

COMPLETING THE REVOLUTION

COMMISSIONING EFFECTIVE TALKING THERAPIES

A paper by Dr Samantha Callan and Benjamin Fry

April 2012



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About the Centre for Social Justice

The Centre for Social Justice (CSJ) aims to put social justice at the heart of British society.

Our policy development is rooted in the wisdom of those working to tackle Britain's deepest social problems and the experience of those whose lives have been affected by poverty. Our Working Groups are non-partisan, comprising prominent academics, practitioners and policy makers who have expertise in the relevant fields. We consult nationally and internationally, especially with charities and social enterprises, who are the champions of the welfare society.

In addition to policy development, the CSJ has built an alliance of poverty fighting organisations that reverse social breakdown and transform communities.

We believe that the surest way the Government can reverse social breakdown and poverty is to enable such individuals, communities and voluntary groups to help themselves.

The CSJ was founded by Iain Duncan Smith in 2004, as the fulfilment of a promise made to Janice Dobbie, whose son had recently died from a drug overdose just after he was released from prison.

Managing Director: Dr Jeffrey Bailey

Commissioning Effective Talking Therapies

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Benjamin Fry

Benjamin Fry developed an interest in psychotherapy during varied personal treatment which began in his twenties. After a degree in physics and philosophy, Benjamin studied psychotherapy at Regent's College in London. Benjamin founded Khiron House to bring effective treatment to the private sector; and the social enterprise Get Stable to make access to these and other treatments more available via the state.

Declaration of interest: Benjamin Fry founded the voluntary sector organisation Get Stable which provides therapeutic services to the Work Programme, and would be able to do so to the NHS under a Payment by Outcomes model for talking therapies.

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Executive summary

In October 2011 the Centre for Social Justice (CSJ) published *Completing the Revolution: Transforming mental health and tackling poverty*.¹ This report emphasised the need for more accessible mental health services and early intervention to prevent problems from becoming entrenched. We also argued that the Government's current commissioning reforms offer an opportunity for creative and flexible service design that breaks out of existing professional silos. Although we welcomed the advent of the Improving Access to Psychological Therapies (IAPT) programme for adults and children, we were clear that it needs developing and improving, particularly in terms of choice and accessibility, if people's needs are to be met.

The Government has committed to spend an additional £400 million over the next four years on a limited range of National Institute for Health and Clinical Excellence (NICE) approved talking therapies, despite a recovery rate of only around 15% of all referrals.^{2,3} We noted that many forms of psychological therapy that may be able to achieve good outcomes and so increase the rate of recovery have not yet had the opportunity to undergo the research procedures necessary to achieve NICE approval. As a result, many people are losing out on accessing a wider range of effective therapies through the National Health Service (NHS) because IAPT is limited to using NICE approved methods.

The Department of Health (DH) is currently working to develop the regulatory criteria for increasing the supply of adult talking therapy. A number of Primary Care Trusts (PCTs) have elected to become pathfinders in establishing this precedent.⁴ This paper is therefore particularly written for decision makers in these early processes, and those involved in subsequent national iterations.

A key issue is which providers will be allowed to supply talking therapy to the NHS and be considered suitable for Any Qualified Provider (AQP) status. Current draft DH guidelines for defining AQP recommend commissioning only from suppliers providing an analogous service

1 Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, 2011

2 Department of Health, *Talking therapies: A four-year plan of action. A supporting document to No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, London: Department of Health, 2011 [accessed via: <http://www.iapt.nhs.uk/silo/files/talking-therapies-a-four-year-plan-of-action.pdf> (15.02.12)]

3 NHS Information Centre, *Improving Access to Psychological Therapies Key Performance Indicators (IAPT KPIs) Q1 2011/12 final and Q2 2011/12 provisional*, The Health and Social Care Information Centre, 2011 [accessed via: <http://www.ic.nhs.uk/pubs/psychologicaltherapies1112> (24.02.12)]

4 These are currently NHS Tees; Calderdale; Kirklees; Wirral; Nottinghamshire; Derbyshire; Cheshire; Gloucester; Swindon; Bristol; North Somerset; Dorset; Cornwall; Isle of Scilly; Surrey; West Kent; Eastern and Coastal Kent [to track on-going additions to this list see: <http://www.supply2health.nhs.uk/AQPResourceCentre/AQPMap/AQPMap.aspx> (20.01.12)]

to the IAPT programme, which is by far the largest existing NHS Talking Therapy service.⁵ This risks there being no tangible increase in choice for the service user.

The first service specification inviting public tender for AQP was published on 19 March 2012 by Dorset PCT. It has followed DH guidelines and specified its intention to 'build firmly on the Improving Access to Psychological Therapies (IAPT) programme...[using] NICE approved/recommended psychological therapies in line with relevant clinical guidance'.⁶ This means that a DH process which began with a consultation with the public about choice finishes with a tender to the market that will deliver no additional choice in terms of available treatment. This is despite patients and doctors wanting choice of treatment, not simply choice of providers of the same treatment. Finally there are key implications for the personalisation agenda: it should be possible for personal health budgets to be spent on as wide a range of therapies as possible, taking into account all the safety considerations outlined here

This paper proposes a means by which choice and access can be significantly improved to enable more people to recover from mental illness and avoid dependency and despair. We recommend using a Payment by Outcome commissioning approach, whereby voluntary and private sector providers of talking therapy are commissioned by the NHS to work at their own financial risk (delivering therapies recognised by the NHS) until they have achieved a proven effective outcome with each client. Minimum standards are essential for the safe delivery of therapy but the Payment by Outcome mechanism would obviate the need, in this area of healthcare, for the higher barrier of NICE guidelines. The need to comply with NICE guidelines severely limits the types of therapies that can be widely delivered through the IAPT programme.

Many other types of therapies (or 'modalities') for which an evidence base is gradually growing are recognised by the NHS and delivered in a handful of locations. A large number of therapists have been trained in these modalities but can only practise in the private and voluntary sectors because the vast majority of NHS Talking Therapy funding is invested in IAPT. The needs of those who cannot afford to pay for treatment, but whose recovery will not be achieved through the limited range of therapies IAPT offers, routinely go unmet.

Currently the Government's Work Programme can address the mental health needs of some of its client base through a 'black box' approach.⁷ In doing so it does not specify the therapies which can be delivered but instead rewards outcomes. It therefore operates in the opposite way to NICE guidelines, which very precisely specify activities, regardless of outcomes. This means that if an individual on the Work Programme needs talking therapy, they can be sent to a therapist who is not following NICE guidelines, but at the same time a GP cannot send an individual with the same problem for identical treatment. This results in a perverse inequality of access

5 Department of Health, *Primary Care Psychological Therapies (Adults) Implementation Pack* [accessed via: http://www.supply2health.nhs.uk/AQPResourceCentre/Documents/111130%20PCPT_Adults_%20Implementation%20Pack%20FINAL.pdf (20.02.12)]

6 Bournemouth and Poole NHS Trust, *2012/13 NHS Standard Contract For Acute, Ambulance, Community and Mental Health and Learning Disability Services (Multilateral)* [accessed via: <http://www.bournemouthandpoole.nhs.uk/WVS-Pan-Dorset/Downloads/Shared-Content/About%20us/Contracts%20and%20tenders/Primary%20care%20psychological%20therapies/PCPT%20Service%20Specification%20%20final.pdf> (22.03.12)]

7 The Work Programme is a Department for Work and Pensions (DWP) programme which provides tailored support for welfare claimants to help them find and stay in work. It is delivered by a range of DWP-contracted service providers who are paid almost entirely on the basis of results, defined as sustained job outcomes for participants.

whereby someone who is out of work and on benefits is able to take advantage of a far greater choice of talking therapies through the Work Programme than someone who is in work.

The Work Programme's service providers routinely synchronise interventions to prevent entrenched dependency. However this synchronisation could be greatly enhanced if talking therapy was also delivered on a Payment by Outcome basis as standard across the NHS, and if all health services in general were more focussed on enabling people to stay in work or get back to work when they encounter mental health problems. If NHS Talking Therapy services were 'pulling together' more effectively with the aims of the Work Programme, and therapists paid on a consistent basis, budgets for therapy could be pooled to far greater effect.

This paper describes how, using a similar approach, the DH can make Payment by Outcome commissioning a positive change, creating a range of safe, fresh choices without having to invest in a new workforce, and without wasting public money on unsuccessful treatments. Finally there are key implications for the personalisation agenda: it should be possible for personal health budgets to be spent on as wide a range of therapies as possible, taking into account all the safety considerations outlined here.

Recommendations

1. The DH should explicitly propose to commissioners a pricing tariff for AQP commissioning for talking therapy which allows for 'pure' Payment by Outcome contracts to be written for services which operate to standards of NHS safety, but which supply therapies beyond NICE guidelines.

This will provide a mechanism for NHS service users to gain access to thousands of qualified and experienced therapists and counsellors working in the private sector and some hundreds of established services, mostly in the voluntary sector. Currently, an NHS patient can only very rarely choose to be treated by one of these therapists or services.

It was the DH's intention that the AQP programme should respond to requests for patient choice of therapists or services. Payment by Outcome commissioning removes the barriers to doing so and thus allows the implementation of AQP for talking therapy to provide patients with the widest possible choice amongst proven services and therapists.

2. Alongside this tariff commissioning advice, the DH should provide clear guidelines to NHS commissioners that the barrier for entry for AQP, in all aspects of safety, including the type of therapy they deliver when commissioning competition from the private and voluntary sectors for talking therapy, should be set to equivalence with the common requirements of all the in-house NHS psychotherapy services, rather than at the level of NICE guidelines.

Specifically, qualifying therapists must:

- Be accredited by UKCP, BACP, BPS, BPC, CPCAB or CPC, with all of the on-going requirements of accreditation and adherence to their complaints procedures;

- Provide proof of regular attendance at supervision with an accredited supervisor; hold valid insurance and have an enhanced Criminal Records Bureau certificate;
 - Undertake to practise only modalities of therapy professionally recognised (by UKCP, BACP, BPS, BPC, CPCAB and CPC) and in which the therapist has been trained and qualified;
 - Ensure that every patient is routinely assessed for risk (of suicide, self-harm or harm to others). Appropriate risk management protocols must be followed where risk is believed to exist.
3. To reflect differing case-mixes across services and to avoid 'cherry-picking' the easier cases, the difficulty of reaching recovery should arguably be reflected in the level of tariff paid to achieve that outcome. This can be done by basing it on the existing NHS mental health clustering tool (HoNOS-PbR) which measures which cluster the person falls into and therefore can be used as an established metric for assessing the distance that a service user is from recovery when starting with the service. Payment by Outcome commissioning needs to offer different tariffs for different clusters, analogous with the Work Programme's existing pricing structure.
 4. The DH should make it clear that it is the Government's aim to move decisively towards Payment by Outcome for all talking therapy services wherever possible, and to provide adequate public data to compare different talking therapy services on their outcomes for the same cost. The quality metric of measuring patient recovery is well established in psychological therapies but never quoted against cost. Existing IAPT and other NHS provision should become accountable for their recovery rates per unit of funding as a clear measure of the quality of their services. A Payment by Outcome model should aim to avoid barriers to participation for effective providers, such as those faced by small voluntary sector organisations in the Work Programme.
 5. In terms of local organisation, we also recommend that one main ('prime') provider subcontract the therapy workload to a fairly large number of small providers of therapy services under the AQP policy. This transfers a large part of the administrative and organisational burden from PCTs and Clinical Commissioning Groups (CCGs) to the main provider. If this provider had to compete for the main contract renewal every few years, this would enable the 'market' to offer a high degree of both choice and competition.
 6. Due to the confusion generated by DH using the term 'Payment by Results' (PbR) in a way that is quite different to other Departments, we recommend that the DH's use of the term is brought into conformity with that employed by the rest of Government.

Note on terminology

The DH and the NHS tend to use the term 'Payment by Results' (PbR) to mean something different to policy makers elsewhere in Government, such as in the Cabinet Office, the Department for Education (DfE) and the Department for Work and Pensions (DWP). Table 1 explains the different use of terms to avoid confusion.

Table 1: Glossary of terms	
DH/NHS	Government policy
Payment by Results (PbR) <i>is the equivalent of</i>	Payment for Activity
Payment by Outcome <i>is the equivalent of</i>	Payment by Results (PbR)

As this paper focuses on commissioning in the NHS, it will focus on the DH/NHS language of Payment by Outcome to refer to the idea that payment is only made if a desired *outcome* is reached.

This paper also touches on these issues from a broader policy perspective, so occasionally it is necessary to reference the idea of 'PbR'. Thus when 'PbR' is used in this paper, it refers to the bottom right-hand corner of the table: the Government policy which dictates that it is only when a desired outcome of a service is reached that some or all payment is made to the supplier of that service. In a 'pure' form, this involves a hard binary relationship (no outcome, no fee) but more than one outcome may be included.

Due to the confusion generated by DH using the term 'Payment by Results' (PbR) in a way that is quite different to other Departments, we recommend that the DH's use of the term is brought into conformity with that employed by the rest of Government.

chapter one

Introduction

The Centre for Social Justice (CSJ) published a major report on mental health in October 2011 which emphasised the need for more accessible mental health services and early intervention to prevent problems from becoming entrenched.¹ We also argued that the Government's commissioning reforms provide a chance for creative and flexible service design that breaks out of existing professional silos. We stated that 'Clinical Commissioning Groups, especially those serving the more deprived areas, should make this a priority and vigorously use the new rules on competition and choice to increase access (for example to psychological therapies) and drive up quality'.²

Although we welcomed the advent of the Improving Access to Psychological Therapies (IAPT) programme for adults and children, we were clear that it needs developing and improving, particularly in terms of choice and accessibility, if people's needs are to be met. Much more needs to be done to ensure that:

- Therapy is available to all those who may benefit from it and people are given a real choice of effective treatments, and;
- Waiting times from referral to treatment reduce markedly and people receive sufficient sessions to make genuine progress.

Psychological therapies, or talking therapies, refer to a range of interventions which are intended to help people understand and make changes to their thinking, behaviour and relationships in order to relieve distress and to improve functionality. We noted that many forms of talking therapy that may be able to achieve good outcomes have not yet had the opportunity to undergo the research procedures necessary to achieve National Institute for Health and Clinical Excellence (NICE) approval.³ As a result many people are losing out on accessing a wider range of effective therapies through the National Health Service (NHS).

1 Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, 2011

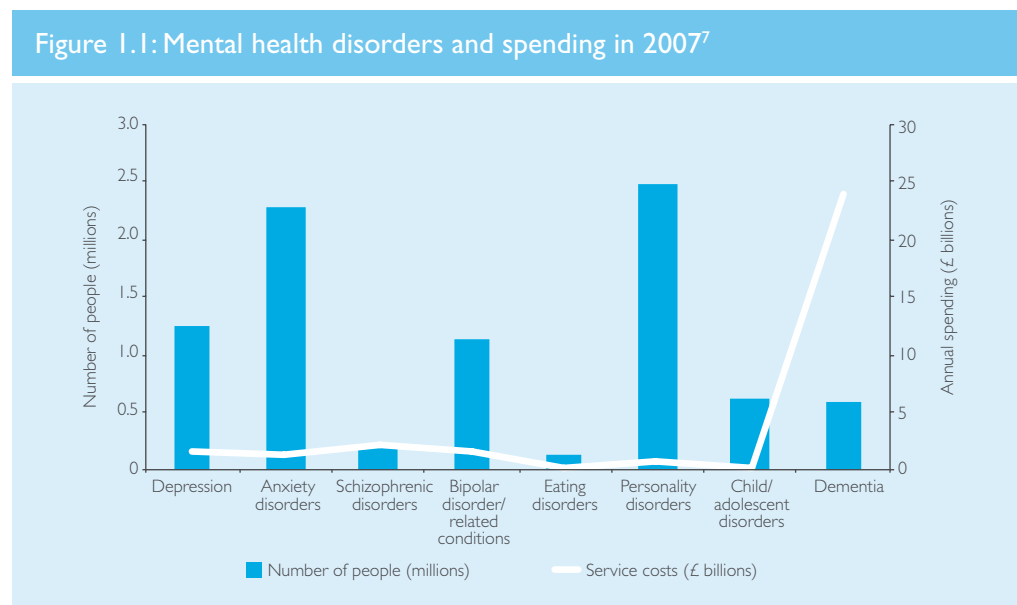
2 Ibid, p19

3 NICE develops guidance and other products to support healthcare professionals by working with experts from the NHS, local authorities, and others in the public, private and voluntary sectors, including patients and the public

The aim of this paper is to propose a means by which choice and access can be significantly improved so that more people recover from mental illness and thus avoid dependency and despair. We recommend using a Payment by Outcome commissioning approach, whereby the voluntary and private sector providers of talking therapy are commissioned by the NHS to work at their own financial risk (delivering therapies recognised by the NHS) until they have achieved a proven effective outcome with each client.

1.1 Broad policy context

Mental health problems are estimated to cost the economy around £105 billion annually.⁴ Public spending on mental healthcare makes up approximately 12 per cent of the commissioning budgets of NHS primary care trusts (PCTs).⁵ As Figure 1.1 shows, treating depression and anxiety disorders in England cost nearly £3 billion in 2007, with an estimated loss of around £13 billion in earnings sustained by people of working age.⁶



Completing the Revolution highlighted the immense human costs of untreated mental health problems and the need for effective and early intervention:⁸

Depression, anxiety and trauma do not discriminate in who they affect. Once they have hit at concentrated, disabling levels, they can take the individual on a whirl-wind rollercoaster ride to decline: from a secure life to extreme poverty, homelessness, debt, unemployment, family breakdown, stigma, and social exclusion in less than three months (or even quicker).

4 Centre for Mental Health, *The Economic and Social Costs of Mental Health Problems in 2009/10*, London: Centre for Mental Health, 2010 [accessed via: http://www.centreformentalhealth.org.uk/pdfs/Economic_and_social_costs_2010.pdf (15.02.12)]

5 The King's Fund, *NHS Spending, Local variations in priorities: an update*, London: The King's Fund, 2008 [accessed via: http://www.kingsfund.org.uk/publications/nhs_spending.html (15.02.12)]

6 Department of Health, *Primary Care Psychological Therapies (Adults) Implementation Pack* [accessed via: http://www.supply2health.nhs.uk/AQPRResourceCentre/Documents/111130%20PCPT_Adults_%20Implementation%20Pack%20FINAL.pdf (15.02.12)]

7 The King's Fund, *Paying the price: the cost of mental health care in England to 2026*, London: The King's Fund, 2008, p118, graphic provided by 2020

8 Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, 2011

Recovery could take years and the fall-out effects on other family members (children, parents, siblings, grand-parents, cousins) can mean that this individual nuclear bomb of depression and anxiety can cascade to others and affect others for further generations.⁹

Failing to move people into recovery following mental health problems can cause damaging and unacknowledged depths of despair, which in turn severely limits their potential, puts greater stress on family relationships and greatly increases the likelihood of welfare dependency.

It is widely recognised how crucial it is for governments to reduce unnecessary dependency on the state, not only for fiscal reasons, but also in the interests of social justice, given the lack of opportunities such dependency entails. Far too many people are trapped in a vicious cycle of dependency that is often intergenerational and ensues from the interaction of the five 'pathways to poverty' that the CSJ has identified. These are:

- Family breakdown;
- Educational failure;
- Economic dependency and worklessness;
- Addiction to drugs and alcohol;
- Damaging and unmanageable personal debt.

Compelling research shows that these pathways also contribute to the development or sustainment of poor mental health, and usually build on pre-existing vulnerabilities towards such conditions which may themselves have a variety of deeper or earlier causes.¹⁰ These can include the intergenerational consequences of being the child of a parent who has been subject to one or more of the interlocking pathways to poverty described above, or current difficulties with maintaining supportive adult relationships which can enhance resilience and offer some protection to these pre-existing vulnerabilities. This perpetuates a cycle of social injustice.

These individuals often find it very hard to get a good education, hold down a job or stay debt-free (and thus avoid this major stressor). Many people with mental health problems self-medicate with drugs and alcohol. This creates poor environments and family systems which reduce a child's opportunity to grow into a mentally healthy adult.

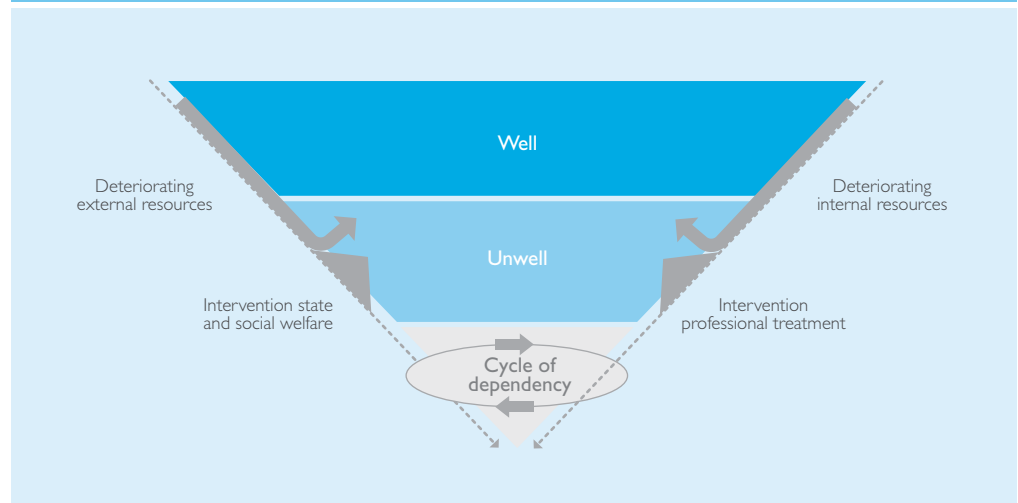
Mental health problems can affect anyone, at any time. Whilst it is true that poor mental health can lead to family breakdown, it is also true that unhappy relationships and family breakdown drive poor mental health. A survey of comorbidity shows clear links between increased levels of mood disorder, anxiety disorders and substance abuse and marital distress.¹¹ It is therefore essential that effective help is available as early as possible to prevent a sharp downward fall into the vicious cycle of dependency which tends to result from a loss of both external and internal resources and is perpetuated by worsening mental health. This is illustrated in Figure 1.2, as is the intended effect of intervention on these pathways.

9 My Time CIC, *Evaluation Report: Family Action for Choice Tomorrow* (2009–2011), p2 (project validated by C4EO); for more details see C4EO, *Early Intervention* [accessed via: <http://www.c4eo.org.uk/themes/earlyintervention/vlpdetails.aspx?lpeid=312> (19.03.12)]

10 Centre for Social Justice, *Mental Health: Poverty, Ethnicity and Family Breakdown, Interim Policy Briefing*. London: Centre for Social Justice, 2011

11 Whisman A, 'Marital dissatisfaction and psychiatric disorders: results from the national comorbidity survey', *Journal of Abnormal Psychology*, 108(4), 1999, pp701–706

Figure 1.2: Pathways into a cycle of mental distress and dependency



Deteriorating internal resources, such as a descent into depression, tend to lead to declining external resources, such as the loss of a job, a relationship or home. These then tend to lead to worsening internal resources, as explained above. The effect thus becomes compounded without timely and coordinated intervention.

Successive governments have invested considerable resources in order to shore up the left-hand side of Figure 1.2, but work to support the right-hand side is neither synchronised nor sufficiently developed. If both sides were supported simultaneously and effectively, then the cycle of dependency would naturally begin to ease as fewer people fall into it. This would allow external resources to function more efficiently and internal personal resources inherent in strong relationships to flourish.¹²

Intervention in the form of direct financial assistance on the left-hand side of Figure 1.2 is being redirected by the Treasury and the Department for Work and Pensions (DWP) and investment is instead being made in PbR activities such as the Work Programme.

The right-hand side of Figure 1.2 is dominated by NHS treatment provision, which is expensive to deliver and not funded on the basis of outcomes. Talking therapies are an important alternative as well as complement to pharmacological forms of this intervention.

By meeting 'internal' mental health needs as well as ensuring that individuals have 'external' resources (such as benefits, back-to-work training etc), the Work Programme routinely synchronises interventions to prevent entrenched dependency. This synchronisation could be greatly enhanced if therapy was delivered on a Payment by Outcome basis as standard across the NHS, and if all health services in general were more focussed on enabling people to stay in work or get back to work when they encounter mental health problems. If NHS therapy services were 'pulling together' more effectively with the aims of the Work Programme, and

¹² Balfour A, Morgan M and Vincent C, *How couple relationships shape our world: clinical practice, research and policy perspectives*, London: Karnac Books Ltd, 2012

therapists paid on a consistent basis, budgets for therapy could be pooled to far greater effect. In summary, a better-coordinated national response to worklessness and dependency would be facilitated by the widespread delivery of therapy on a Payment by Outcome basis in the way we propose below.

The DH announced in July 2011 that the NHS should increase the choice of adult talking therapy.¹³ Whilst this was a development we welcomed, existing guidelines¹⁴ exclude from this at least 17,000 of the UK's available, accredited and trained talking therapy professionals.¹⁵ Such exclusion is on the grounds that they deliver services which do not as yet fit into the slowly evolving NICE guidelines treatment recommendations for psychological therapies.

The DH is currently working to develop the regulatory criteria for increasing the supply of adult talking therapy. A number of PCTs have elected to become pathfinders in establishing this precedent.¹⁶ This paper is therefore particularly written for decision makers in these early processes, and those involved in subsequent national iterations.

A key issue is which providers will be allowed to supply talking therapy to the NHS and be considered suitable for Any Qualified Provider (AQP) status. Current draft DH guidelines for defining AQP recommend commissioning only from suppliers providing an analogous service to the IAPT programme, which is by far the largest existing NHS Talking Therapy service.¹⁷ This risks there being no tangible increase in choice for the service user.

The first service specification inviting public tender for AQP was published on 19 March 2012 by Dorset PCT. It has followed DH guidelines and specified its intention to 'build firmly on the Improving Access to Psychological Therapies (IAPT) programme...[using] NICE approved/recommended psychological therapies in line with relevant clinical guidance'.¹⁸ This means that a DH process which began with a consultation with the public about choice finishes with a tender to the market that will deliver no additional choice in terms of available treatment. This is despite patients and doctors wanting choice of treatment, not simply choice of providers of the same treatment.

This paper reviews the current barriers to delivering cost-effective talking therapy nationwide using the full capacity of the existing national talking therapy workforce. It proposes a Payment

13 Department of Health, *Liberating the NHS: greater choice and control – Government response. Extending patient choice of provider (Any qualified provider)*, London: Department of Health, 2011 [accessed via: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128539.pdf (15.02.12)]

14 *Improving Access to Psychological Therapies, IAPT Programme Review*, Improving Access to Psychological Therapies, 2011 [accessed via: <http://www.iapt.nhs.uk/silo/files/iapt-programme-review-december.pdf> (21.02.12)]

15 Estimate based on BACP and UKCP combined numbers provided in 2012. These two bodies have around 9,500 (BACP) and 7,300 (UKCP) accredited practitioners who are available and working (delivering therapies)

16 These are currently NHS Tees; Calderdale; Kirklees; Wirral; Nottinghamshire; Derbyshire; Cheshire; Gloucester; Swindon; Bristol; North Somerset; Dorset; Cornwall; Isle of Scilly; Surrey; West Kent; Eastern and Coastal Kent [to track on-going additions to this list see: <http://www.supply2health.nhs.uk/AQPResourceCentre/AQPMap/AQPMap.aspx> (20.01.12)]

17 Department of Health, *Primary Care Psychological Therapies (Adults) Implementation Pack* [accessed via: http://www.supply2health.nhs.uk/AQPResourceCentre/Documents/111130%20PCPT_Adults_%20Implementation%20Pack%20FINAL.pdf (20.02.12)]

18 Bournemouth and Poole NHS Trust, *2012/13 NHS Standard Contract For Acute, Ambulance, Community and Mental Health and Learning Disability Services (Multilateral)* [accessed via: <http://www.bournemouthandpoole.nhs.uk/WVS-Pan-Dorset/Downloads/Shared-Content/About%20us/Contracts%20and%20tenders/Primary%20care%20psychological%20therapies/PCPT%20Service%20Specification%20%20final.pdf> (22.03.12)]

by Outcome commissioning solution based on the PbR methodology currently being applied elsewhere in Government (and included in the welfare interventions indicated on the left-hand side of Figure 1.2 above).

We recommend, accordingly, the possibility of creating a unified commissioning structure which works equally efficiently on both the left and the right-hand sides of Figure 1.2. This could lead to a breakthrough in tackling the overarching problem of deteriorating personal resources. Couple therapy, for example, can tackle family breakdown, which is emotionally and financially costly. At present, interventions necessary to augment internal and external resources are being delivered 'out of sync' and without sufficient intensity. Any problem which is not dealt with effectively on both sides of this triangle risks becoming a failure for each of them; like two holes in a dyke, they both need plugging simultaneously and effectively to solve the overall problem of the descent into dependency.

chapter two

Talking therapy in the UK

2.1 The private and voluntary sectors

There is a very large talking therapy market outside the NHS provided by the voluntary and private sectors. As Figure 2.1 illustrates, an individual with a mild to moderately severe level of mental ill-health has a range of local service centres to choose from. These can be national, such as Relate or Mind, or local, such as a faith-based counselling service, a Black and Minority Ethnic counselling service, a women's centre, a gay and lesbian service etc. There is also a choice of a substantial number of professionally qualified and experienced therapists in private practice locally.

There are hundreds of private practitioners working in many local settings and, as stated earlier, around 17,000 professionally qualified therapists accredited at the highest level by registration bodies, many of whom work in private practice. The voluntary and private sector talking therapy provision has a capacity to supply at potentially eight times the size of the existing provision within the NHS.¹

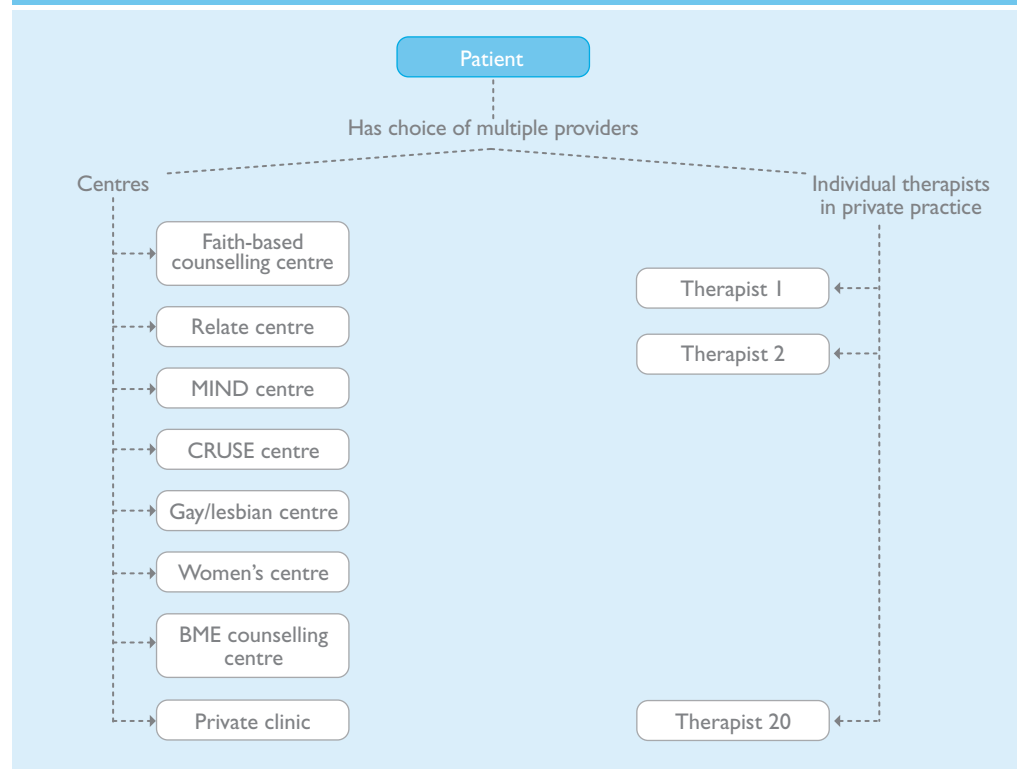
However, many people currently have very limited access to these services because of the fees charged in the private sector. Even voluntary sector services generally require a minimum contribution towards fees, and the pressure to collect revenue is currently building because other sources of funding are declining.

Given the highly personalised nature of mental distress, choice plays a more significant role in the talking therapy field than in many other fields of healthcare. Two key drivers of patient recovery are the quality of a therapist and engagement by the patient. Greater choice will promote both of these and so choice is important not just for its own sake but in order to drive up recovery. Accordingly, a requirement to provide extra choice in the NHS for

¹ Improving Access to Psychological Therapies, *IAPT Programme Review*, Improving Access to Psychological Therapies, 2011 [accessed via: <http://www.iapt.nhs.uk/silo/files/iapt-programme-review-december.pdf> (21.02.12)]

patients in adult talking therapy would lead to better outcomes from existing services without requiring the creation of any new services.

Figure 2.1: Range of counselling and talking therapy options typically available outside the NHS



Evidence gathered from service users² shows that the key elements and influences within a patient's decision-making include:

- Convenience of location (for example, our experience shows that the centre or therapist simply being on a convenient bus route can be decisive);
- Availability at a convenient time (it can often be hard to take time off work or arrange childcare around a series of weekly visits);
- The particular specialisation required (such as faith-based counselling, BME, sexual orientation);
- How the individual perceives their problem (for example, whether it is viewed as a relationship-based problem, a bereavement, or an issue which requires couple therapy);
- Therapeutic orientation;
- The therapist's personal profile (for instance, gender, age, ethnicity, life experience as a parent and living with a disability can all be important factors);
- The cost of the service.

2 For example, see Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, 2011

The range of choice of talking therapy open to the patient is much greater in the voluntary and private sectors than in existing NHS provision. This is because most NHS Talking Therapy services are IAPT services which supply exclusively according to relatively restrictive NICE guidelines for psychological therapies. This typically results in only a small range of modalities being available to NHS patients, most notably cognitive behavioural therapy (CBT).

2.2 Improving Access to Psychological Therapies (IAPT) and the role of NICE

The NHS provides talking therapy through in-house psychotherapy services and IAPT. Talking therapy is a subset of the NHS's mental health treatment options and is usually used for clients with less severe mental health problems, or in conjunction with medication for more severe cases.

The 2005 Layard report highlighted the economic impact of common mental health disorders (particularly depression and anxiety) and made a case for raising government spending on talking therapy as an effective means of treatment.³ As a result, IAPT commenced with two pilot services in 2006, which expanded rapidly over the course of the next five or six years to the point where it now effectively covers the whole of England.

NICE guidelines for the treatment of depression and anxiety, which were being developed over much the same time period, recommended a particular form of talking therapy, CBT, on the grounds that this form of therapy had the most Randomised Controlled Trial (RCT) supporting evidence for its effectiveness. More recently, NICE guidelines have been relaxed to include a few other types of talking therapy for the treatment of somewhat limited conditions.

Non-IAPT NHS Talking Therapy services generally employ a wider range of therapies and do not adhere to NICE guidelines for depression and anxiety closely, although they do of course adhere to the patient safety aspects of NICE guidelines very strictly.

In contrast, until relatively recently in most IAPT services only CBT was available, on the grounds that they were following NICE guidelines for depression and anxiety (with which the vast majority of clients present at this level of treatment) very closely. Recently, and in keeping with the more relaxed NICE guidelines, some IAPT services have been offering a slightly wider choice of therapy. The IAPT position on which talking therapies are provided can be seen as somewhat anomalous because over 70 per cent of patients present with *mixed* anxiety/depression and NICE have not published any guidelines for the treatment of mixed anxiety/depression.⁴

3 Layard R, *Mental health: Britain's biggest social problem?*, Paper presented at the No.10 Strategy Unit Seminar on Mental Health, 20 January 2005 [accessed via: <http://cep.lse.ac.uk/textonly/research/mentalhealth/RL414d.pdf> (22.03.12)]

4 National Institute for Health and Clinical Excellence, *Cognitive behavioural therapy for the management of common mental health problems, Commissioning guide: Implementing NICE guidance*, April 2008, p21 states 'NICE clinical guideline CG22 on anxiety states that when someone has anxiety with depression the NICE clinical guideline CG90 on depression should be followed' [accessed via: <http://www.nice.org.uk/media/878/F7/CBTCommissioningGuide.pdf> (05.03.12)]

The Government has committed to spend a further £400 million over four years to 2014/15 on talking therapies.⁵ Yet psychotherapists and counsellors who do not practise CBT, or the other few therapies approved by NICE guidelines in rarer circumstances, are unable to benefit patients who need more choice than is currently on offer. This has become a source of bitter division and disagreement among the different mental health professions, and has limited the number of experienced therapists available to supply to the NHS at a time when the need for their effective contribution has never been more urgent. IAPT is currently spending around £10 million per year training up a new parallel workforce specialising in CBT to meet its service goals, and continues to increase its training targets.⁶ These practitioners are usually trained for just one year, whereas the majority of the 17,000 accredited therapists and counsellors in private practice have been trained for four years, and many have a decade or more of practical experience.⁷

Although NICE states clearly that 'In using guidelines, it is important to remember that the absence of empirical evidence for the effectiveness of a particular intervention is not the same as evidence for ineffectiveness', in practice, the absence of RCT evidence is used by commissioners to imply that such provision does not help people to recover.⁸

By way of illustration, NICE initially recommended only CBT for anxiety and depression but has subsequently updated its recommendations to include previously excluded modalities. A small number of other forms of talking therapy (as well as counselling) are now included as NICE recommended treatments. Clearly therefore previous recommendations were incomplete and we believe that it would be wise to view present NICE guidelines in the same way. There is an evidence base for many non-NICE recommended modalities of talking therapy and counselling which continues to develop.⁹

2.3 Non-IAPT and non-NICE compliant NHS services

Current draft guidelines from the DH specifying which providers qualify for AQP status imply that all new services commissioned by the NHS should follow NICE guidelines.¹⁰ Yet it should be remembered that NHS in-house psychotherapy services, which predate IAPT,

5 Department of Health, *Talking therapies: A four-year plan of action*. A supporting document to *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, London: Department of Health, 2011 [accessed via: <http://www.iapt.nhs.uk/silo/files/talking-therapies-a-four-year-plan-of-action.pdf> (15.02.12)]

6 Impact Assessment of the expansion of talking therapy services as set out in the mental health strategy, Department of Health, 2011 [accessed via: <http://www.iapt.nhs.uk/silo/files/impact-assessment-of-the-expansion-of-talking-therapies.pdf> (02.03.12)]

7 Chiron Association for Body Psychotherapists (CABP), *Criteria for Full Membership and Accreditation for UKCP Registration*, 2009 [accessed via: <http://www.body-psychotherapy.org.uk/documents/CABPFullMembershipcriteria.pdf> (20.03.12)]

8 National Collaborating Centre for Mental Health Commissioned by the National Institute for Health and Clinical Excellence, *Depression in Adults (update)*, *Depression: the treatment and management of depression in adults*, *National Clinical Practice Guideline 90*, 2009, p9. For an extended discussion of the limitations of relying too heavily on RCTs and focussing solely on proven effectiveness and not also on the feasibility and appropriateness of an intervention, see Centre for Social Justice, *Making Sense of Early Intervention*, London: Centre for Social Justice, 2011 and Rogers A, Maidman J and House R, 'The bad faith of evidence-based practice: beyond counsels of despair', *Therapy Today*, 22(6), 2011, pp 26–29

9 Stiles WB, Barkham M, Connell J and Mellor-Clark J, 'Responsive Regulation of Treatment Duration in Routine Practice in United Kingdom Primary Care Settings: Replication in a Larger Sample', *Journal of Consulting and Clinical Psychology*, 76(2), 2008, pp 298–305; Stiles WB, Barkham M, Twigg E, Mellor-Clark J and Cooper M, 'Effectiveness of cognitive-behavioural, person-centred and psychodynamic therapies as practised in UK National Health Service settings', *Psychological Medicine*, 36, 2006, pp 555–566; Lambert MJ and Ogles BM, 'The Efficacy and Effectiveness of Psychotherapy' in Lambert MJ (5th edn) *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change*, 2004

10 Department of Health, *Primary Care Psychological Therapies (Adults) Implementation Pack* [accessed via: http://www.supply2health.nhs.uk/AQPResourceCentre/Documents/111130%20PCPT_Adults_%20Implementation%20Pack%20FINAL.pdf (20.02.12)]

deliver a number of different modalities of treatment not recommended by NICE guidelines for particular conditions.

Existing services which do not exclusively follow NICE guidelines include the flagship Tavistock and Portman NHS Trust and the pioneering South London and Maudsley Traumatic Stress Unit. There are dozens of other stand alone services, mostly offered through hospital trusts, which do not adhere solely to NICE guidelines yet deliver a wide range of talking therapy modalities. They are delivered from within the NHS but are not as widely available as IAPT.

This creates highly diverging levels of choice for patients, many of whom would benefit from these services which are not yet recommended by NICE guidelines for their condition, and so will not be paid for or available under IAPT. All this should be viewed against the backdrop of published data for IAPT services which shows that 83–86 per cent of people who access IAPT services do not move towards recovery.¹¹ More choice is needed so that they have somewhere else to go.

A public service which only works effectively for between 14 and 17 per cent of the people who access it does not provide a reliable intervention against deteriorating internal resources, and will not therefore be effective in fulfilling the ambition to create a joined up solution to the cycle of dependency seen in Figure 1.2, and thus in tackling social injustice. Neither does it deliver value for money. If patients do not recover through what is available via IAPT, they tend to become regular visitors to the GP surgery, with some GPs performing a counselling role for which they are neither trained nor resourced.

Alternatives for GPs and patients are urgently needed and aspirations to provide this resonate with the Government's desire for greater patient choice.¹² New choices for achieving recovery are vitally necessary if this country is to be able to reverse the core drivers of social injustice and dependency associated with mental ill-health.

11 NHS Information Centre, *Improving Access to Psychological Therapies Key Performance Indicators (IAPT KPIs) Q1 2011/12 final and Q2 2011/12 provisional*, The Health and Social Care Information Centre, 2011 [accessed via: <http://www.ic.nhs.uk/pubs/psychologicaltherapies1112> (24.02.12)]

12 Department of Health, *Liberating the NHS: greater choice and control – Government response. Extending patient choice of provider (Any qualified provider)*, London: Department of Health, 2011 [accessed via: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128539.pdf (15.02.12)]

chapter three

The big issues; recovery versus risk

3.1 The meaning of 'recovery'

There is wide acceptance both within and outside the NHS that the desired outcome for talking therapy is patient recovery. This is defined as a movement from a pre-treatment clinical 'caseness' (where the patient is assessed as having a 'case' requiring treatment) to below 'caseness', post-treatment.

Evaluation of recovery for every patient, using a standardised and academically robust outcome measure, is carried out by all IAPT services and by an estimated 50 per cent of voluntary and private sector services. It is less commonly adopted by therapists in individual private practice.¹ This may be partly because, while they are supervised, they are not part of a larger body to which they are required to report their outcomes; success in private practice is typically 'measured' by word-of-mouth referrals. This lack of systematic outcomes measurement can contribute to a perception that there is a vacuum of accountability.

The two case studies below are typical examples of how people who are offered insufficient choice of treatment are unlikely to reach recovery, not least because more than one issue may need to be addressed when tackling mental ill-health. Whatever the specifics of the missing intervention, when people obtain the help they need there is the very real possibility of alleviating long-term conditions that would otherwise prolong suffering and continue to present an unsustainable drain on the NHS and the public purse more generally.

¹ The estimate is based on the number and size of voluntary/private sector services known to be using outcome evaluation measures such as CORE (the most widely used measure in the voluntary and private sectors)

Case study: Mark and Polly's story

Mark and Polly (not their real names) are a couple who experienced considerable challenges in having their two children, with several miscarriages and a stillbirth. Polly became very low and left her successful career. Mark had a very difficult childhood. His parents violent and stormy relationship spilled over onto the children.

When Polly and Mark's youngest child was two, Polly confessed she had an affair seven years earlier which left her with guilt and shame long after it ended. Mark was utterly devastated by this revelation and fell into a deep depression with unmanageable rages where he would threaten to kill the other man.

Polly developed severe headaches and her GP sent her for tests. On finding nothing wrong, she recommended that Polly have individual counselling focussing on a stillbirth four years previously. After being unable to work and three weeks of sleepless nights, Mark also visited his GP, who referred him to a psychiatrist who diagnosed him as suffering from acute depression and prescribed him anti-depressants.

Meanwhile the couple, now acutely anxious that their relationship was about to break down, approached a voluntary sector service for couple therapy. Over six months, Mark and Polly went to weekly couple therapy and were also offered CBT through IAPT. While they believed the problem was their relationship, health professionals clearly felt the depression itself that needed treatment. However it was in the couple therapy that Polly was able to share her anxieties about her own parents' divorce and how much she did not want her children to suffer like she had.

As the couple therapy progressed, Mark and Polly became more open with each other and began to understand how their relationship problems were a product of both recent and past difficulties impacting on their current situation. Soon after, their concerns and the depression began to recede.

Case study: Rachel's story

Rachel (not her real name) has had a long history of battling with depression. At her worst she was hospitalised, but has never been able to find a way to get effective help from the NHS outside of a hospital setting. On discharge she was left without follow up care and then spent five years under intermittent care from a psychiatrist and the mental health team. She reached the point of suicidal despair, but happened to read an article in a national newspaper which described the treatment ideas that the author had encountered in America.

Rachel asked her doctor for access to Eye Movement Desensitisation and Reprocessing (EMDR), but he failed to agree that it was necessary and did not refer her to any IAPT services. On income support, she paid for her own private EMDR treatment, but could not afford it for long. However it was the springboard for the start of her own sustained recovery. She used 12-step groups and the free grief counselling service CRUSE. She found her father dead at the age of six and no one in her treatment history had engaged with addressing this trauma.

Rachel is now on no medication at all, having been told she would be on it for life, and no longer needs regular home visits. The total cost to her of her recovery was less than the cost to the state of a single day in hospital, or a month of home visits. All she needed was to have access to a treatment not recommended by NICE for her specific presentation; even though EMDR is recommended for some other conditions and routinely supplied safely by the NHS. She is now work-ready and looking forward to moving off welfare payments.

3.2 Managing risk

Given the need for choice and the recent instruction from the DH for commissioners to offer patients a greater range of options in talking therapy services, this raises the question of which of the many existing private and voluntary therapists and services can be considered 'safe' enough to be offered to patients by the NHS, for example through a referral from a GP.

NICE has functioned very well for many years as a guardian of the NHS's funds for medical treatment. The medical community also relies heavily on an evidence-based culture to heed its highest injunction; the Hippocratic Oath to 'do no harm' when carrying out invasive and potentially dangerous activities.

During the last decade, NICE introduced guidelines for talking therapy. These guidelines are taken as seriously by the medical professions as those for the invasive risks of surgery or medication.

It seems important and correct to establish before giving heart surgery or chemotherapy that the risks of the service are justified by the potential rewards. By comparison, NHS-delivered Talking Therapy is typically short-term and low intensity. The large majority of clients see a therapist for one hour a week for less than ten weeks. The risks of supplying this ineffectively are likely to be far less severe than for surgery or medication. They can also be controlled by a routine assessment of risk factors (for suicide, self-harm or harm to others) embedded into the weekly recovery measurement tool for every patient, and by following risk management protocols where a risk warning is identified.

Moreover, other Government departments assess the risk of providing talking therapy differently. For example, the DWP's Work Programme equates the risks of counselling with the risks of giving someone bad advice on how to find a job, rather than the risks of giving someone a bad heart transplant. It therefore does not specify stringent safeguards. The DH takes the opposite approach, equating the risks of short-term counselling with the risk of giving someone a bad heart transplant, and therefore has a completely different attitude towards the issue of risk for identical activity.

This means that if an individual on the Work Programme needs talking therapy, a government contractor delivering the Work Programme can send them to a therapist who is not following NICE guidelines.² However, absurdly, a GP cannot send their neighbour with the same problem to identical treatment.

By remaining in work a person has less choice in accessing talking therapy services. Perversely, this puts those in work at a disadvantage when trying to recover from mental ill-health. Yet getting the right help early is vital to someone's on-going ability to work, and therefore for them to retain their job and, very often, to function well in other areas of life and avoid the descent into dependency described earlier.

² Certain safeguards (such as CRB checks for therapists) are required

3.3 Delivering patient safety

We agree that the need to 'do no harm' must be the uppermost consideration when making choices for treatment in this context. Safety in talking therapy falls into three broad but distinct categories concerning 1) the specific modality of therapy, 2) the specific therapist: their established good character, training they have received and on-going supervision and 3) any risks to specific patients given their circumstances, vulnerabilities and presenting condition. These are described through a series of road safety analogies.

The first category is analogous to the idea of driving in a particular model of car; it must be tested at the manufacturing stage to ensure that it meets certain global standards. The second is analogous to testing an individual car in an MOT to check whether or not it is safe for anyone to travel in that particular car, even if it is from a trusted manufacturer. The third is analogous to how the car is driven in specific conditions; for example if visibility is poor or the road is icy it is necessary to leave more space between the car and the one in front and to slow down. The most risk-averse culture in mental health provision in the UK can be found within the NHS, so observing the work that is currently being done in the NHS to set these safeguards should satisfy even those most concerned with mitigating risk.

1. Modalities

As stated earlier, in addition to IAPT but with far less coverage, the NHS delivers a broad range of talking therapies, such as CBT, person-centred psychotherapy, integrated therapy, humanistic therapy, psychoanalysis and psychoanalytic psychotherapy. Many are itemised in the Table 3.1 alongside the mental health and other trusts where they are being delivered. The list is not exhaustive because the services are so fragmented. All of these are different modalities of talking therapy which have been tested to a greater or lesser extent through the accumulation of practice-based evidence. They are deemed to be able to be delivered safely, and are being done so daily in the NHS.

2. Practitioners

The second way of ensuring patient safety analogous to the MOT for an approved model of car is to ask whether a given individual practitioner is fit to practise safely.

The first basic question to be asked about each therapist is whether or not it is safe for them to be sitting down in a room on their own with someone who is vulnerable and if so, what are the preconditions which make it safe. Again, this simply requires looking at the current safety protocols employed in the delivery of NHS Talking Therapy behind closed doors.

Further to this there are two main considerations: training and supervision. Typically every NHS unit or clinic delivering talking therapy will be very interested in the training history of its personnel, and in the current and future arrangements for supervision.

Training has a wide and varied base in psychotherapy and counselling in the UK. Within the professions there are various bodies which regulate training and register the credentials of therapists who have trained. The United Kingdom Council for Psychotherapy (UKCP)

Table 3.1: Modalities of therapies delivered by the NHS both within and outside of IAPT³

IAPT	Delivered on a fragmented basis by the NHS
Behavioural activation (8)	Acceptance and commitment therapy (33)
Cognitive behavioural therapy (14, 20, 29, 30)	Art therapy (3, 8, 12, 21, 23, 24, 25, 29, 32)
Couple therapy (25)	Autogenic therapy (22)
Dynamic interpersonal therapy (8)	Behavioural activation (8)
Eye movement desensitisation and reprocessing (8, 30)	Behavioural modification therapy (9)
Guided self-help (3, 13, 20)	Chess therapy (11)
Interpersonal psychotherapy (8, 16, 29, 30)	Child psychotherapy (4, 30)
Psychoeducation groups (8, 15, 28)	Cognitive analytic therapy (1, 7, 14, 16, 20, 24, 29, 31)
	Cognitive behavioural therapy (14, 20, 29, 30)
	Cognitive stimulation therapy (17)
	Compassion-focussed therapy (14)
	Couple therapy (25)
	Dance movement psychotherapy (25, 27)
	Dialectical behaviour therapy (16, 25)
	Drama therapy (2, 25, 28)
	Dynamic interpersonal therapy (8)
	Dynamic therapy (15)
	Existential therapy (29)
	Eye movement desensitisation and reprocessing (8, 30)
	Family therapy (8, 16, 19, 24, 25, 29, 30)
	Group therapy (8, 16, 24, 25, 30)
	Guided imagery therapy (5)
	Guided self-help (3, 13, 20)
	Humanistic therapy (29)
	Integrative therapy (8)
	Interpersonal psychotherapy (8, 16, 29, 30)
	Lifespan integration therapy (25)
	Mentalisation-based therapy (1, 3, 8, 16)
	Mindfulness-based cognitive therapy (13, 25, 29)
	Mood, anxiety and personality psychotherapy (10)
	Music therapy (21)
	Narrative exposure therapy (25)
	Object relations pschotherapy (20)
	Occupational arts therapy (6)
	Perinatal psychotherapy (25)
	Play therapy (19)
	Psychodynamic therapy (8, 10, 16, 24, 25, 29)
	Psychoeducation groups (8, 15, 28)
	Psychoanalytic psychotherapy (25, 26, 30)
	Psychoanalytic therapy (1)
	Sensorimotor psychotherapy (25)
	Solution-focussed therapy (8)
	Systemic therapy (8, 24)
	Transference-focussed psychotherapy (16)
	Transpersonal psychology (29)

*A corresponding key for this table can be located in the Appendix

3 Data obtained through a online web search between 09.02.12 and 20.02.12

and the British Association for Counselling and Psychotherapy (BACP) are the two main bodies providing this service. The others are the British Psychological Society (BPS), British Psychoanalytic Council (BPC), Counselling and Psychotherapy Central Awarding Body (CPCAB) and Counsellors and Psychotherapists in Primary Care (CPC). Neither the label of psychotherapist nor counsellor is protected by statute, so the industry has developed its own standards for self-regulation to promote safety and confidence from the public. These are highly developed and have long been accepted as the basis for on-going work to create a unified statutory register for these professions.

A therapist who wishes to be accredited by the BACP or UKCP, for example, must successfully complete several years of academic training and hundreds of hours of supervised clinical practice as a volunteer in a clinical placement. As stated earlier, there are approximately 17,000 therapists qualified at this level in the UK today. Accreditation and registration includes an ethical framework, a complaints procedure, a requirement for on-going supervision and a requirement for on-going professional development.

The NHS only works with accredited therapists or therapists in training who are working towards accreditation, and who are closely monitored by accredited supervisors. The NHS employs around 2,000 of the accredited therapists available in the UK, which is approximately 12 per cent of capacity.⁴

All NHS therapists are supervised by in-house staff in clinical settings where attendance at supervision and performance within supervision can be monitored. Industry standard ratios are suggested for the numbers of hours worked with clients to the number of hours spent in supervision.

This combination of accreditation and supervision allows the NHS to satisfy itself that the individual therapist can be relied upon to deliver an approved modality of treatment safely.

3. Individual patient risk

The third way of ensuring patient safety, which is analogous to deciding how to drive a suitable car but in difficult conditions, is to routinely assess each patient for risk factors (of suicide, self-harm or harm to others) and to follow risk management protocols where such risks are flagged.

Summary of meeting patient safety

Safety can be ensured to NHS risk-adverse standards by (a) building on practice-based evidence of which modalities have been able to operate safely in existing NHS services, (b) by using accredited practitioners who are under on-going appropriate supervision to offer these modalities, and (c) the regular assessment and management of risk for each individual patient.

⁴ Improving Access to Psychological Therapies, *IAPT Programme Review*, Improving Access to Psychological Therapies, 2011 [accessed via: <http://www.iapt.nhs.uk/silo/files/iapt-programme-review-december.pdf> (21.02.12)]

chapter four

Current commissioning practice

4.1 Non-NHS practice

Given the current crisis of mental health in the UK and the social problems which follow,¹ it is worth examining what the 88 per cent of accredited therapists in the UK, who do not work for the NHS, deliver. Many are working in voluntary services, clinics or private practice, and a lot of these services replicate the non-IAPT NHS services and also do not follow NICE guidelines.

It seems logical therefore that those therapists and the services they work in, offering modalities already in use in the NHS (and which may exceed the range of NICE-recommended psychological therapies), would potentially qualify for the safe delivery of therapy, since the methods they use are already in use in the NHS. In addition to meeting this criterion of acceptable modalities, these services would also need to be able to satisfy commissioners that they meet existing NHS standards for accreditation and supervision of staff, so that private and voluntary sector services can satisfy equivalent standards of safety as the NHS.

4.2 Private practice

The vast majority of the unused capacity in the accredited therapists' workforce is not offered in a clinical setting. Many therapists work in private practice, but may do so in the same way as any member of a team in a clinic, seeing clients in premises where other therapists work. Some therapists work from home but others may attend a consulting room where they meet their clients, and all those accredited are required to attend regular supervision, either individually or in a group.

¹ Centre for Social Justice, *Completing the Revolution: Transforming mental health and tackling poverty*, London: Centre for Social Justice, 2011; Centre for Social Justice, *Mental Health: Poverty, Ethnicity and Family Breakdown, Interim Policy Briefing*, London: Centre for Social Justice, 2011

It is common for therapists and counsellors to work far fewer hours in private practice than they would like. The self-pay market for therapy does not have the demand to meet the supply. Meanwhile the state demand for talking therapy is under-staffed. Given this, these therapists could be utilised to provide accredited therapy through the NHS.

With monitoring of supervision, proof of accreditation and on-going insurance, a therapist in private practice can meet the same standards which ensure safe delivery of NHS services elsewhere within the NHS. If these standards are met and maintained, this large group of well-qualified professionals could become a valuable resource for talking therapy services safely delivered and paid for by the state.

Currently the state spends approximately £10 million per annum to train a new NICE guidelines-compliant workforce to replace this existing accredited one.² However this paper argues that suitable practitioners in the existing workforce should be allowed to supply the NHS, thus enabling commissioners to deliver the DH's aspiration to increase patient choice nationwide.

4.3 NICE guidelines

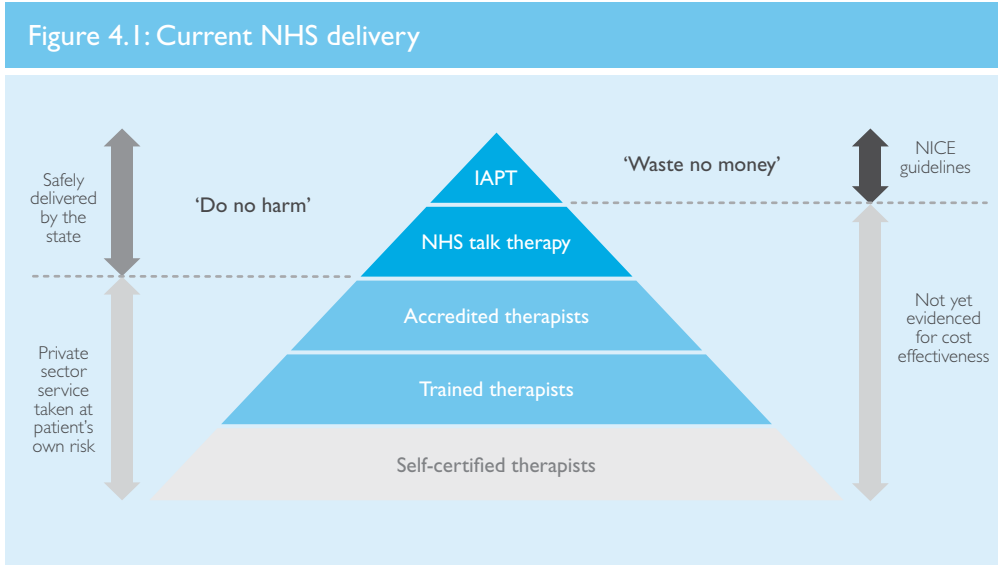
NICE guidelines are generally concerned with two assessment metrics. First, by asking if a procedure minimises potential harm to the patient and, second, with the cost effectiveness of treatment (i.e. what is the cost of this drug and are the forecast outcomes worth that cost).

NICE guidelines for talking therapies are in part concerned with patient safety, following the 'do no harm' dictum. However they go much further than this remit by typically excluding therapies for which there is not a lack of evidence generally, but a lack of effectiveness specifically from RCTs. RCTs are the 'gold standard' of medical evaluation, but little used in psychological therapies, leading to much controversy about the basis on which NICE guidelines have been drawn up.³

Following this medical model of research (which is usually into new medications), the presumption of NICE is that the cost effectiveness of any treatment for which there is some RCT evidence is higher than the cost effectiveness of any treatment for which there is less RCT evidence of effectiveness. In drawing up guidelines in this way, NICE might be said to be following a dictum of 'waste no money' rather than just 'do no harm' as illustrated in the diagram below. 'Do no harm' is a broader category, which explains why the NHS routinely delivers non-NICE recommended treatment in non-IAPT services.

2 Impact Assessment of the expansion of talking therapy services as set out in the mental health strategy, Department of Health, 2011 [accessed via: <http://www.iapt.nhs.uk/silo/files/impact-assessment-of-the-expansion-of-talking-therapies.pdf> (02.03.12)]

3 Rogers A, Maidman J and House R, 'The bad faith of evidence-based practice: beyond counsels of despair', *Therapy Today*, 22(6), 2011, pp 26–29



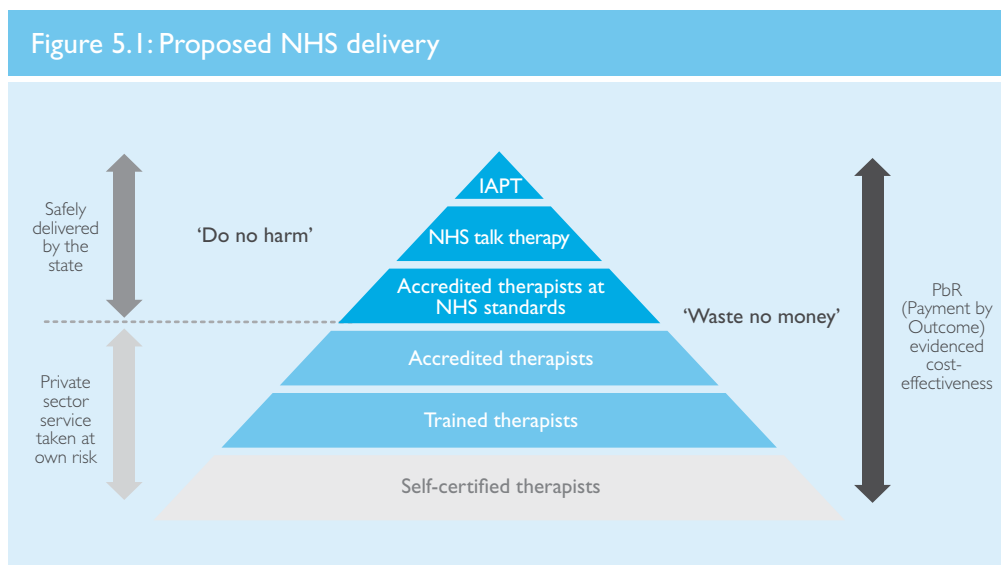
Despite this, the limited evidence available suggests that existing IAPT services, which all follow NICE guidelines, have proven to be less cost effective than the primary care counselling services which they largely replaced, and less cost effective than equivalent voluntary sector services.⁴

⁴ The Artemis Trust, *Comparing the quality of psychological therapy services on the basis of number of recovered patients for a fixed expenditure*, The Artemis Trust, 2011

chapter five

Payment by Outcome

Figure 5.1 below shows how the ‘waste no money’ dictum previously under the guardianship of NICE guidelines can be maintained instead by paying therapists according to their outcomes and not their inputs. This means that they are paid according to what they get done, rather than which method they use to do it. Once the shackles of NICE guidelines are removed, the only necessary barrier to entry is to ‘do no harm’, which releases a substantial proportion of the private and voluntary sector workforce to supply the NHS, paid for on the basis of successful outcomes only.



Payment by Outcome is in operation under the DWP's Work Programme. The rationale for Payment by Outcome commissioning is that the Government sets expectations, standards and frameworks for what it will invest in, but leaves the method of delivery to those best able to provide a public service. Rather than specify activity and the process of delivery, commissioning simply details the outcomes which are expected from interventions.

Part of the activity of the Work Programme addresses the need to improve the mental health of some of the client base of the programme. This work is being done in many ways,

some of which share the Payment by Outcome reward basis. The Work Programme is a 'black box' approach, not specifying activities but rewarding outcomes. It therefore operates in the opposite way to NICE guidelines, which very precisely specify activities, regardless of outcomes.

Thus non-NICE recommended talking therapies are frequently available for clients of the Work Programme (and are publicly funded in other contexts, such as schools and prisons). Due to the way NICE guidelines are interpreted within the NHS (by IAPT services), the same range of talking therapy services are not routinely available for their neighbours who are in work.

This creates a dual standard within Government for the supply of talking therapy services to different client groups, and different experiences for service users depending on the Department with ultimate responsibility for funding their care. It means that a person has more state resources for supporting their mental health if they leave work than they do to help them to sustain themselves in work. This runs completely counter to the emphasis of recent Government-commissioned reports (such as Dame Carol Black's *Working for a healthier tomorrow*¹) on enabling people who are suffering from mental and other illnesses to stay in work wherever possible.

'The Work Programme is a 'black box' approach, not specifying activities but rewarding outcomes. It therefore operates in the opposite way to NICE guidelines, which very precisely specify activities, regardless of outcomes.'

In keeping with early intervention principles, talking therapy tends to work best if accessed as soon as possible during a client's episode of distress. Equally it is easier to help someone to stay in their job than to find them a new job, and to find someone a new job if they have been out of work for a short time rather than a long time. (Many categories of people only become eligible for the Work Programme a year after they started to claim out-of-work benefits).²

5.1 Commissioning outcome-based partnerships

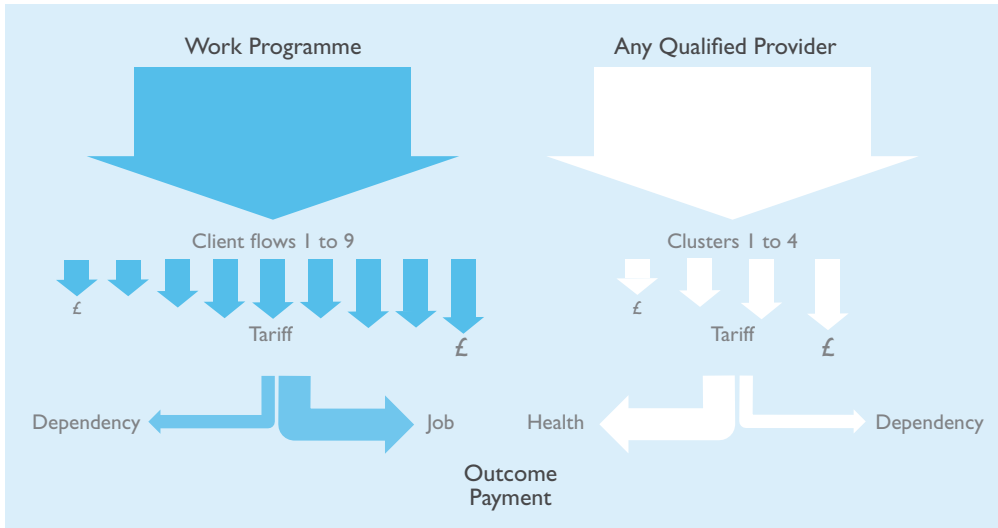
Work has begun in the private and voluntary sectors under the leadership of Get Stable (which provides therapeutic services to the Work Programme) to build a register of private and voluntary sector services and private sector therapists who are willing to work on a Payment by Outcome basis. Under this, a significant proportion of the fee paid is dependent on the patient achieving recovery. This requires that the therapists are prepared to work

1 Department for Work and Pensions, *Working for a healthier tomorrow, Dame Carol Black's Review of the health of Britain's working age population*, London: Department for Work and Pensions, 2008

2 Department for Work and Pensions, *The Work Programme*, London: Department for Work and Pensions, 2011

with publicly funded clients, and to then accept payment proportionate to their results. Their work is supplied mostly at their own risk rather than at the state's risk. Therefore it is only reasonable to allow these well trained and accredited therapists to do the work that they believe will be effective, based on the evidence of their own practice, and their assessment of each individual patient.³ Routinely this work currently being done in the private and voluntary sector is not recommended by NICE guidelines.

Figure 5.2: Coordinating assistance to tackle dependency



As implied in Figure 5.2 above, what this currently means in practice is that Payment by Outcome talking therapy services which supply the Work Programme are not yet able to supply the NHS on the same basis. In order to correct this anomaly, there would need to be new commissioning advice issued by the DH which addresses the specific challenges and opportunities thrown up by a new commissioning paradigm of Payment by Outcome. The DWP has taken the lead in implementing Payment by Outcome and has had to work through many changes in its own commissioning processes which worked against existing, deeply ingrained norms. It seems that the DH is now facing the same challenge, in addition to all of the other controversies in talking therapy.

Figure 5.2 shows how fees paid out by the Work Programme vary according to Client Flow, a scale that compensates for the level of difficulty the provider will face in helping someone to get into work, based on that client's disadvantages. Similarly, the NHS has put significant time and energy into addressing the question of quantifying the severity of distress in presenting mental health patients. They have formulated an NHS mental health clustering tool (HoNOS-PbR) which separates patients into clusters 1 to 21. Clusters 1–4 may be suitable to be considered for treatment in primary care, with clusters 1–3 being most likely to be treatable at that level. (So the model proposed in this paper is relevant for the treatment of people presenting with conditions and severity at the Cluster 1–4 level.) It seems logical that commissioning of outcomes pays some attention to the difficulty of reaching that outcome,

3 Which would use recognised scales such as those provided by the NHS mental health clustering tool (HoNOS-PbR)

and therefore that tariffs for outcomes be correlated with cluster of need. Skilful setting and management of these tariffs, although potentially introducing a significant layer of complexity into the system, will help to avoid 'cherry-picking' by providers.

Payment by Outcome commissioning is a sea change for all organisations at every level of the supply chain. It implies change in existing processes and procedures which are challenging even the most commercially reactive private companies. The DH has an opportunity to make this a positive change, creating a range of safe, new choices without having to invest in a new workforce, and without paying for unsuccessful treatments. It does not currently operate anything approaching a 'pure' PbR programme where outcomes and payments are binary (with clients either falling below 'caseness' following treatment or remaining above it). However GPs are starting to request 'Payment by Outcome' mental health services.⁴ This paper has been written in response to that demand.

The first AQP service specification inviting public tender was published on 19 March 2012 by Dorset PCT.⁵ It has set a tariff, of which only 14.9% of the fee for successful treatment is based on the outcome. No alternative price structure is allowed by bidders so a 'pure' Payment by Outcome bid, with all of the choice-based merits which could come with it, is not possible. This tender also specifies treating 'Payment by Results (PbR) Care Clusters 1–4' but the remuneration structure indicates that it remains focussed far more on activity than outcomes.

5.2 Survival of the fittest

This revised system, based on Payment by Outcome, would have an inbuilt 'Darwinian' function that would ensure that patients have access to effective *therapists*, rather than just to practitioners trained in apparently effective therapies. In other words, only effective therapists would 'survive' as suppliers.

Notwithstanding the need for more choice in therapies, there is considerable evidence from many years of analysis and meta-analysis that outcomes from different modalities are not significantly different. The emerging body of evidence shows that it is the individual therapist who varies greatly in the outcome of his or her work regardless of modality, making it all the more important that we are paying for successful *therapists* rather than for their activity.⁶

4 Mental Health Commissioning: Delivering the New National Mental Health Strategy (event), 7 July 2011, The King's Fund, London

5 Bournemouth and Poole NHS Trust, 2012/13 NHS Standard Contract For Acute, Ambulance, Community and Mental Health and Learning Disability Services (Multilateral) [accessed via: <http://www.bournemouthandpoole.nhs.uk/WS-Pan-Dorset/Downloads/Shared-Content/About%20us/Contracts%20and%20tenders/Primary%20care%20psychological%20therapies/PCPT%20Service%20Specification%20%20final.pdf> (22.03.12)]

6 Examples include Lambert MJ and Ogles BM, 'The Efficacy and Effectiveness of Psychotherapy' in Lambert MJ (5th edn), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change*, 2004; Stiles WB, Barkham M, Twigg E, Mellor-Clark J and Cooper M, 'Effectiveness of cognitive-behavioural, person-centred and psychodynamic therapies as practised in UK National Health Service settings', *Psychological Medicine*, 36, 2006; Stiles WB, Barkham M, Connell J and Mellor-Clark J, 'Responsive Regulation of Treatment Duration in Routine Practice in United Kingdom Primary Care Settings: Replication in a Larger Sample', *Journal of Consulting and Clinical Psychology*, 76(2), 2008, pp 298–305

Research studies have repeatedly shown a wide variability in the effectiveness of therapists (measured as 'recovery'), with some practitioners obtaining results substantially above their less effective colleagues.⁷ This scale of difference is much wider than has ever been suggested by any comparison of different mainstream modalities, including CBT.

Figure 5.3: Therapists' outcomes⁸

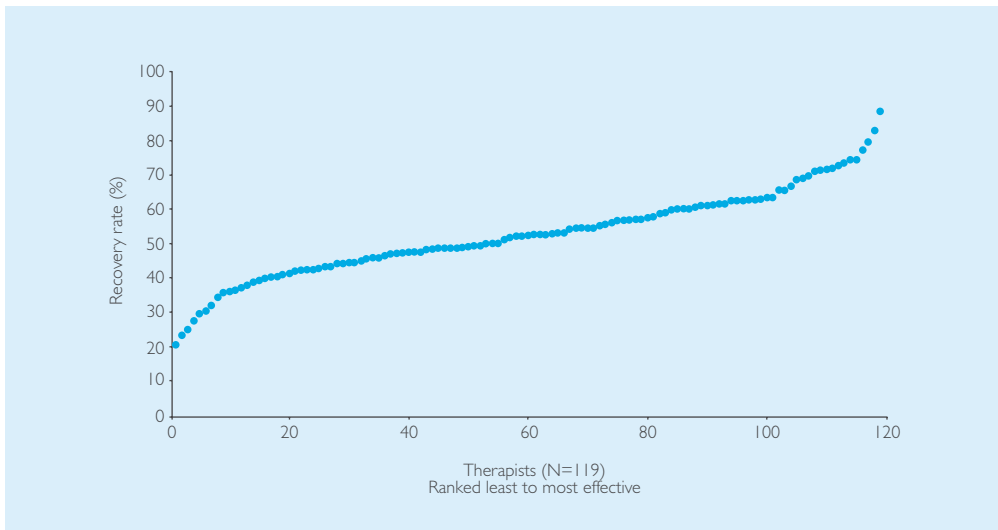


Figure 5.3 above plots the full range of outcomes from all therapists, showing an outcomes range of 18–90 per cent effectiveness. This suggests the welcome possibility of being able to filter supply over time so that only the most effective therapists (rather than therapies) are funded by the NHS, without the need to stipulate so narrowly the modality they must follow.

Just as with the Work Programme, the expectation is that the least effective period of commissioning will be the first few iterations of the programme, during which time the least effective practitioners are naturally removed from the supply chain and the most effective receive more and more work. Commissioners need to be mindful of this dynamic and take the long term view in order to allow time for the effective practitioners to be identified, and then prioritised.

7 Examples include Wampold B and Brown J, 'Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care', *Journal of Consulting and Clinical Psychology*, 73 (5), 2006, pp914–923; Beutler L, Malik M, Alimohamed S et al, 'Therapist variables', in Lambert M (ed.), *Handbook of Psychotherapy and Behavior Change* (5th ed), New York: Wiley; Brown J, Lambert M, Jones E and Minami T, 'Identifying highly effective psychotherapists in a managed care environment', *The American Journal of Managed Care*, 11, 2005, pp513–520

8 Adapted from Saxon D and Barkham M, *Patterns of therapist variation using multilevel modelling: Therapist effects and the contribution of patient severity and risk*, Centre for Psychological Services Research, University of Sheffield, 2011

chapter six

Comparing talking therapy services

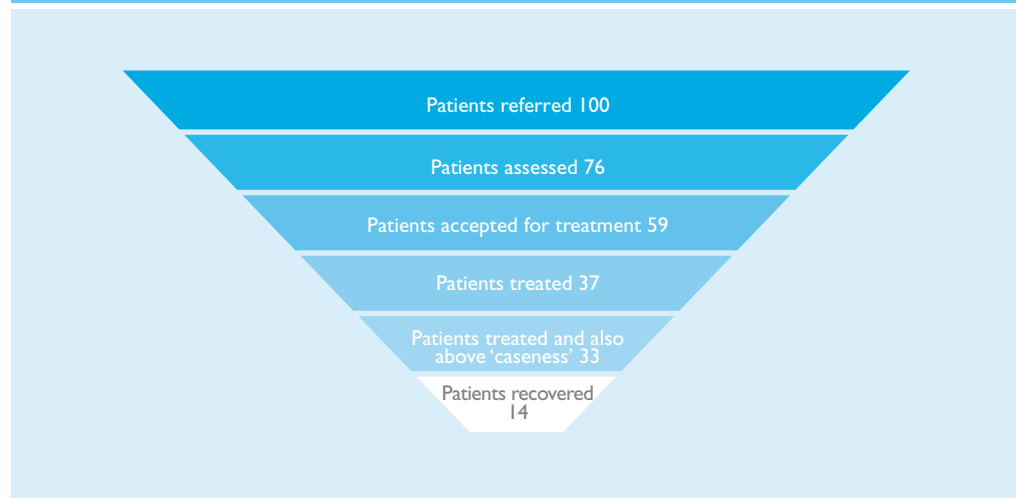
Radical change in the delivery of talking therapy services needs to remain accountable, and comparable to existing services. Reporting on the costs and outcomes of talking therapy should be very simple. Typically the same activity is repeated somewhat formulaically: people talk to each other, usually in units of one hour, usually one-to-one, or in the case of couple therapy one-to-two. It is a repetitive and unitised service.

When talking therapy is measured, the outcomes are relatively simple too. There is an input and an output; a certain number of people come into the service needing help, and another number are measured as being successfully helped (falling below 'caseness' and thus achieving 'recovery'). Collecting and reporting these statistics should therefore be straightforward. The picture is complicated by considering the client's journey through a therapy service. There are different milestones along the way; referral, acceptance, assessment, attendance for further sessions, completing all recommended sessions, completing all necessary paperwork and 'recovery'. At each milestone the population in treatment reduces, like a narrowing funnel (see Figure 6.1) – the goal is for the funnel to remain as wide as possible all the way down.

Many recovery rates are based on population statistics from a narrower segment further down this funnel. In the case of IAPT, it cites 'recovery rates' as a proportion of patients treated and also above 'caseness', rather than as a proportion of the baseline (patients referred), thus improving the outcome percentage. As described in more detail below, IAPT figures claim recovery as over 40 per cent (14/33, see funnel below) but from the point of view of commissioners and referring GPs, 86 per cent are not being helped by the IAPT service.¹

¹ NHS Information Centre, *Improving Access to Psychological Therapies Key Performance Indicators (IAPT KPIs) Q1 2011/12 final*, The Health and Social Care Information Centre

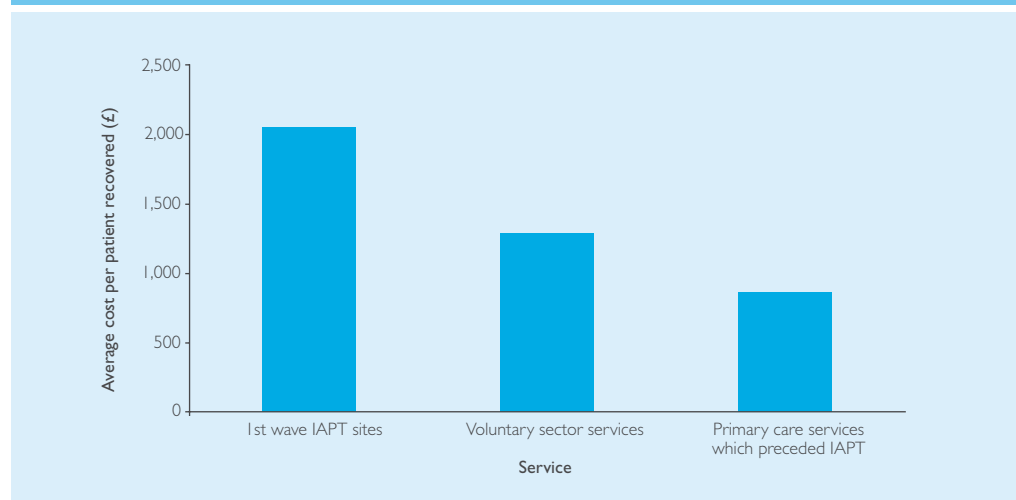
Figure 6.1: Patient journey showing proportions of those referred and recovered from IAPT



6.1 Costs per recovery

An Artemis Trust study using Freedom Of Information requests to obtain cost and patient recovery data from the '1st Wave' IAPT sites for the last quarter of 2009–10 shows that the average cost of treatment per patient recovered ranged from £883 to £3,176 and averaged £2,052 (all had been operating for at least a year). A comparative small scale study in 2008 of counselling in primary care services which preceded IAPT (and which have been largely replaced by IAPT services) showed an average cost per patient recovered of £866 (or substantially under half the cost of IAPT services). A comparative small scale study of voluntary sector services seeing a similar mix of patients showed an average cost per patient recovered of £1,289.² This large variation in average cost is clear from Figure 6.2 below.

Figure 6.2: Average cost per patient recovered



² The Artemis Trust, *Comparing the quality of psychological therapy services on the basis of number of recovered patients for a fixed expenditure*, The Artemis Trust, 2011

chapter seven

Summary and recommendations

Despite the high costs of depression and treatable mental illness to the NHS and the wider economy, the services currently available to alleviate such conditions are failing to move sufficient numbers of people into recovery. As a result there are significant levels of preventable distress, dependency and family breakdown which health reforms have to address.

The former Health Secretary and present chair of the Health Select Committee, Rt Hon Stephen Dorrell MP, effectively expresses the emphasis of the CSJ's work on mental health in stating that:

The main game is to change the way care is delivered otherwise we will not meet the demands of patients out of the resources available... better value and better quality care is doable if we deliver more integrated care, more preventative care, intervene earlier, more community-based care, all talked about endlessly for more than 20 years.¹

This paper proposes radical changes in the way talking therapies are delivered and meets all the criteria he lists; we simply can no longer afford the human and financial costs of delaying such reform when the status quo is failing so many people.

State-sponsored activity to prevent someone's internal and external resources from declining as a result of mental health difficulties is not at present sufficiently integrated or synchronised. The deterioration of important internal resources, such as their sense of self-efficacy and ability to maintain key relationships, can lead to someone falling into a cycle of dependency with all the diminished opportunities this entails. In the same way that intervention to support failing external resources through the Work Programme is funded on a Payment by Outcome basis, our proposals could form the basis for the provision of talking therapy to help those struggling with deteriorating internal resources in the form of mental health difficulties.

¹ The Independent, *Radical NHS change needed or patient care will suffer, warns MP*, 31 December 2011

In order to address unmet need in this area, this paper recommends that the voluntary and private sector providers of talking therapy work for the state at their own financial risk until they have proven effective outcomes, via a Payment by Outcome model. Clearly there must be a minimum standard of regulation for undertaking this work, but the barrier to entry should be the maxim to 'do no harm', rather than the higher barrier to entry of NICE guidelines.

Although we have not examined these in any detail in this paper, there are also implications for the personalisation agenda. Individuals commissioning their own services using personal health budgets should be able to spend these on as wide a range of therapies as possible (taking into account all the safety considerations outlined here).

There are two standards of regulation that are either explicitly stated or implied by practice in the current delivery of NHS Talking Therapy services:

1. The NICE guidelines for psychological therapies which dictate what IAPT can offer;
2. The clinical practices which ensure the safe delivery in all existing NHS services of all existing current modalities of talking therapy (which exceeds those delivered according to the NICE guidelines) in all existing NHS services.

The former is intended as a guarantee of both cost effectiveness and safety. The latter is only a guarantee of safety. The former requires training up a new workforce of (mainly) CBT staff at a large on-going cost to the state. The latter allows for an existing workforce, which has already paid to train itself, to be employed immediately by the state.

'Light touch' regulation is necessary to ensure that the quality and activity delivered by the much greater pool of private and voluntary sector providers available under such a funding model mirrors existing NHS delivery standards. We argue that the level of evidence required for therapies to be approved by NICE is currently preventing many potentially effective courses of treatment from being delivered, but suggest that if the risk of failure falls on practitioners, this obviates the need for the 'waste no money' dictum followed by NICE.

It is preferable to use existing and experienced therapists who can satisfy equivalent NHS standards of clinical safety, rather than to train new and inexperienced therapists at great cost. The difficulty is how to avoid paying for any non-NICE recommended work from the first group which may not be cost-effective.

As long as voluntary and private sector therapists are providing services which are recognised as modalities supplied by existing NHS services, and as long as individual therapists satisfy the safeguards and checks of existing NHS clinical settings, then, we argue, they should be allowed to supply their work via the NHS to be rewarded later if they prove they are effective.

Yet this paper has been written in the shadow of the AQP Implementation Pack for Psychological Therapy recently issued by the DH. The pack proposes an 'IAPT Plus' solution adhering to NICE guidelines that does not give the patient any significantly greater choice, continues to broadly

exclude the private and voluntary sectors from providing services to NHS patients, and will not result in an early introduction of Payment by Outcome commissioning.

Even if a PCT or Clinical Commissioning Group (CCG) disregards the Implementation Pack, if it interprets the NICE guidelines for talking therapy in the restrictive manner adopted to date by IAPT it will be unable to place meaningful contracts with potential providers in the voluntary or private sectors because of restrictions on the modalities of therapy which may be used.

Therefore we recommend that:

1. The DH should explicitly propose to commissioners a pricing tariff for AQP commissioning for talking therapy which allows for 'pure' Payment by Outcome contracts to be written for services which operate to standards of NHS safety, but which supply therapies beyond NICE guidelines.

This will provide a mechanism for NHS service users to gain access to thousands of qualified and experienced therapists and counsellors working in the private sector and some hundreds of established services, mostly in the voluntary sector. Currently, an NHS patient can only very rarely choose to be treated by one of these therapists or services.

It was the DH's intention that the AQP programme should respond to requests for patient choice of therapists or services. Payment by Outcome commissioning removes the barriers to doing so and thus allows the implementation of AQP for talking therapy to provide patients with the widest possible choice amongst proven services and therapists.

2. Alongside this tariff commissioning advice, the DH should provide clear guidelines to NHS commissioners that the barrier for entry for AQP, in all aspects of safety, including the type of therapy they deliver when commissioning competition from the private and voluntary sectors for talking therapy, should be set to equivalence with the common requirements of all the in-house NHS psychotherapy services, rather than at the level of NICE guidelines.

Specifically, qualifying therapists must:

- Be accredited by UKCP, BACP, BPS, BPC, CPCAB or CPC, with all of the on-going requirements of accreditation and adherence to their complaints procedures;
 - Provide proof of regular attendance at supervision with an accredited supervisor; hold valid insurance and have an enhanced Criminal Records Bureau certificate;
 - Undertake to practise only modalities of therapy professionally recognised (by UKCP, BACP, BPS, BPC, CPCAB and CPC) and in which the therapist has been trained and qualified;
 - Ensure that every patient is routinely assessed for risk (of suicide, self-harm or harm to others). Appropriate risk management protocols must be followed where risk is believed to exist.
3. To reflect differing case-mixes across services and to avoid 'cherry-picking' the easier cases, the difficulty of reaching recovery should arguably be reflected in the level of tariff paid to achieve that outcome. This can be done by basing it on the existing NHS mental health

clustering tool (HoNOS-PbR) which measures which cluster the person falls into and therefore can be used as an established metric for assessing the distance that a service user is from recovery when starting with the service. Payment by Outcome commissioning needs to offer different tariffs for different clusters, analogous with the Work Programme's existing pricing structure.

4. The DH should make it clear that it is the Government's aim to move decisively towards Payment by Outcome for all talking therapy services wherever possible, and to provide for adequate public data to compare different talking therapy services on their outcomes for the same cost. The quality metric of measuring patient recovery is well established in psychological therapies but never quoted against cost. Existing IAPT and other NHS provision should become accountable for their recovery rates per unit of funding as a clear measure of the quality of their services. A Payment by Outcome model should aim to avoid barriers to participation for effective providers, such as those faced by small voluntary sector organisations in the Work Programme.
5. In terms of local organisation we also recommend that one main ('prime') provider subcontract the therapy workload to a fairly large number of small providers of therapy services under the AQP policy. This transfers a large part of the administrative and organisational burden from PCTs and CCGs to the main provider. If this provider had to compete for the main contract renewal every few years, this would enable the 'market' to offer a high degree both of choice and competition.
6. Due to the confusion generated by DH using the term 'Payment by Results' (PbR) in a way that is quite different to other Departments, we recommend that the DH's use of the term is brought into conformity with that employed by the rest of Government.

Appendix

Key for Table 3.1: Delivery sites for modalities of therapies delivered by the NHS both within and outside of IAPT

Code	Service
1	Barnet, Enfield and Haringay Mental Health Trust
2	Cambridgeshire and Peterborough NHS Foundation Trust
3	Camden and Islington NHS Foundation Trust
4	Central and North West London NHS Foundation Trust
5	Christie NHS Foundation Trust
6	City and Hackney Centre for Mental Health
7	Dorset Healthcare NHS Foundation Trust
8	East London NHS Foundation Trust
9	Gateshead Health NHS Foundation Trust
10	Guy's and St Thomas' NHS Foundation Trust
11	Heart of England NHS Foundation Trust
12	Homerton University Hospital NHS Foundation Trust
13	Lancashire Care NHS Foundation Trust
14	Leeds and York Partnership NHS Foundation Trust
15	Lincolnshire Partnership NHS Foundation Trust
16	Manchester Mental Health and Social Care Trust
17	Norfolk and Waveney NHS Foundation Trust
18	North East London NHS Foundation Trust
19	Northamptonshire Healthcare NHS Foundation Trust
20	Northumberland, Tyne and Wear NHS Foundation Trust
21	Oxleas NHS Foundation Trust
22	Royal London Homeopathic Hospital
23	Sheffield Health and Social Care NHS Foundation Trust
24	Somerset Partnership NHS Foundation Trust
25	South London and Maudsley NHS Foundation Trust
26	South West London and St George's Mental Health NHS Trust
27	South West Yorkshire Partnership NHS Foundation Trust
28	Surrey and Borders Partnership NHS Trust
29	Sussex Partnership NHS Foundation Trust
30	Tavistock and Portman NHS Foundation Trust
31	Tee, Esk and Wear Valleys NHS Foundation Trust
32	The Christie NHS Foundation Trust
33	The Walton Centre NHS Foundation Trust

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