June 2008
ISBN: 978-0-903593-29-8

Published by Artemis Trust

PURE Design (Newcastle) Limited • joan.nicklin@blueyonder.co.uk PL438 6/08

Survey of the Current Provision of Psychological Therapy Services in Primary Care in the UK

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1. Executive summary

A survey of psychological therapy services in primary care was carried out between June and September 2007 to build a factual map of services in the UK, against which future development can be measured. The survey was funded by the Artemis Trust, overseen by a stakeholder Steering Group and run by Durham University. Information was gathered on 127 services and the key findings were as follows:

- NHS primary care organisations (e.g. Primary Care Trusts in England) have poor records of the primary care psychological therapy services that are provided in their areas.

- It appears likely that there is a very wide (50:1) "postcode" variation in level of provision of psychological therapies across the country.

- Over half of services (52%) were provided in the voluntary and independent sectors and 48% by primary care organisations and mental health trusts.

- 59% of services identified themselves as a face-to-face talking therapy service while 49% identified as stepped care services that conformed to the NICE guidelines.

- The actual differences in interventions provided by the two types of service were blurred indicating that a transition to stepped-care is already well underway. The most commonly provided interventions were signposting, assessment and other (unspecified) talking therapies. Stepped care services were likely to provide information, referral to secondary services and CBT but these interventions were also provided by over half of talking therapy services. Talking therapy services were unlikely to provide guided self-help and bibliotherapy, computerised CBT, medication management or psycho-educational groups.

- Similarities and differences marked the staffing of the two models of care. Psychotherapists and counsellors were the most commonly employed staff, with 76% of services reporting them on their staff team. Clinical psychologists and graduate mental health workers were most likely to be employed by stepped care services. Stepped care services were also most likely to employ staff from a range of professions to create multidisciplinary staff teams.

- The average size of teams was 11 staff. The 91 services reporting team size indicate a total primary care psychological therapy service workforce of just under 1000 individuals.

- Psychological therapy services generally offered patients a range of choices - typically five different kinds of modalities of talking therapy or therapeutic approaches. All services were likely to use CBT approaches, but stepped care services were more likely to offer cognitive, behavioural and cognitive analytic therapy, while talking therapy services were more likely to offer humanistic or person centred approaches and psychodynamic therapy.

- Group therapy was mainly provided by stepped care services.

- The majority of services (60%) provided up to 8 sessions of treatment on average and sessions tended to be of 50 minutes in length.

- Therapy was available in languages other than English in 32% of services but it was unclear to what degree this provision met the needs of the local population.

- Services adopted different pathways for assessment and access to treatment, 31% providing a one-stop shop, 35% directing referrals straight to the staff delivering the service and 34% running a mix of other referral routes and systems.

- A minority of services offered interventions to children and young people but it was rare for services to operate an upper age restriction, treating adults on the basis of need and not age.

- The average waiting time for services was 50 days (7 weeks) but waits ranged from 1 to 270 days. Only 9% of stepped care and 7% of traditional talking therapy services had waits of over 18 weeks.

- Out-of-hour services were provided by 46% of services.

- Managers were drawn from a range of professional backgrounds including psychology, counselling and psychotherapy.

- Services operated with very little administrative support and half of services had no paid administrator.

- Only limited information was collected on the cost of services. The average cost per clinical hour was £41.

- The average number of annual referrals received ranged from 20 to 3,131 with an average of 650 referrals per year. The average number of cases treated was 485 per year. Overall, 71% of cases referred were accepted for treatment.

- Outcome measures were used in more than 60 per cent of psychological therapy services, of these over 90% of which used one or more CORE measures.

Given the findings from the survey, estimates can be generated for the likely provision of primary care psychological therapy services in the UK. These include:

- 325 services that providing primary care psychological therapy.
- with a workforce of around 3,500 staff, who treat around 160,000 patients per year.
- 8,800 of the 10,000 GP practices with access to psychological therapy services.

This survey has been a useful first step in establishing a benchmark of primary care psychological therapy provision. It is recommended that it should form the basis for an annual exercise which would monitor progress in the removal of the current “postcode” variation in levels of service provision and progress towards the provision of a full range stepped care talking therapies as envisaged by the Government’s Improving Access to Psychological Therapies (IAPT) programme.

2. Introduction and background

2.1 Introduction

The wide availability of psychological therapies in Britain is very recent. The first counsellors worked in primary care in the late 1960s, with 31% of practices having counsellors in 1992[1] , rising to 51% of practices by 2001[2] . It is helpful to understand something of the history of this development, and the evidence and the policies that now support it.

There are several different strands to the development of psychological therapies in Britain. These include Freud's theories and practice of psychoanalysis from the late nineteenth century, and modifications of his approach, by such as Carl Jung, to form 'Schools' of psychotherapy of their own. The American psychologist Carl Rogers established the 'Person Centered' approach to psychological therapy from the 1940s. The opening of the Marriage Guidance Council in London in 1943 was a key step in the provision of counselling in Britain, and 'Balint' groups, set up in the 1960s, were important in exposing GPs to psychological ways of working. The British Association for Counselling was formed in 1970, bringing together a number of counselling organisations and initiating national standards for counselling training. Clinical psychologists were involved in therapy with adults from 1960s, with the introduction of behaviour therapy, now very much modified by the cognitive theories initiated by American psychiatrist Aaron Beck.

These diverse strands of development have led to a complex situation. People now train as psychological therapists through a number of routes. Those trained as counsellors and/or psychotherapists may not necessarily have trained within a health-care profession: those trained in a health care profession may have followed different training routes: and the psychological therapy skills acquired during professional training may have been significantly extended by further training. The mode of training, or the profession of origin, of an individual therapist accordingly gives little clue to the therapeutic modalities in which they are skilled, or the presenting problems with which they are most experienced.

It is against this background that the current emphasis on evidence for the effectiveness of psychological therapies, and the need for government policy, has arisen. The first well-designed trial of psychiatric medication did not take place until 1955, and the careful evaluation of psychological therapies only dates from the 1960s. The movement for the need for evidence of effectiveness of treatments is itself relatively new, and is often seen as dating back to the early work of Archie Cochrane (1972)[3] . The Cochrane Collaboration, named after him, is a major vehicle for the promotion of evidence-based practice, and, for example, there is a Cochrane review on counselling in primary care [4] , updated to 2006. There is now a large body of research work on the effectiveness of psychological therapies, with the text by Roth & Fonagy [5] being one of the most comprehensive. There are however, major methodological difficulties in this area. Different psychological therapies may have different objectives, commonly used outcome measures may not be equally applicable to all therapeutic modalities and research designs for medical treatments may not be appropriate.

From the mid 1990s a number of British government policy statements on psychological therapies have been produced. The first was a strategy review published in 1996[6] . Then in 1999, *the National Service Framework for mental health for adults of working age* - the NSF[7] set out an overall policy framework for mental health services, within which the development of primary care services was a priority. 'Policy Implementation Guides' accompanying the NSF, and other more detailed guidance for both service commissioners and providers have continued to address the organisation and delivery of psychological therapies[8] .

Another form of policy guidance, more closely related to clinical practice, is contained in clinical practice guidelines, the most important of these being produced by the *National Institute for Health and Clinical Excellence* (NICE). These guidelines now cover most common and major mental health conditions.

These policies are reshaping the way psychological therapy services are provided in primary care settings, with increasing emphasis on improving access to multi-agency and multidisciplinary services. There has been a substantial increase in resources to make psychological therapies and other related social support more available. New mental health professionals such as Graduate Primary Care Mental Health Workers and support workers now work alongside both longer-established GP counselling services, and community based specialist mental health workers.

This increase has taken place at great speed, within a rapidly changing organisational framework, with staff from a range of professional backgrounds, and with very different levels of skills and experience. For their skills to be fully utilised remains a challenge. Building a picture of this complex situation, drawing together information collected directly from primary care psychological therapy services, would be of great value to inform further development.

2.2 Introducing the mapping survey

In order to start putting together a picture of service provision, a survey of psychological therapy services in primary care was carried out between June and September 2007. The aim of the study was to build a factual 'map' of services in the UK identifying where they were provided, what was delivered, and how they were staffed, managed and funded. It was intended that the results would fill a gap in knowledge because, although primary care psychological therapy services have become well established, there is no authoritative picture of current provision.

The survey was carried out by Durham University and commissioned by the Artemis Trust. A project steering group was set up to oversee the project. This included representatives from the Association of Counsellors and Psychotherapists in Primary Care (CPC), the British Association for Counselling and Psychotherapy (BACP), the British Psychological Society (BPS), the CORE user network and the United Kingdom Council for Psychotherapy (UKCP). It also had the support of the Royal College of Psychiatry, the Healthcare Commission and the Improving Access to Psychological Therapies Programme.

This report summarises the findings of the survey. The methodology adopted for the survey is explained and responses to the survey analysed. The report then follows the logic of the survey questionnaire looking at:

- The types of services reporting, their employment arrangements and models of care
- The staffing of services including the professions represented, workforce size, hours of input and the settings in which services are delivered
- The interventions and treatment provided
- The accessibility of services including access criteria, the availability of policies for managing contact with patients and waiting times
- Management arrangements and costs
- Issues arising from the findings.

2.3 Scope

The survey covered services across the UK. Throughout the report the term primary care organisation (PCO) is used to include the 152 Primary Care Trusts in England, the 22 Local Health Boards in Wales, the 14 Health Boards in Scotland, 4 Health and Social Service Boards in Northern Ireland, the Channel Islands and the Isle of Man.

A primary care psychological therapy service was defined as one that was commissioned or funded by the NHS and provided within primary care. Therefore, the survey was designed to include services regardless of whether they were provided, or managed, by: primary care organisations; NHS mental health provider trusts; voluntary sector agencies; or private companies or partnerships.

Where a PCO purchased primary care psychological therapy services from a NHS mental health provider trust that also provided secondary psychological therapy services, information was only requested on the part of the service delivered in primary care. Similarly, GP and practice nurse provision that could be considered part of "normal GP care", such as, provision of brief supportive consultations or handing out information leaflets was excluded. Practice nurse consultations could only be considered as of 'talking therapy' and therefore be included in the survey where a practice nurse had received specific CBT, counselling or similar training.

Only services which received direct or indirect public or statutory funding (including joint) were mapped. To take account of GP referrals to local voluntary sector psychological therapy services (such as a voluntary, charitably funded counselling service), services were only considered to be primary care psychological therapy services if there was a contract between the NHS and the voluntary service concerned for the purchase of services.

Note that throughout the report, psychological therapy services include the provision of counselling and psychotherapy.

3. Method

3.1 On-line survey

The survey was conducted using an on-line questionnaire. The survey and questionnaire design was coordinated by John Hall of the Health and Social Care Advisory Service (HASCAS) in collaboration with members of the Steering Group. The questionnaire was administered using the established online survey methodology developed by Durham University for national service mapping exercises. This data collection method required a website to be set up on which respondents could access a confidential questionnaire. As the questionnaire requested detailed information, it was important that it could be saved and revisited as often as respondents wished during the data collection period. Once the survey was completed, the same website could be used to display results from the survey.

Psychological therapy services in primary care were alerted to the survey in two ways.
1. Members of the Steering Group agreed to publicise the survey through their networks and publications
2. A list of services was generated and a message was sent out through the Durham mapping system inviting services to take part in the survey.

3.2 Identification of services

As there was no reliable list of psychological therapy services working in primary care, it was anticipated that the generation of an email contact list would be problematic. Therefore, a commercial provider of directories for the NHS was initially contracted to draw up the list. They agreed to telephone all primary care organisations (PCOs) and ask for the contact details of primary care psychological service provided within their area. However, they found that PCOs had extremely poor records of psychological service providers and, as this exercise was being carried out in early 2007 just after the widespread reorganisation of PCTs in England, staff often had only limited understanding of the questions being asked. As a result, the initial exercise yielded a very unreliable list of services. To rectify this situation the help of a number of organisations was enlisted and a consultant was engaged to update and revise the lists.

The final list contained 525 addresses but, because a cascade approach was adopted, the list was known to include umbrella and other organisations which did not provide services themselves but might know of relevant services to pass the request on to. Of the 525 addresses contacted, 127 were positively verified as being active providers of primary care psychological therapy services.

3.3 Response rates

It is not possible to give a definitive rate of response to the survey as the total number of primary care psychological therapy services is not known. It is also difficult to report the number of services that engaged with the survey as a proportion of questionnaires that were set up on the website in the course of data collection were left incomplete. There is no way of knowing whether services that did not complete were relevant to the survey or inappropriate and therefore correct in not submitting data. Overall, 183 questionnaires were set up. Of these, 155 provided some identifiers, such as name and/or address, but only 127 provided usable data.

As some sections of the survey were more comprehensively completed than others, response rates varied considerably between questions. Information submitted was most complete on descriptions of service type, models of care and the interventions delivered and poorest on issues of management and finance. To take account of this, all the percentages in the report have been calculated on the number of completed responses to that particular question and the number of responses has been indicated.

3.4 How representative was the survey?

Looking at how representative the data were, Table 1 shows the distribution of primary care organisations in the UK and the number of services reported in each country. In England services were reported from 43% of PCTs, in Scotland from 29% of Health Boards and in Wales from 14% of Local Health Boards. No responses were received from Northern Ireland, the Channel Islands or the Isle of Man. As it is expected that all PCOs will commission at least one primary care psychological therapy service for their areas, it can be assumed that there should be over 195 services in the UK. Therefore the survey provided a considerable underestimate of UK provision. However, if provision everywhere is at the same rate as in the PCOs for which data have been reported (a ratio of 127 services in 73 PCOs or 1.7 services per PCO), it could be estimated that there should be 325 services. If this were the case, the survey captured only 37% of services.

Table 1: Distribution of services and estimates of UK provision

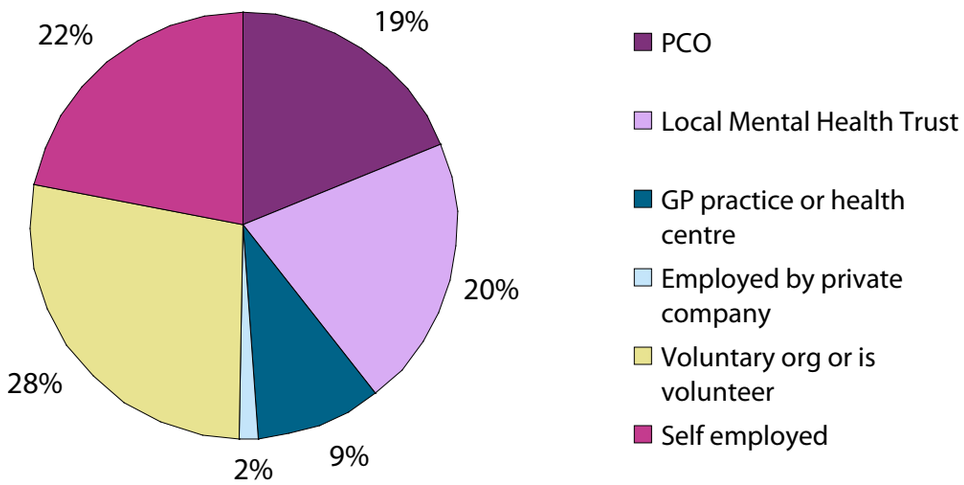
	Number of primary care organisations	Number of PTO represented in the survey	% of PTO represented	Number of services in survey	National estimates at same rate of provision
England	152	66	43%	115	265
Scotland	14	4	29%	9	32
Wales	22	3	14%	3	22
Northern Ireland	4				4
Channel Islands	2				2
Isle of Man	1				1
Total	**195**	**73**	**37%**	**127**	**325**

4. Findings - service types

4.1 Service types and contracts

In total, 127 psychological therapy services provided information on the type of service provided and the employment of staff. In just under half of these services (48%) staff were employed directly within the NHS, in 19% by PCOs, in 20% by mental health provider trusts and in 9% by GP practices (Fig.1). The other 52% of services were in the independent sector. Twenty-eight percent of services were provided by voluntary sector agencies or services provided by volunteer staff, 22% by self employed psychotherapists of counsellors and just 2% by private companies or individuals.

Fig.1: Employment of staff (N=127)



Non-NHS services were asked about the security of their contract with the primary care organisation. Overall, 58% of services reported having a contract of 12 months or longer (Table 2).

Table 2: Non -NHS Services with a contract with the PCO of at least 12 months duration

Employed by	Has PCO contract 12 months +	PCO contract UNDER 12 months +	Not answered
Private company		1 (33%)	2 (66%)
Voluntary org or is volunteer	22 (63%)	13 (37%)	
Self employed	16 (57%)	12 (43%)	
Total	**38 (58%)**	**26 (39%)**	**2 (3%)**

4.2 Models of care

The survey identified two broad models of primary care psychological therapy services (see definitions in Box1). The first is the model of one-to-one talking therapy. The second is the stepped care model in which a range of therapeutic interventions of differing intensities are delivered. A key characteristic of the stepped care model is that recommended treatment should be the least restrictive that is considered likely to provide significant health gain and the results of treatment should be monitored so that changes can be made to 'stepping up' the intensity of treatment if the desired health gain is not achieved[9] .

Box1: Definitions of models of care

Models of care: definitions

Face-to-face talking therapy: The service will carry out assessment but this will be an assessment of suitability for talking therapy. A small proportion of those assessed may be referred back or referred on. Staff may also engage in very occasional telephone calls with clients of a supportive nature but this is not considered to be a major part of the service. The service will typically provide an average of 4-6 one-hour sessions to each patient (up to a maximum of perhaps 12). The service is likely to be staffed mainly by counselling psychologists, counsellors and psychotherapists.

Stepped care: A service providing a range of stepped care interventions such as assessment (for a variety of possible interventions or referrals), signposting, referral, guided self help, CBT, telephone support, supervised CCBT, psycho-educational groups, case management, collaborative care, etc. The service may include some face-to-face 'talking therapy' but only as one of a much wider range of interventions. The service is likely to be staffed by a variety of staff including graduate mental health workers, assistant psychologists, nurses and other mental health workers.

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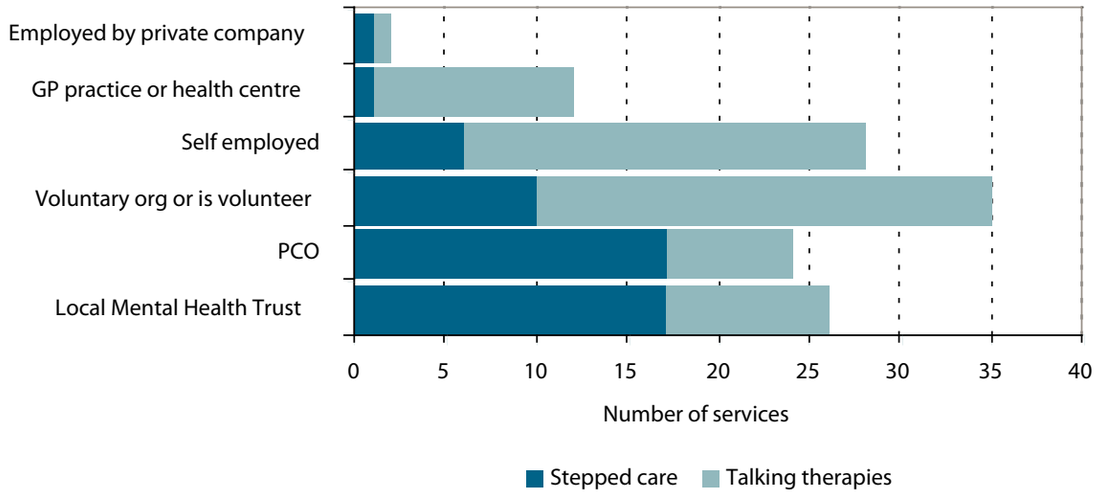
It was found that 59% of services provided face-to-face talking therapy while 41% provided a range of stepped care services. Stepped care was mainly provided by PCO and local mental health trust run services. Overall, 71% of PCO services and 65% of mental health trust run services identified with the stepped care model compared to 29% of voluntary sector services and 21% of self employed practitioners (Fig. 2). The least likely to provide stepped care were those employed by GP practices.

Secondary care was provided by 27% of services overall, but the proportion of psychological therapy services provided by local mental health trusts that also provided secondary care was higher at 42%.

Fig. 2: Employment of staffing in Talking Therapy and Stepped Care Services



Within both models of care, a variety of services were indicated by free-text descriptions submitted. These ranged from brief statements on GP counselling services to long descriptions of comprehensive stepped care services. On the whole stepped care services tended to be described in terms of the range of interventions provided and the mental health problems or conditions of the service users the services were designed to treat, such as, common mental health problems or recent on-set to long-standing difficulties. One-to-one talking therapy services tended to be described in terms of the arrangements they had with GPs, or their voluntary sector or self-employed status. No talking therapy service used the terminology of mental illness. A number of services described the hard-to reach groups that they were set up to serve, such as women, survivors of sexual abuse, victims of violence, people experiencing relationship difficulties and young people.

5 Findings – staffing

5.1 Staffing – professional profile

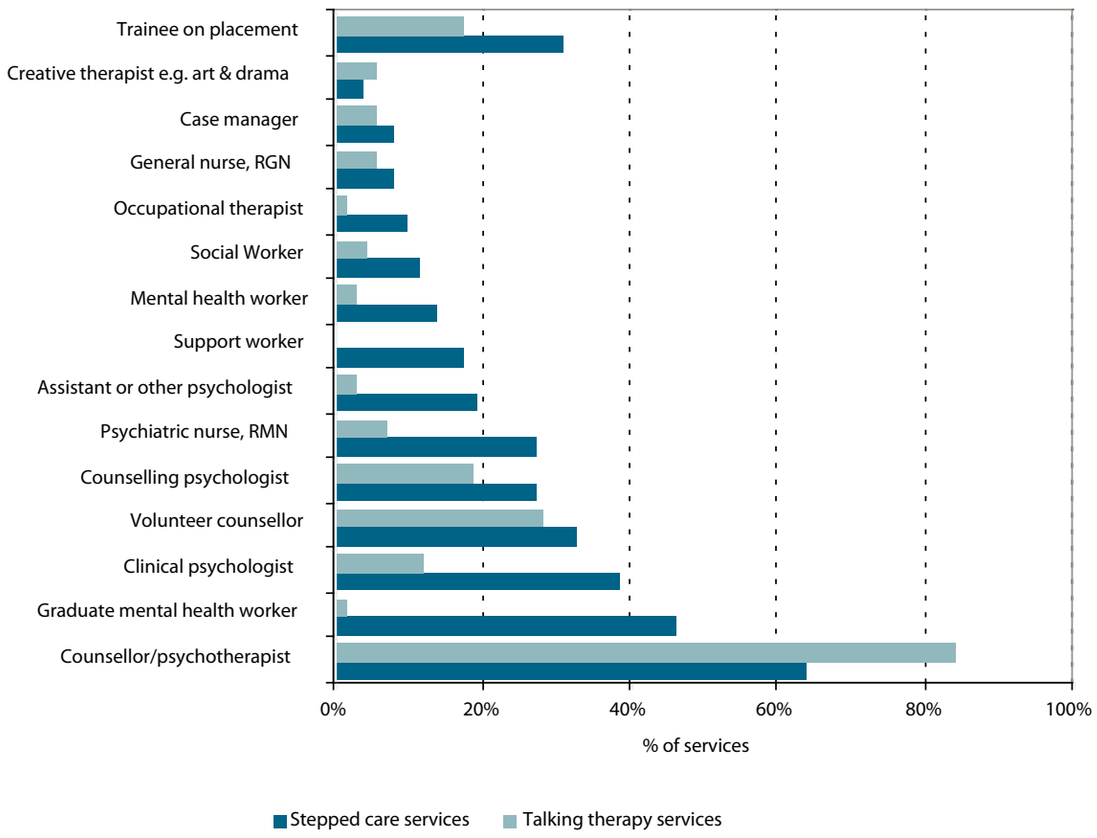
Information on the staffing of services showed up both similarities and differences between the two models of care. The most commonly employed staff were counsellors and psychotherapists who were found in 84% of talking therapy services and 63% of stepped care (Fig. 3). Clinical psychologists and graduate primary care mental health workers were most likely to be employed in stepped care services. Graduate mental health workers were found in 46% of stepped care, as opposed to 1% of talking therapy services, while clinical psychologists were employed in 38% of services offering stepped care compared to 12% offering talking therapy. Generally, there was a wider range of practitioners involved in stepped care, including, counselling psychologists, nurses, social workers and non-professionally aligned support workers.

As it is understood that there were approximately 600 graduate primary care mental health workers (GMHW) employed in England at the time of the survey, and only 24 of responding services reported their employment, it is likely that services employing graduate workers may have been significantly underrepresented. There were a number of possible reasons for this. Some respondents may not have considered the delivery of talking therapies to be part of the remit of graduate mental health workers. It was also found that some services used different terms to describe 'graduate mental health worker' which may have caused them to be omitted, or described under another name.

Trainee staff and those on training placements were found in 31% of stepped care services and 17% of talking therapy services. The distribution of volunteer counsellors was interesting as they were found in both models of care. As might be expected 66% of voluntary sector services used volunteer staff but they were also found in 23% of PCO-run services, 25% of services run by NHS trusts, 18% of GP-run services and with 12% self employed practitioners. This reflected the practice of counsellors and psychotherapists seeking opportunities to broaden their experience by working in a voluntary capacity in a range of service settings, including the statutory sector.

In considering the make up of staff teams in the services taking part in the survey, it should be noted that no information was gathered about the number of hours worked and therefore the size of the staff resource available. This information was included in the pilot survey but the feedback received was that the task of providing the whole time equivalent of staff by profession was too burdensome. As a result the question was dropped. In retrospect, this weakened the value of the staff data and it is recommended that if the mapping exercise were to be repeated, the whole time equivalent of staff input should be included.

Fig. 3: Professional staff groups employed in services (N=127 services)



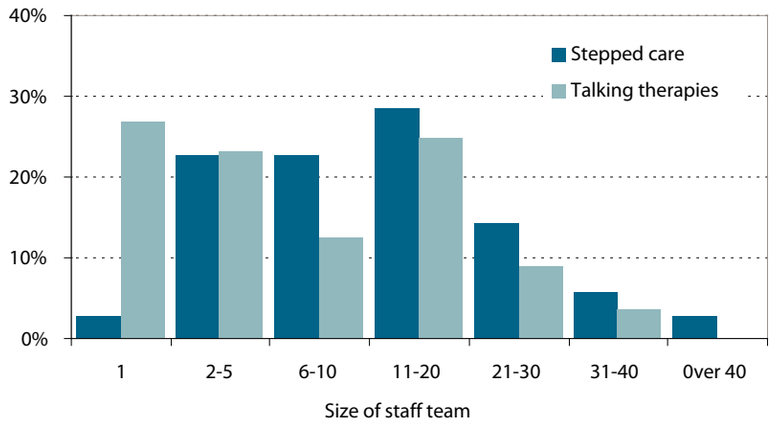
5.2 Service size

The total headcount of staff reported was 981. As this was reported by 91 services, it gives an average team size of 11 members of staff. If this average team size is applied to the estimated 325 primary care psychological therapy services in the UK, it indicates a possible total workforce in the order of 3,500 staff.

Team sizes ranged from 1 to 45 members of staff. Fifty seven percent of services had team of 10 or less and 42% reported teams larger than 11. Over 26% of services had teams of 11 to 20 staff. The principle difference in the team size between services offering the two models of care was the proportion of single-handed practitioners amongst talking therapy services (Fig. 4). Forty-one per cent of single-handed practitioners were self-employed therapists and a further 29% were employed directly by GPs. However, 12% were employed by PCOs, 6% by voluntary agencies, 6% by NHA trusts and 6% by private companies, demonstrating the variable arrangements.

The larger teams (over 20 staff) tended to provide a range of stepped care services.

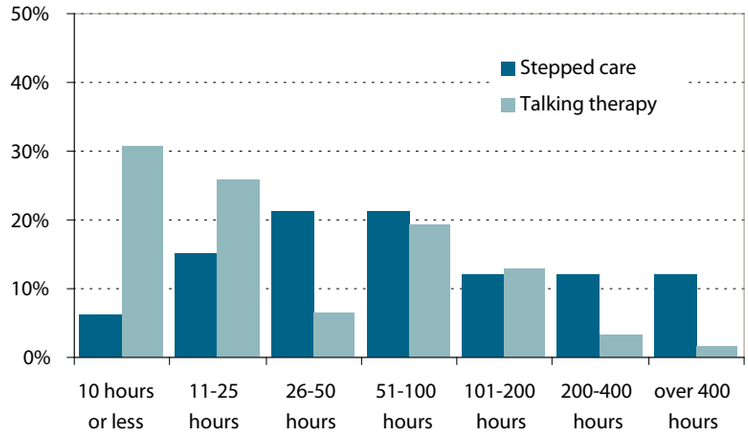
Fig. 4: Staff team size (N=91 services)



5.3 Clinical hours provided

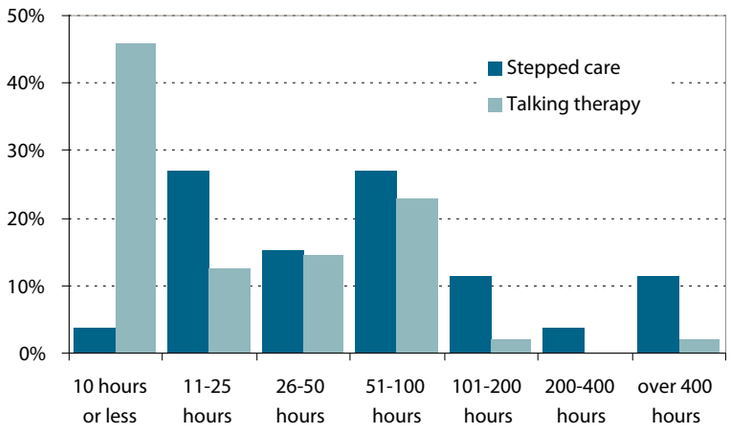
No information was collected on the whole time equivalence of staff members but services were asked to record the number of clinical hours per week spent on direct client contact and the number of non-clinical hours delivered. The findings from the 95 services providing this data suggest that 44% of services delivered under 25 contact hours per week (Fig. 5) which would of course include single-handed practitioners. This included 21% of stepped care services and 57% of talking therapy services (31% delivering under 10 contact hours). At the other end of the scale, 36% of stepped care services delivered over 100 contact hours a week compared to just 18% of talking therapy services. However, this data should be read with caution as 19% of services did not give any information on contact hours.

Fig. 5: Clinical hours per week spent on direct client contact (N=95 services)



Looking at the non-clinical hours provided by services, the difference between the two models of care was again very marked at the lower end of provision (Fig. 6). Almost half (46%) of talking therapy services input 10 or less non-clinical hours per week, and 25% input 11 to 20 hours. By comparison, only 4% of stepped care services provided less than 10 non-clinical hours while 42% provided from 11 to 50 hours and 28% of services provided over 100 hours. Again, caution in interpretation is needed as 40% of services did not report on the delivery on non-clinical time, possibly because some services may be paid for clinical work only. Also in some services the non-clinical hours worked exceeded the number of clinical hours. The ratio of non-clinical to clinical hours ranged from 4:1 to 1:6 with an average of 1: 2.4 hours.

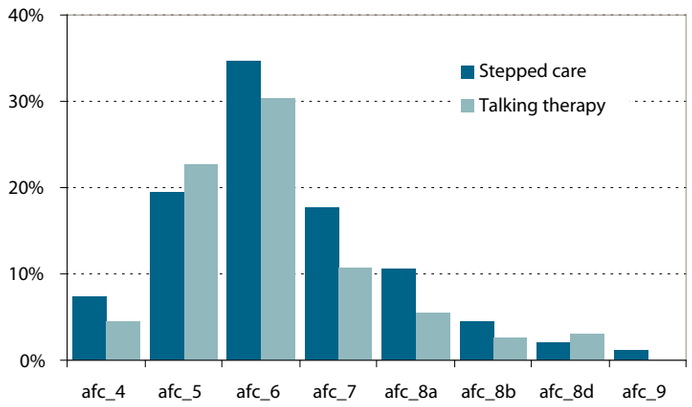
Fig. 6: Hours per week spent on non-clinical work (N=74 services)



5.4 Staff grades and pay

Information on the Agenda for Change pay bands held by staff was provided by 53% of services and a further 33% of services specified the use of other pay scales. A wide spread of Agenda for Change pay bands was found with 25% of services paying staff at band 5 rates (£15,900 to £23,500), 39% at band 6 (£18,900 to £29,300) and 16% at band 7 (£22,000 to £34,400) (Fig. 7). Little difference was found between services delivering the two models of care and a similar spread was reported in the services which use other pay scales. Although pay as low as £12.50 per hour for a qualified counsellor was reported, rates of up to £50 per hour could be found and the majority were spread between £20 and £30 per hour. As it is difficult to match pay to jobs and qualifications, a deliberate decision was made to avoid collecting data at the level of the individual and therefore this information should be regarded as indicative only.

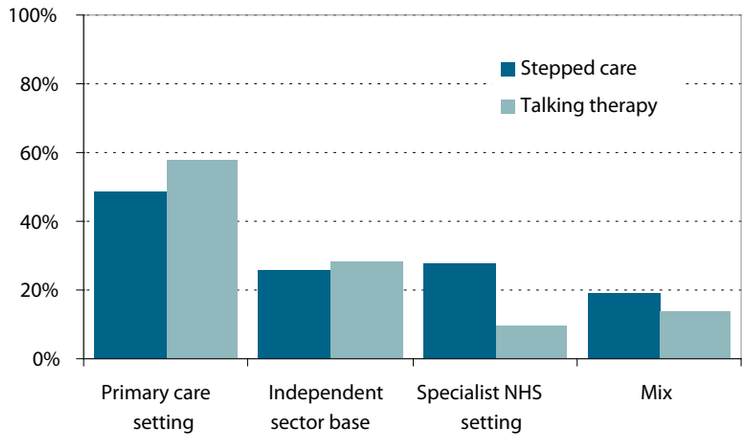
Fig. 7: Agenda for Change grades held by staff (N=62 services)



5.5 Settings

As might be expected, over 60% of services were delivered from health centres and GP surgeries, referred to as primary care settings in Figure 8. A further 16% of services worked in NHS settings such as community mental health teams, hospitals or other health bases. Centres run by voluntary or independent agencies were the setting for 34% of services and 18% reported working in a mix of settings, such as, GP surgeries and voluntary agency bases or mental health team offices. Very little difference was found in the models of care provided in these bases except stepped care was more likely to work from NHS premises than talking therapy services.

Fig. 8: Settings in which primary care psychological therapy services are delivered (N=93 services)



6. Findings – the service provided

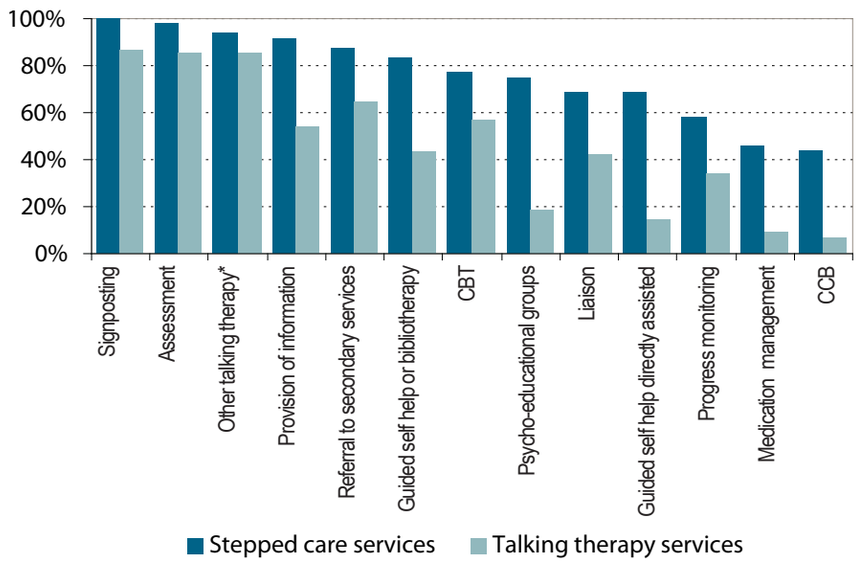
6.1 Interventions

This section of the survey was completed by the highest number of respondents (125 services) suggesting services were more confident, or willing, to describe the work that they did than to give information on how the service was staffed, managed and funded. In order to identify what interventions were being offered by each service, respondents were asked to indicate from a list which interventions they provided. It was found that a high proportion of services were delivering a range of the stepped care interventions that are specified in the NICE guidelines for the treatment of people with depression and/or anxiety[10] . However, there were considerable differences between services delivering the two models of care although it should be noted that the survey only captured the nature of what was being provided and not the level of activity.

The most widely available intervention was signposting to the voluntary sector, self help groups etc. This was provided by 92% of services overall, including 100% of stepped care services and 86% of talking therapies. Other interventions that were commonly available were assessment, provided by 90% of services, and other unspecified forms of face-to-face talking therapies provided by 89% of services.

For all other interventions there was a marked difference between provision by stepped care services and taking therapies (Fig. 9). Stepped care services were more likely to provide information (90% of services), referral to secondary care (88% of services), guided self help and bibliotherapy (83% of services) and CBT (77% of services). Despite this, it was clear from the variety of interventions provided by talking therapy services that they now tend to offer a considerable choice of interventions. Over half of them provided information, referral on to secondary services and CBT. However they were unlikely to provide computerised CBT, medication management and compliance, supervised guided self help or psycho-educational group work.

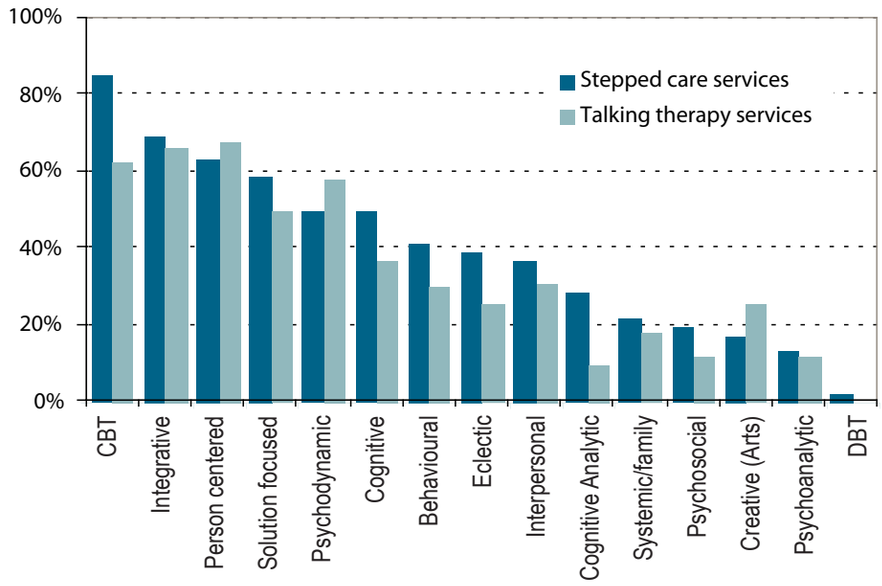
Fig. 9: Percentage of services offering given interventions (N=125)



6.2 Modalities

Most services offered a choice of modalities of talking therapy or therapeutic approaches. Only 10% of services offered a single modality while 11% offered 10 or more. The average number provided was five. Except for the use of CBT, which was offered by 85% of stepped care services and 62% of talking therapy services, there were few differences between the modalities offered by the two models of care (Fig. 10). Stepped care services were somewhat more likely to offer Cognitive, Behavioural and Cognitive Analytic therapy. The only modalities more likely to be used by talking therapies were humanistic or person centred approaches and psychodynamic therapy.

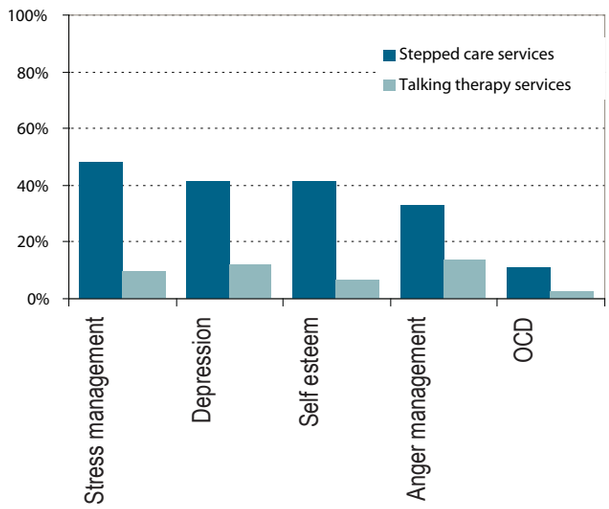
Fig. 10: Percentage of services offering specific modalities of therapy (N=125)



6.3 Group therapy

Group therapy was mainly provided by stepped care services. Of these, 48% offered stress management groups, 41% depression groups, 41% groups for people with low self esteem and 33% anger management groups (Fig. 11). Obsessive compulsive disorder groups were provided by 11% of stepped care services.

Fig. 11: Percentage of services offering group sessions



6.4 Number and length of sessions

The average number of one-to-one talking therapy sessions provided during treatment was very similar for services offering both models of care. Overall, 60% of services provided up to 8 sessions on average, 27% provided an average of 9 to 16 sessions and in 12% of services the average number was higher. Slightly more stepped care services delivered treatment with more sessions.

When face-to-face talking therapies were provided, the length of sessions most commonly conducted was 50 minutes or over. Eighty six percent of talking therapy services and 68% of stepped care services reported the use of these long sessions. Shorter sessions were used by 38% of stepped care services and 16% of talking therapy services but only 2% of stepped care made use of sessions of less than 15 minutes.

6.5 Language

All services were asked to list any languages in which the staff were fluent enough to conduct therapy and 32% of services reported being able to offer interventions in more than one language. The largest number of languages offered by a single team was seven. The complete list of languages offered is given in Table 3. From this it can be seen that although therapy is available in a wide range of languages across the UK, including a number of community languages, the most commonly available language is French for which there is unlikely to be high demand. The list suggests serious gaps in access to psychological therapy in the mother tongue of refugees and asylum seekers and members of black and ethnic minority communities.

Table 3: Languages in which staff are fluent enough to conduct therapy (N=41)

Language	Number of services	Language	Number of services
Albanian	1	Israeli	3
Arabic	2	Italian	5
Bangladeshi	1	Malay	1
Bengali	3	Maltese	1
Bosnian	1	Polish	6
BSL	1	Punjabi	4
Croat	2	Rumanian	1
Danish	1	Russian	1
Farsi	2	Singhala	1
French	16	Somali	3
German	2	Spanish	9
Greek	2	Swahili	1
Gujerati	5	Tamil	1
Hindi	5	Turkish	3
Hungarian	1	Urdu	11

7. Access to services

7.1 Access policies

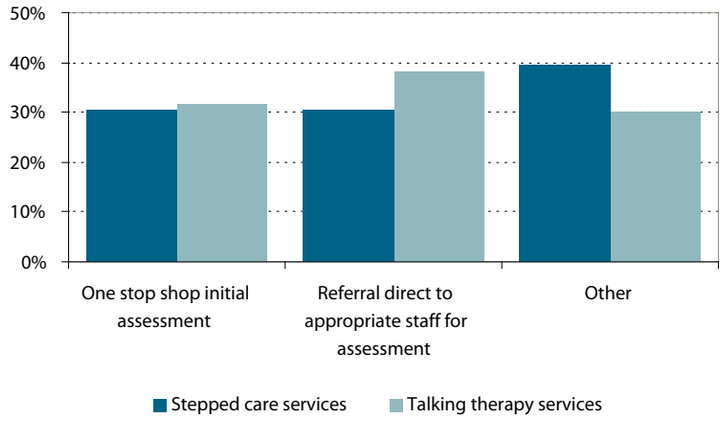
Services were asked to report on some key policies that affected the accessibility of their services. First, in order to obtain a picture of how services were accessed, they were asked about their approach to the initial assessment. They were given two options, or asked to describe another approach. The options given were:

1. All patients referred by GPs are channelled to an initial assessment where they are referred to particular forms of treatment interventions – the one-stop shop approach
2. Each patient is referred by the GP to one of a number of staff members who will assess suitability for the treatment interventions that they provide, and then provide the intervention, referring on if unsuitable.

Similar proportions of services operated each policy; 31% providing a one-stop shop approach, 35% referring to appropriate staff who carried out the assessment themselves. A different option was used by 34% of services (Fig. 12). The different options specified included:

- Use of an initial screening process before patients were allocated for assessment, including telephone screening
- A policy of seeing all referrals for an initial assessment
- A team allocation process in which referrals are discussed at team meetings and allocated to individual staff members as appropriate
- Use of information packs to steer patients in the right direction.

Fig. 12: Assessment options (N=106)



The majority of services operated an 'opt in' policy that requires patients to formally agree to the treatment being offered (a strategy we understand to have been found to reduce the numbers of missed assessment and first session appointments). Overall, 84% of services had established this policy but it was found more often in talking therapies where it was a requirment in 90% of services compared to 77% of stepped care services.

The majority of services also operated a lower age limit below which patients would not be accepted. In total, 88% of services had a lower age limit but the level of this varied. Of the services that reported restricting access to young people, 19% specified the age of nought, and it was not clear whether this meant no age limit or whether the only restriction was on infants. Only 4% of services provided a service

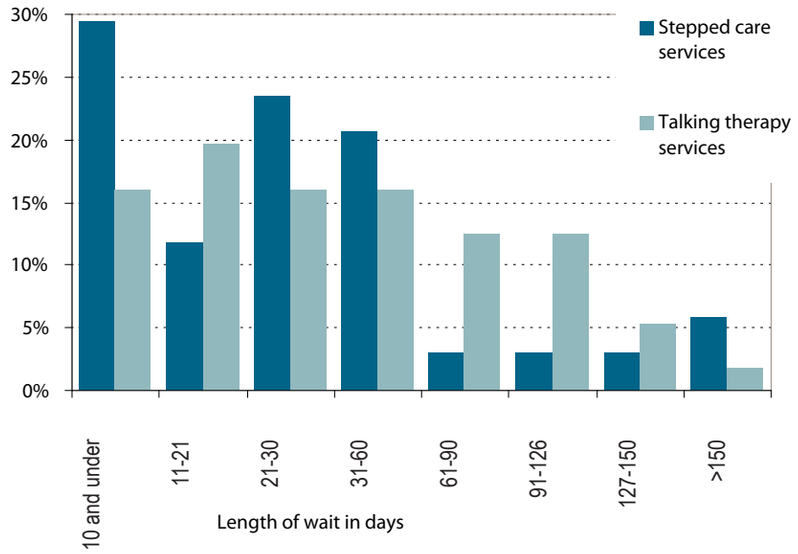
for pre and primary school aged children and 12% of stepped care services provided a service for young teens. More commonly, services worked with the lower age limit of 16 to 18 year olds and policy was very similarly implemented between the two models of care. Very few services used a higher age limit with 86% of stepped care and 94% of talking therapy services reporting that they offered access to older people on the grounds of need and not age.

With regard to treatment out-of-hours, 51% of talking therapy services reported provision compared to only 40% of stepped care services. This could have referred to evening sessions arranged for the convenience of patients outside the working day.

7.2 Waiting times

Information about waiting times was provided by 91 services. Average waiting times between referral and the start of treatment ranged from 1 to 270 days and the mean wait was 50 days, or seven weeks. Short waits of 10 days or less were reported in 21% of services overall but in 29% of stepped care services and 16% of talking therapy services (Fig.13). Longer waits of over 60 days were more common in talking therapy services with 33% of services reporting waits of 60 days (2 months) plus compared to only 15% of stepped care services. However, waits of 18 weeks or more were similar across models of care affecting 9% of stepped care services and 7% of talking therapy services.

Fig. 13: Length of wait from referral to start of treatment (N=90)



It was rare for services to have to close their waiting list. Only 30% of talking therapy services had to resort to this action, as had 18% of stepped care services. Few services reported placing a limit on the number of referrals a GP could make.

7.3 Patient contact

The majority of services reported having policies and procedures in place for the management of patient contact. Policies for contacting patients and monitoring their progress at scheduled intervals were in place in 61% of services. Overall, 81% of services had a procedure for contacting patients who fail to attend without giving notice, but talking therapy services were more likely to report this (87% of services)

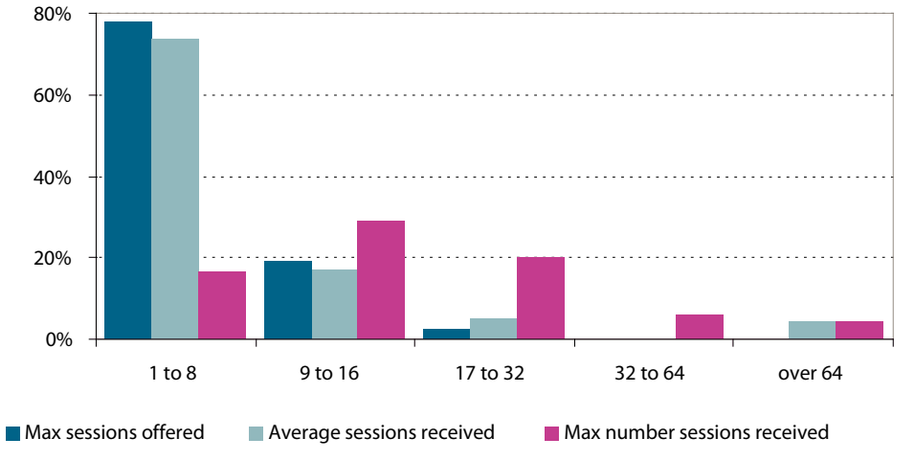
than stepped care (69% of services).

Similarly, talking therapy services were more likely to offer a maximum number of sessions from the outset with 75% of them operating this policy compared to 61% of stepped care services. Reflecting the flexibility needed, 97% of stepped care services and 85% of talking therapy services had a procedure for providing additional sessions for patients

Where a maximum number of sessions was initially offered to a patient, the number offered was usually 8 or less. Only 14% of services offered more than 9 sessions and they tended to be delivering talking therapies (Fig. 14). The use of interventions requiring more than an initial 16 sessions was only reported in 2% of services.

When the number of sessions initially offered was compared to the average number received by patients in the previous 6 months, it was found that the majority of patients did not exceed the number of sessions agreed. However, records of the maximum number of sessions received by patients over the previous six months showed that some long-term treatments were being provided for a few patients (Fig. 14).

Fig. 14: Maximum number of sessions offered compared to average (N=114)



8. Management

8.1 Management arrangements

The management arrangements again reflected the independent nature of many talking therapy services. Only 43% of talking therapy services had a service manager compared to 51% of stepped care services and just 11% were managed by a 'service lead' compared to 23% of stepped care services. On the other hand, 16% of talking therapy services were self employed practitioners without a manager compared to 2% of stepped care services. Only 2% of either model of care were managed by a manager from the mental health trust. However, given the number of primary care psychological therapy services provided by a mental health trust on the initial contact list for the survey, these results suggest that mental health trust run services under contract to a PCO were under-represented in the survey. This was possibly because of the way the survey was publicised which meant that information about it did not reach the community of psychologists.

Overall, 21% of services had other management arrangements, including management by:

- A Chief Executive Officer and Board of Directors
- A senior GP
- Self management reporting to a lead GP
- A primary care mental health team co-ordinator
- A GP practice manager.

Less than 30 responses were received on the grading and salaries of managers. The salaries that were given ranged from £28,000 per annum to £40,000 but there is no way of knowing how representative this might be.

Information on the professional and psychological therapy qualification held by managers was provided by 91 services and demonstrated the breadth of skills and experiences that service managers held. Precise analysis was not possible because of the range of descriptions of academic and professional qualifications listed but it was clear that managers have been drawn from counselling and psychotherapy as well as from psychology.

The years of experience in psychological therapy of managers was reported by 72 services and ranged from 2 to 45 years. The average was 16.4 years. Little difference was found in the experience of managers in the two models of care.

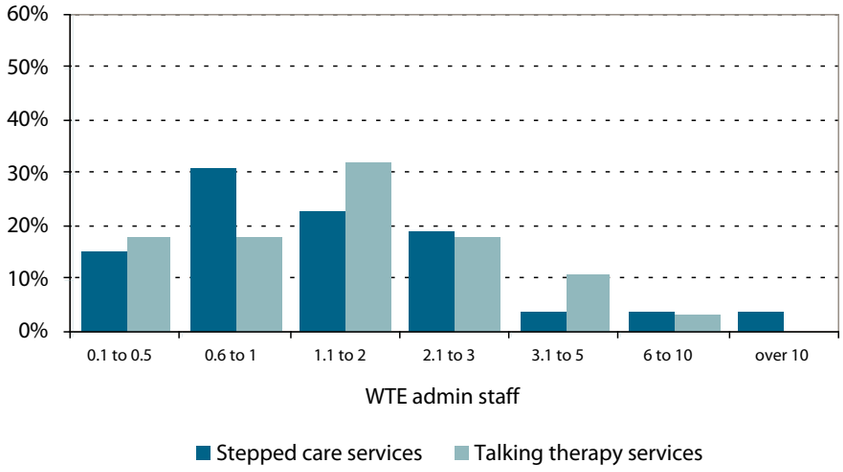
Managers' experience in management tended to be less than their time spent in a professional role. The length of time in management ranged from 1 to 30 years and the average number of years was 9.6. The managers of talking therapy services tended to have shorter managerial experience than their counterparts in stepped care services.

Membership of professional bodies was high amongst managers with 86% of the 84 respondents reporting membership of BACP, BPS, CPC or UKCP.

8.2 Administrative support

The constrained budgets of many of the therapy services were demonstrated by the lack of administrative staff reported. Half of services reported having no paid administrative worker and a further 20% of services employed one whole time equivalent (wte) or less (Fig. 15). No relationship could be found between the size of clinical team and the amount of administrative support available.

Fig. 15: Whole time equivalent administrative staff employed in services (N=54)

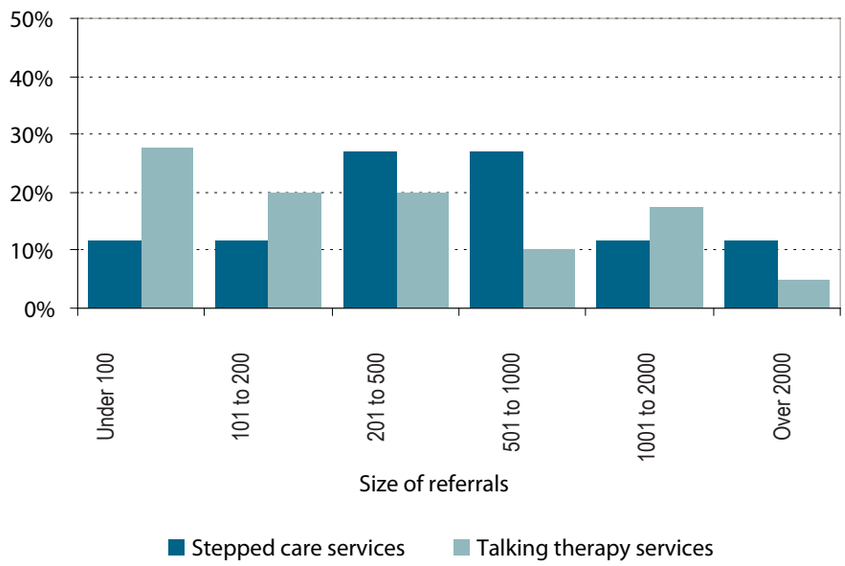


9 Activity, costs and level of provision

9.1 Activity

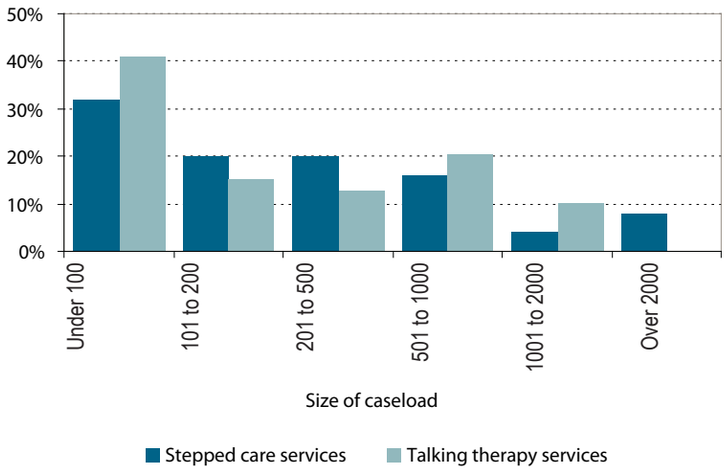
Sixty five services gave information on the number of patients that were referred and treated in the last 12 months. The number of referrals ranged from 20 to 3,131 and the average rate of referral was 650. The distribution of referrals between the two models of service indicated that the services with smaller number of referrals tended to be talking therapy service and annual referrals of 250 to 1,000 were more likely to be in stepped care services. However, there were exceptions and a number of talking therapy services reported annual referrals of over 1,000 (Fig. 16).

Fig. 16: Number of patients referred to the services in a year (N=65)



The numbers of patients treated ranged more widely, running from services that treated only a handful to a service that treated over 6,500 cases in a 12 month period. The average number of patients treated per year was 485. Overall, talking therapy services were more likely to carry smaller caseloads but differences between the two models of care were small (Fig. 17). The number of cases treated as a proportion of the number of referrals received ranged widely but on average, 71% of referrals were accepted for treatment.

Fig. 17: Number of patients treated by services in a year (N=64)



9.2 Costs

Information on costs was very poorly completed in the survey. Concern about confidentiality may have been a factor as psychological therapy services operate in a very competitive environment. Another factor may have been that the person completing the questionnaire did not know the details, or did not have the time to obtain the information requested.

The following cost information was submitted:

- Annual budget data including the staff and non-staff costs of a service but no overheads was collected from 24 services. This showed annual turnovers of up to £430,000 though there were 6 services working with budgets of £100 or less.
- Cost of clinical time was provided by 21 services and ranged from £12 to £90 per clinical hour. The average cost was £41.1 per hour of clinical work.
- 84% of services received funding from the PCO, 10% directly from GPs and 6% from other sources (Table 4).

Table 4: Source of funding for services

Funding source	Stepped care services	% of stepped care services	Talking therapy services	% of talking therapy services	Total	% total
NHS PCO	29	81%	38	86%	67	84%
NHS GP	4	11%	4	9%	8	10%
NHS other	3	8%	2	5%	5	6%
Total	**36**		**44**		**80**	**100%**

Other sources of funding listed included:

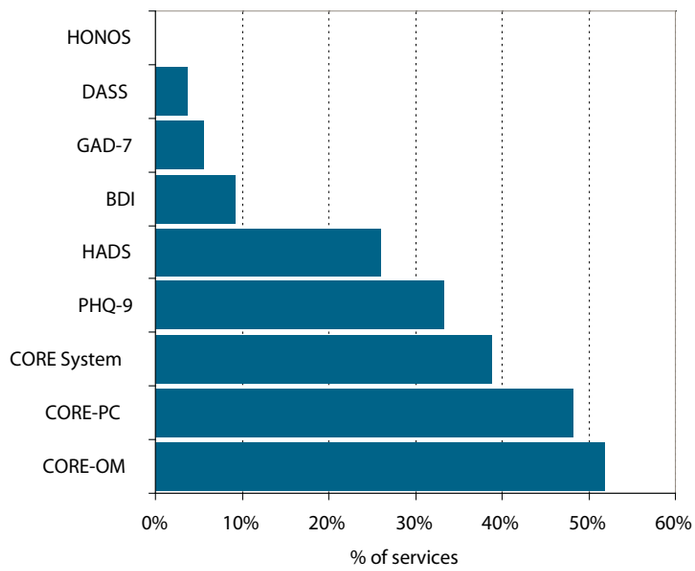
- Local authority and Government initiatives, such as, Neighbourhood Renewal Fund, DAT, Mental Health Grant
- Central Government Departments, such as, Department of Innovation, Universities and Skills, Department of Health and Home Office

- Charitable sources, such as, Big Lottery, Comic Relief, local charitable trusts
- Client and church donations and membership subscriptions
- Training Income
- Private health insurance
- Private practice and client fees.

9.3 Use of outcome measures

High use of outcome measures was found with 62% of services collecting outcome measures routinely, a further 11% collecting measures from at least 50% of cases and 9% using measures with only a minority of patients. The most commonly used outcome measures were CORE (Clinical Outcome in Routine Evaluation) measures. Of the 62% of services using outcome measures, 56% used only 1 measure, 20% used 2, 22% used 3 and 9% used 4 measures. Overall, 96% of services reporting the regular use of outcome measures used one of the three versions of CORE (Fig. 18).

Fig. 18: Outcome measures used regularly (N=54)



9.4 Changing provision

The majority of services reported that their service had expanded in the previous 12 months but this growth was often putting considerable pressure on the service. Comments on recent expansion could be summarised as follows:

- Increase in demand but no or limited increase in funding and therefore pressure on resources to meet the demand
- Widening access, e.g. extending a specialist service to men in addition to women
- Employment of new staff, especially the employment of graduate mental health workers
- Launch of new interventions, such as, CCBT and telephone CBT.

9.5 GP practices served

Services were reported in 73 PCOs in the survey and within these organisations, 53 services reported the number of GP practices that they served. In total 1,442 GP practices were supported, with the number of practices benefiting from a single service ranging from 1 to 77, probably a whole PCO area. This indicated that, on average, primary care psychological therapy services were delivering a service

to around 30 GP practices. Extrapolating from these figures, if there are 10,000 GP practices in the UK and the survey captured information from a 16% sample (53 services from an estimated 325 in total) of primary care psychological therapy services, then nationwide 88% of GP practices could have access to a service.

As might be expected, the types of service most likely to deliver a service to a single GP practice were those employed directly by the GP, or self-employed practitioners. Overall 20% of services fell into this category. A further 21% of services provided for between 2 and 10 GP practices and again they were more likely to be self-employed or voluntary sector services. Services delivering to a large number of GP practices tended to be PCO or mental health trust run services but there were also a few voluntary sector services. Altogether, 31% of services supported 30 or more GP practices.

9.6 Estimated level of provision in UK

Applying the information given above to the estimate of 325 primary care psychological services in the UK as a whole suggests that about 210,000 patients per annum are likely to be referred to existing services, and 160,000 are likely to be receiving treatment.

In terms of total referrals per PCO, the numbers of patients referred ranged from 1000 per 100,000 population on the patient list down to 20 per 100,000 – indicating a likely 50-fold geographic variation in the availability of primary care psychological therapy services.

10. Discussion and conclusion

The survey was timely as it was carried out at a time of considerable change for psychological therapy services in primary care in England. In November 2007, the Secretary of State announced a major investment of £173M in the Improving Access to Psychological Therapy (IAPT) Programme[11] . The IAPT Programme aims to help people with depression and anxiety disorders by widening access to a range of evidence-based stepped care interventions in accordance with NICE guidelines on the treatment for depression and anxiety[12].

The existing provision of psychological therapy services in primary care is, of course, an important factor to be considered by any PCO considering participation in the IAPT programme and indeed the IAPT Commissioning Toolkit[13] recommends that commissioners should review what services are currently available and what gaps exist in meeting needs. However, the limited knowledge of existing psychological therapy service provision at PCO level revealed by this survey, taken together with the complexity and diversity of provision (involving PCOs, individual GP practices or groups of GP practices each of whom may have some sort of arrangement for service provision with mental health trusts, voluntary sector agencies, independent providers and self employed practitioners) suggests that the review of existing services may not be an entirely straightforward task. It would be to the detriment of existing services – and thus to the estimated 160,000 patients already being treated by these services – if PCOs, in an effort to meet tight IAPT funding deadlines were unable to properly review existing services and plan for their integration into an IAPT compliant service. It would also, of course, represent a poor use of resources.

The IAPT programme, as described in the National Implementation Plan[14] and other documents is also highly focused on the provision of CBT based interventions. It is clear that whilst the majority of existing services offer CBT as one form of talking therapy (85% in the case of stepped care services and 62% in the case of talking therapy services) they also typically offer about five different therapeutic approaches (integrative, person centered, solution focused, psychodynamic, etc). While the IAPT programme has as its initial focus the delivery of CBT services, patient choice is high on the DH policy agenda and the importance of providing a range of evidence based therapies to facilitate patient choice cannot be over emphasised. The IAPT Commissioning Toolkit recommends the delivery of counselling and couples therapy besides CBT: existing services appear able to deliver on the issue of patient choice. The longer term consequence of substituting a therapeutic monoculture for the rich diversity of approaches which has been built up over the years would likely to be the loss of experienced and effective therapists who are currently working within the NHS and a loss of innovation in clinical practice.

The survey did not explore the quality or effectiveness of services but it was notable that the majority were making a considerable effort to measure their own quality and effectiveness by the use of outcome measures. Eighty three percent of services collected outcome data from patients with 62% collecting them routinely from the majority of patients (in almost all cases using the CORE System for outcome and quality measurement). This data collection has been building up valuable practice-based evidence[15] on the effectiveness of psychological therapy interventions that usefully complements the findings of RCTs.

This survey has been a useful first step in establishing a benchmark of primary care psychological therapy provision and it is recommended that it should form the basis for an annual exercise. This would allow monitoring of progress in removal of the “postcode” variation in the level of service provision and of progress towards the provision of a full range of stepped care talking therapies as envisaged by the Government’s Improving Access to Psychological Therapies (IAPT) programme.

Acknowledgements

With thanks to:

- the Artemis Trust for funding the survey and publication of this report
- members of the Steering Group for their guidance throughout the project, and their comments on the report
- the contributors to the survey for giving their time to give us the information that we requested.

The Artemis Trust has made substantial grants over the last 20 years directed towards improving the provision and quality of primary care psychological therapies in the UK.

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Appendix 1: Project Steering Group

Membership:

Richard Evans	Artemis Trust
Di Barnes	Durham University Research team
Tony Roth	BPS
John Hall	BPS
Nancy Rowland	BACP
Cris Holmes	BACP
John Eatock	BACP
Joan Foster	UKCP
Antonia Murphy	CPC
Jane Rosoman	Network of Service Providers
Geoff Mothersole	CORE User Network
John Mellor-Clark	CORE IMS Ltd
Pete Bower	NPCRDC
Dave Richards	University of York
Chris Manning	PRIMHE

Role

The role of the Steering Group was to agree:

- The aims, scope and methodology of the research
- The content of the survey
- Who would carry out the survey
- The contact list of services to be asked to complete the survey
- The timetable
- Issues of “commercial confidentiality”
- Questionnaire design
- Evaluation of the results of a pilot survey with researchers and modifications to questionnaire
- Final paper summarising the data
- Mechanisms governing access to the data.

Appendix 2: Survey questionnaire

Mapping Psychological Therapy Services in Primary Care in Britain

[NOTE: this was a web-based questionnaire and not laid out in the format below]

Questionnaire Preamble
This survey is being carried out by Durham University in conjunction with a steering group. The survey was funded by the Artemis Trust, with the support of the I*mproving Access to Psychological Therapies* (IAPT) Board. The Research Management and Governance Unit covering Durham University have determined that the project does not require NHS governance or ethics approval.

The survey will cover England, Scotland, Wales and Northern Ireland.

Although primary care psychological therapy services are now widely provided throughout the NHS there is no accurate current overall picture of that provision.
The aim of this mapping survey is to build an authoritative, factual "map" of existing statutorily and publicly funded NHS primary care psychological therapies services covering provision, staffing, management and practice. The information obtained from the survey will be published in the form of a report which will describe the current level and form of services, and will also be helpful to you to see how your own service fits into the national picture and how it compares with other services in level of provision, services provided, etc. The report will also we hope be of value to policy makers and professional bodies, particularly in planning for the provision of primary care psychological therapy services.

The data will also be available in the form of a website database provided by Durham University.

In the questionnaire, "staff" includes anyone whose job includes providing a psychological therapy service in a publicly funded NHS primary care psychological therapies service, whether psychologist, counsellor, psychotherapist, nurse, CPN, graduate mental health worker, social worker, support worker, mental health worker, etc. This includes those who are employed by the NHS or other agency, and those who are self-employed.

The questionnaire is divided into the following sections:-

- Service identifiers
- Respondent details
- Service type
- Services/interventions provided
- Staffing
- Access to the service
- Management, finance & activity level
- Use of outcome measures.

Section 1. Service Identifiers

1.1 The name of the service in which you work _____

The postcode of the service in which you work _____

1.2 The name of the Primary Care Organisation(s) you serve _____

Section 2. Contact details

2.1 Telephone _____

2.2 Fax _____

2.5 Email address _____

2.3 Opening hours of service _____

2.4 Description _____

Section 3. Service Type

3.1 Is the service best described as one where the staff are (please tick ✓ one box)

Employed by the Primary Care Trust (PCT) ☐

Employed by the local Mental Health Trust ☐

Employed directly by a GP practice or health centre ☐

Employed by a private company or individual ☐

Employed by, or are volunteers with, a voluntary organisation or charitable organisation ☐

Self employed ☐

Other – please write in ..... ☐

3.2 If you ticked (e) or (f) above (that is, if the service providers are employed by, or are volunteers with, a voluntary or charitable organisation, or self-employed).
Does the organisation (or individual staff members if they
are self employed) have a contract of at least 12 months duration with the PCT ?

Yes ☐ No ☐

What is the approximate annual value of the contract? £ .....

3.3 Would the service be best described as providing (please tick ✓ either A or B)

A. Face-to face "talking therapy"

The service will carry out assessment but this will be an assessment of suitability for talking therapy. A small proportion of those assessed may be referred back or referred on.
Staff may also engage in very occasional telephone calls with clients of a supportive nature but this is not considered to be a major part of the service. The service will typically provide an average of 4-6 one-hour sessions to each patient (up to a maximum of perhaps 12). The service is likely to be staffed mainly by counselling psychologists, counsellors and psychotherapists

B. A range of stepped care interventions
A service providing a range of stepped care interventions such as assessment (for a variety of possible interventions or referrals), signposting, referral, guided self help, brief CBT, telephone support, supervised CCBT, psycho-educational groups, case management, collaborative care, etc. The service may include some face-to-face 'talking therapy' but only as one of a much wider range of interventions. The service is likely to be staffed by a variety of staff including graduate mental health workers, assistant psychologists, nurses and other mental health workers.

3.4 Does the service also provide secondary services?

(Primary care services are defined as those normally provided in a primary care setting and targeted at patients with mild to moderate common MH problems – although in practice a proportion of the patients referred may actually prove to be in the severe category when assessed.
Secondary services are defined as those provided in a secondary care setting and targeted at patients with severe and enduring MH problems).
If the answer to this question is Yes, please complete data only for the primary care part of the service in the remainder of this questionnaire

Yes ☐ No ☐

Section 4. Services or interventions provided

In completing this section please do NOT include assessment, referral, brief supportive consultations, handing out information leaflets or other brief treatment provided by GPs or practice nurses – except where a practice nurse provides consultations specifically identified as providing "talking therapy" and where the practice nurse has received specific CBT, counselling or similar training

4.1 What interventions or services are provided (please tick ✓ as many as are appropriate).

Assessment	Yes ☐
Referral to secondary services	Yes ☐
Signposting to voluntary sector, self help groups, etc	Yes ☐
Liaison with workplace, other agencies, voluntary sector, schools, etc	Yes ☐
Provision of information on common MH problems	Yes ☐
Guided self help or bibliotherapy	Yes ☐
CCBT (computerised cognitive behaviour therapy)	Yes ☐
Medication compliance and management	Yes ☐
Progress monitoring	Yes ☐
Guided self help where patient is directly assisted or supervised by a staff member	Yes ☐
CBT	Yes ☐
Other forms of Face to face talking therapy	Yes ☐
Psycho-educational groups	Yes ☐
Other (please specify)	Yes ☐

4.2 If face to face talking therapy is provided what therapeutic modalities are offered (please tick ✓as many as are appropriate).

Creative (Arts)	Yes ☐
Behavioural	Yes ☐
Cognitive	Yes ☐
Cognitive	Yes ☐
Analytic	Yes ☐
CBT	Yes ☐
DBT	Yes ☐
Eclectic	Yes ☐
Integrative	Yes ☐
Interpersonal	Yes ☐
Person centered (or other humanistic)	Yes ☐
Psychoanalytic	Yes ☐
Psychodynamic	Yes ☐
Psychosocial	Yes ☐
Solution focused	Yes ☐
Systemic/family	Yes ☐
Other (Please specify)	

4.3 If face to face talking therapy is provided what is the average number of sessions provided?

Up to 8	Yes ☐
9-16	Yes ☐
17 or more	Yes ☐

4.4 If face to face talking therapy is provided what lengths of session are most commonly conducted?

Up to 15 minute sessions	Yes ☐
16-49 minute sessions	Yes ☐
50 minute or more sessions	Yes ☐

4.5 If groups are provided what groups are run?

Anger management	Yes ☐
Stress management groups	Yes ☐
Depression	Yes ☐
Low self esteem	Yes ☐
OCD	Yes ☐

Other (please specify) .....

4.6 Please specify any language(s) that staff are fluent in to allow them to conduct therapy in that language.

Section 5. Staffing

5.1 How many staff do you employ on a clinical contract? Total headcount ☐

5.2 Which professions are represented by your staff team? (Tick as many as are relevant)

Counselling psychologist	☐
Clinical psychologist	☐
Health psychologist	☐
Assistant or other psychologist	☐
Counsellor or psychotherapist	☐
Psychiatric Nurse, RMN	☐
General Nurse, RGN	☐
Occupational Therapist	☐
Creative Therapist	☐
Social Worker	☐
Support worker	☐
Case manager	☐
Support worker	☐
Case manager	☐
Graduate Primary Care MH worker	☐
Mental health worker	☐
Voluntary or unpaid counsellors (irrespective of profession)	☐

Other (please specify) .....

5.3 How many clinical hours per week are spent on direct client contact? ☐

5.4 How many non-clinical hours are delivered? ☐

5.5 Number of staff by *Agenda for Change* grade (if known) or salary band

4 (£15,000-20,000)	☐
5 (£20,001-25,000)	☐
6 (£25,001-30,000)	☐
7 (£30,001-35,000)	☐
8a (£35,001-40,00 0)	☐
8b (£40,001-50,000)	☐
8d (£50,001-60,000)	☐
9 (over £60,000)	☐
Not graded	☐

5.6 How many of your staff are registered with the BPS, BACP or UKCP? ☐

5.7 For employers not using Agenda for change grades, please give an indication of the pay scales or salary/session/hourly rates paid? ☐

5.8 In which setting(s) do individual staff members each work?

One or more specific practice/health centres to which the individual is permanently attached	Yes ☐
A specialist NHS centre (e.g. community team base)	Yes ☐
A centre run by a voluntary or independent agency	Yes ☐
Some of the time at each of the above	Yes ☐
Other (please specify)	Yes ☐

Section 6. Access to the service

6.1 Is the patient normally required to "opt in" to treatment by the service ? Yes ☐ No ☐

6.2 Is there an age limit below which clients are not accepted Yes ☐ No ☐

If Yes, what is that age .....

6.3 Is there an age limit below which clients are not accepted Yes ☐ No ☐

If Yes, what is that age .....

6.4 How does the assessment process operate ? (please tick ✓only one of the two options)

All patients referred by GP are channelled to an initial assessment where they are referred to particular forms of treatment intervention (the "one stop" shop policy) Yes ☐

Each patient is referred by the GP to one of a number of staff members who assess suitability for the treatment interventions they provide and then provides the interventions (referring elsewhere if unsuitable) Yes ☐

Other (specify) .....

6.5 What is your estimate of the average waiting time (over the last 6 months) in days from referral to first session/intervention/consultation? (tick ✓ only one option)

40 days or less ☐

41-70 days ☐

71-90 days ☐

91 days or over ☐

6.6 Is the waiting list closed from time to time either centrally or locally by GPs?

Yes ☐ No ☐

6.7 Is there a limit on the number of patients a GP is allowed to refer to the service per month?

Yes ☐ No ☐

If Yes what is the limit? .....

6.8 What is your estimate in days of:

The minimum waiting time experienced by clients over the last 6 months .....

The maximum waiting time experienced by clients over the last 6 months .....

6.9 Are clients commonly assigned to a counsellor/therapist for a period of some weeks? Yes ☐ No ☐

6.10 Are patients commonly assigned to a case worker / case manager / key worker / link worker for a period of some weeks? Yes ☐ No ☐

6.11 Is there an agreed policy or procedure for contacting patients and monitoring progress at scheduled intervals? Yes ☐ No ☐

Is there an agreed policy or procedure for contacting patients who fail to attend without giving notice? Yes ☐ No ☐

6.12 Is there a maximum number of sessions initially offered to a client? Yes ☐ No ☐

If Yes, what is that maximum number

6.13 Is there a procedure by which additional sessions can be given to a client? Yes ☐ No ☐

6.14 What is your best estimate of the average number of therapy sessions received by clients over the last 6 months?

6.15 What is your best estimate of the maximum number of therapy sessions received by a client over the last 6 months?

Section 7. Management & Finance

7.1 Is the overall management of the service best described as being the responsibility of (please tick ✓ only one option)

A service manager (who may or may not have a number of team leaders reporting to them) Yes ☐

A service "lead" Yes ☐

A number of team leaders or "leads" within the service Yes ☐

A lead in the Mental Health Trust Yes ☐

Not managed as a group – e.g. the service consists of a group of self employed practitioners providing a service Yes ☐

Other (please specify) ..... Yes ☐

7.2 If there is a service manager or lead

What is their *Agenda for Change Grade?* (If not graded please indicate) .....

What are their professional and psychological therapy qualifications? .....

How many years of psychological therapy experience do they have? .....

Which professional bodies are they members of? .....

How many years of managerial experience do they have? .....

If they have received any formal management training, please give details .....

7.3 How many whole time equivalent administrative staff are employed by, or available to, the service

7.4 What is the annual budget (covering only staff and on-costs) for the service?

7.5 What is the source of funding (please tick ✓ only one option)

NHS only Yes ☐

NHS & other Yes ☐

Other only (please specify ..... Yes ☐

7.6 If you know it, what is the cost per clinical hour ?

7.7 What is the total number of patients referred to the service each year (please give figures for the last full year)

7.8 Please tick all of the GP practices or health centres to which you provide a service. If the practice you serve does not appear in the list then please add the first part of the postcode to the list above and click 'Save' at the top or bottom of the page.

7.9 Has the service expanded in the last 5 years? Yes ☐ No ☐

Has the service contracted in the last 5 years? Yes ☐ No ☐

If either, please give details, including the size (in wte or %) of the change

Are you forecasting any major change in your contract or the service that you deliver in the next 12 months? Yes ☐ No ☐

Section 8. Use of outcome measures

8.1 Does the service use an outcome measure? (please tick ✓ only one of the four options)

Yes, use is obligatory on a routine basis with nearly all patients (except where client declines)	Yes ☐
Yes, with a substantial proportion (50% or more) of patients	Yes ☐
Yes, but with only a minority (49% or less) of patients	Yes ☐
No, not at all	Yes ☐

8.2 If Yes, please specify outcome measure(s) used

CORE-OM	CORE-PC	BDI	HADS	PHQ-9	GAD-7	DASS	Others (pl specify)

Section 9. Is there any other information about your service that you think is distinctive, or that helps to better describe it?