental health difficulties (harder to achieve when counsellors work in isolation in a standalone service). Other opportunities have been the link with Job Centre Plus and other Department of Work and Pensions initiatives. However, these advantages have also brought a number of challenges with them, such as the danger of role confusion for counsellors and the expectation that they can be all things to all people. Clear guidelines regarding the nature of counselling have been essential, and referral guidelines are now in the process of being developed across the board as part of the development of an operational policy for the new set-up.

The growth of the IAPT programme, with its remit to recruit and train a combination of just over 3,000 high and low-intensity workers, left LCFT counsellors concerned about their future in the NHS. There were also concerns that they might be obliged to re-train in view of the initial focus of IAPT on increasing CBT skills in the workforce. The anxieties raised by these issues have at times given rise to confusion and the conflation of IAPT with CBT in practitioners' minds. However, there is a very clear place for counsellors in the new developments within LCFT. This is being further reinforced at a national level, as a result of the new Enhancing the Psychological Therapies Workforce agenda<sup>6</sup> in the IAPT programme, which is designed to bring additional modalities into IAPT, including counselling.

In its report, *Commissioning IAPT for the whole community*<sup>7</sup>, the Department of Health (DH) stated that it wished to see counselling included in services commissioned as part of the IAPT programme. The DH has also been extremely clear that no service should be decommissioned as a result of IAPT developments. In keeping with the spirit of this, developments within LCFT have successfully mapped new IAPT services onto existing psychological services in primary care, and this has been further supported by our commissioners. The mix of new and existing ingredients has created an ideal opportunity to develop a new style of service that builds on innovative ideas alongside current successes. All this is clear recognition that the keys to designing effective services are creativity, diversity and flexibility.

Including counsellors in the IAPT developments at LCFT has heralded new ways of working in the changing culture, which are implicit in the requirement for routine collection of the IAPT minimum data set (MDS). It means that having worked through the challenge of incorporating CORE outcome measurement into their practice, counsellors have once again had to adapt to using several other scales at every face-to-face contact with clients. At the same time, recent organisational decisions to move to electronic (computerised) recording of

sessional content have raised a number of challenges around managing the confidentiality of information within a multidisciplinary setting. This is currently an ongoing topic of discussion within LCFT, involving the collaborative engagement of practitioners, senior managers and IT personnel.

Brief therapy and counselling in primary care have effectively been synonymous over the past decade in Lancashire. However, the introduction of IAPT and the stepped-care model have resulted in referrals for mild-to-moderate mental health problems being picked up at the lower end of the spectrum, with the knock-on effect that more complex work that is unsuitable for either CBT or secondary care services is directed to counsellors at step 3 of the stepped-care model. This has created

a number of challenges, and has left counsellors feeling that their roles are being redefined in the context of some of their work becoming more difficult to manage within a time-limited brief model of counselling. The option of longer interventions may eventually be required, together with investment in research based on the effectiveness paradigms currently under development around evidence-based therapies. Ideally this should be supported by the involvement of service users in order to build an evidence base with a sound ethical foundation grounded in the real issues and experiences of individuals who have experienced mental distress. With vision and effective leadership, a number of opportunities can be created for different types of therapies to meet the needs of clients, in addition to CBT.

## Supervision

For historical reasons, there have been a variety of models of counselling supervision provision across the adult services network in LCFT, ranging from in-house supervision, provided by staff employed by LCFT, to external provision. This has given rise to a number of challenges with regards to ensuring good governance and safe practice. The advent of MPCEB and the endorsement of a career structure for counsellors within the programme have provided the opportunity to reconsider the provision of supervision to counsellors across the adult network in order to ensure parity regarding career development for all counsellors within the trust and the development of a supervision-skilled workforce. As a result, counselling supervision provision within LCFT has begun to acquire a distinct identity



as a discipline, and LCFT is developing a clear concept of both the nature of supervision and ways of defining how it should be provided.

The roles of Agenda for Change Bands 5 and 6 counsellors and Band 7 senior counsellors have been clearly endorsed by MPCEB. Key to this is the expectation that the senior counsellor role would include providing supervision as well as some professional support for the teams in which they are based. The development of senior counsellor roles across the adult network is currently in progress, while mentoring and supervisory responsibilities are also included within the job descriptions for Band 5 and 6 counsellors, as part of establishing a tiered approach to the provision of supervision to trainee counsellors, among others. This will ensure that the necessary skills base is developed for senior counsellor roles as opportunities arise.

Supervision is the cornerstone of counselling practice, and a process by which counsellors commit to regular review of the work they undertake as a way of safeguarding clients and learning to work more effectively. It also supports high quality care to patients and high quality outcomes, both of which are important to the values of LCFT and to the approach promoted by the IAPT programme. Developing supervision provision within LCFT as part of these recent developments is viewed as a vital aspect of counselling provision, and requires that the supervision being delivered is professional in its quality, standardised in its organisation and accountable in its delivery. This should also ensure that high quality care runs through the workforce. The qualities valued in supervisors are their highly developed sense of personal and professional curiosity, leadership and authority. In developing these skills, the counselling workforce builds on the values and skills inherent in the counselling model. Developments such as IAPT and the requirement for robust supervision arrangements have decisively tilted the direction of change.

## Conclusion

Never before have psychological therapies had such a high profile

within LCFT, as with the advent of MPCEB and IAPT. However, we currently face a number of challenges, not least of which is ensuring survival in the face of the coming storm – the interaction of a rapidly increasing demand for our services in the context of a parallel funding reduction. There will be a need for counselling, as for all disciplines, to demonstrate the efficacy and effectiveness of interventions outside the rarefied environment of the well-funded research trial. Innovative ways of working are vital, alongside protecting professional identity in the face of competing demands, and these will be the focus of training events in the future for clinicians and leads within LCFT. Moreover, benchmarking exercises, such as the Foundation Trust Network<sup>8</sup> benchmarking of services and a similar exercise being undertaken by the Royal College of Psychiatrists<sup>9</sup> (see article, pp38), will set out to establish whether and where commissioners are getting 'value for money' for psychological therapy services in comparison with other actual and putative mental health service provision. It is essential that we continue to develop new ways of working to meet these and other challenges as yet unknown – diversity will be key not only to maintaining but also to developing services.

From the standpoint of the professional leads for both psychological therapies and counselling, we wish to see the continuing development of direct access to timely and appropriate psychological interventions – be they formal therapies delivered by qualified and well supervised therapists, or care packages delivered by a range of individuals, teams and agencies, informed by sound psychological principles.

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3. A copy may be obtained by contacting Zubeida Ali, Professional Lead for Counselling, Lancashire Care NHS Foundation Trust, Daisyfield Mill, Appleby Street, Blackburn BB1 3BL <http://www.lancashirecare.nhs.uk>
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