

THE MATRIX | 2014

A Guide to Delivering Evidence-Based Psychological Therapies in Scotland

PART 1: DELIVERING EVIDENCE-BASED PSYCHOLOGICAL THERAPIES

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INTRODUCTION AND OVERVIEW

THE SCOTTISH GOVERNMENT IS COMMITTED TO INCREASING THE AVAILABILITY OF EVIDENCE-BASED PSYCHOLOGICAL INTERVENTIONS, AND THE LOCAL DELIVERY PLAN GUIDANCE FOR 2011-12 INTRODUCED FOR THE FIRST TIME A NEW MAXIMUM WAITING TIMES ACCESS TARGET FOR PSYCHOLOGICAL THERAPIES.

In recent years targets for Psychological Therapies, CAMHS and Alcohol Misuse have been set as part of a wider effort to address some of Scotland's most serious health, social and economic problems.

The Mental Health and Protection of Rights Division is also committed to supporting NHS Boards to meet HEAT targets in a way which best fits with local services and circumstances and will be sustainable in the long term.

The Matrix project grew out of requests from NHS Boards for advice on commissioning Psychological Therapies in local areas to enable them to plan and provide the most effective psychological treatments available for their particular patient population. The Matrix is a guide to planning and delivering evidence-based Psychological Therapies within NHS Boards in Scotland. It provides a summary of the information on the current evidence base for various therapeutic approaches, a template to aid in the identification of key gaps in service, and advice on important governance issues.

The Matrix has been produced to help NHS Boards:

- Deliver the range, volume and quality of Psychological Therapy required to achieve the HEAT Psychological Therapies Access Target, and to meet local ICP accreditation standards.
- Provide evidence-based psychological interventions in other key government priority areas.

by

- Summarising the most up-to-date advice on evidence-based interventions.
- Providing information and advice on strategic planning issues in the delivery of efficient and effective Psychological Therapies services.
- Explaining the levels of training and supervision necessary for staff to deliver Psychological Therapies safely and effectively.
- Describing the additional support available from Government in terms of related Mental Health initiatives-the Mental Health Quality and Efficiency Support Team (MH QuEST); the Information Services Division (ISD); and NHS Education for Scotland (NES).

As such, it aligns with the ambitions of the Scottish Government's 20:20 Vision and the NHSScotland Healthcare Quality Strategy, by promoting the delivery of efficient and effective treatments, and by seeking to minimise wasteful and harmful variations in practice through the clarification of training standards and supervision requirements. In addition it offers guidance on service structures and governance arrangements necessary to ensure patient safety.

EXPANSION AND UPDATE OF THE EVIDENCE TABLES

THE SUMMARY EVIDENCE TABLES IN THE CURRENT DOCUMENT COVER:

- KEY AREAS WITHIN ADULT AND OLDER PEOPLE'S MENTAL HEALTH SERVICES
- KEY AREAS WITHIN SERVICES FOR CHILDREN, YOUNG PEOPLE AND FAMILIES
- SOME ASPECTS OF LONG TERM CONDITIONS MANAGEMENT AND PHYSICAL HEALTH CARE.

The range of conditions covered by The Matrix evidence tables has been further expanded since the 2011 version; however the tables do not yet encompass all diagnoses or mental health patient groups. We have continued to focus on common mental health problems and disorders, the conditions covered by the ICPs, and other key Scottish Government priority areas.

The intention is to continue to extend the evidence tables over time to give more comprehensive coverage, and to update the recommendations as new evidence becomes available.

There is no suggestion that NHS Boards should provide all of the therapies and interventions listed in the tables. For any patient group, choices over which evidence-based intervention to deliver will have to be made locally, based on the published evidence, the costs of training and sustainable service delivery, the expertise available within the Board, and existing strategic plans.

It is expected that Psychological Therapies will be delivered within a matched/stepped-care model of service delivery, and this document should be read in conjunction with the publications outlining the competences necessary to provide safe and effective psychological care at different tiers of the system (See Chapter 3).

The document is not intended to be prescriptive, to replace local strategic planning processes or to stand alone. It is to be seen as guidance which will be adapted to local circumstances by local experts within the relevant strategic planning settings, such as multi-disciplinary Psychological Therapies strategic planning groups.

SUMMARY GUIDANCE ON 'WELL-FUNCTIONING PSYCHOLOGICAL THERAPIES SERVICES'

PSYCHOLOGICAL THERAPIES (PTs) SERVICES SHOULD BE STRUCTURED, STAFFED AND GOVERNED IN SUCH A WAY AS TO MEET PEOPLE'S EXPECTATIONS IN TERMS OF BOTH WAITING TIMES AND THE QUALITY OF CARE THEY RECEIVE.

This section, which replaces the more traditional 'executive summary', encapsulates the attributes essential to any service in achieving these standards. The content of this summary guidance is elaborated in the subsequent sections of the document.

APPROACH

WELL-FUNCTIONING PSYCHOLOGICAL THERAPIES SERVICES SHOULD BE EMBEDDED IN A 'PSYCHOLOGICALLY-INFORMED' SYSTEM ENCOMPASSING HEALTH, SOCIAL CARE, THE VOLUNTARY SECTOR AND SERVICE USERS AND THEIR FAMILIES, WITHIN WHICH STAFF FROM ALL DISCIPLINES DELIVER PSYCHOLOGICALLY INFORMED CARE.

In addition, many staff will have the competences necessary to offer specific, evidence-based psychological interventions as a core aspect of their work.

There should be multi-disciplinary delivery of psychological interventions and therapies at a variety of levels in both mental and physical health settings. Training and accreditation in therapeutic approaches should be competence-based.

The system should:

- deliver evidence-based care.
- sit within a framework of values-based practice - as laid out in 10 Essential Shared Capabilities (Scotland).
- have a recovery focus.
- engage with service users and carers at all stages of the process.

SUMMARY GUIDANCE ON 'WELL-FUNCTIONING PSYCHOLOGICAL THERAPIES SERVICES'

Recognising that access is not simply a function of availability, the well-functioning system should identify groups which are having difficulty engaging with services as currently configured, and support innovative approaches to deliver care which are acceptable and accessible by the target population.

The system should be strategically managed at National and NHS Board level in a manner which creates confidence around effectiveness, efficiency and patient safety. Effective strategic management should involve oversight and planning at a level above that of the delivery of individual treatment, as outlined next.

STRATEGY

THERE SHOULD BE DIRECT ACCOUNTABILITY FOR PSYCHOLOGICAL THERAPIES AT NHS BOARD LEVEL, AND AN APPROPRIATE MECHANISM (FOR EXAMPLE A LOCAL MULTI-PROFESSIONAL AND MULTI-AGENCY PSYCHOLOGICAL THERAPIES STRATEGIC PLANNING AND MANAGEMENT GROUP) TO ENSURE COHERENT AND COMPREHENSIVE PLANNING ACROSS AN NHS BOARD AREA.

Consideration should be given to equity of provision/availability of treatment across NHS Board areas and across specialist areas of service.

The planning group should have the authority to disinvest in therapies and services which are ineffective, inefficient or not cost-effective.

Planning groups should oversee service audit and re-design, workforce planning, training and governance of psychological therapies. They should also promote service-based research to advance the evidence base.

Links should be made between the work around the Psychological Therapies HEAT target, the Mental Health Quality and Efficiency Support Team, and NHS Education for Scotland.

The well-functioning system should involve staff in developing the processes around the monitoring and delivery of the various HEAT targets, in order to harness local expertise and maximise subsequent engagement.

Boards should have IT systems which can collect information with minimal investment of time and effort, and will feed meaningful and clinically relevant information back to staff to inform both direct patient care and service audit and re-design.

SUMMARY GUIDANCE ON 'WELL-FUNCTIONING PSYCHOLOGICAL THERAPIES SERVICES'

IMPLEMENTATION**WELL-FUNCTIONING PSYCHOLOGICAL THERAPIES SERVICES SHOULD OPERATE WITHIN THE FRAMEWORK OF A CLEARLY ARTICULATED AND WELL GOVERNED MATCHED/STEPPED CARE SYSTEM.**

Each matched/stepped care service will be audited and managed pro-actively to manage demand and capacity, and to maximise effectiveness, efficiency, cost-effectiveness and patient safety, in the context of achieving the HEAT targets.

Processes within 'Matched/Stepped Care':

- The services which are providing the various tiers of care should be clearly identified and described, and there should be explicit links between the different tiers of service serving a particular geographical area.
- There should be clarity around the thresholds for accessing the various tiers of service, based on complexity of presentation. GPs should have guidance to enable them to refer appropriately, and within the system staff should be clear about the criteria for assignment to the different levels of intervention.

- There should be clear pathways through the system, specifying how patients will be allocated to levels of intervention, and how they will be stepped up or down as necessary. The system should gather intelligence on activity levels within each tier, on the numbers of those who are not considered as suitable for psychological intervention and on what happens to those individuals.
- There should be drivers which strongly encourage clinicians to match to the least intensive intervention which will provide significant health gain.
- There should be 'direct access' options to the service which will help to address issues of low uptake by 'hard to reach' groups.
- Patients and carers should be involved in decision making around care.
- Patient outcomes should be collected routinely, and services should be moving towards 'session-by-session' outcome monitoring to maximise data completeness for purposes of service audit and continuous improvement, to drive 'stepping-up', and to inform clinical supervision and improve patient outcomes.

SUMMARY GUIDANCE ON 'WELL-FUNCTIONING PSYCHOLOGICAL THERAPIES SERVICES'

- Staff should have the training and supervision necessary to deliver the functions required to operate the system effectively, as appropriate to their role.
- There should be continuous monitoring and feedback on the performance of the matched/stepped-care model and referral system, and outcome data should be used to drive improvement.
- Properly funded research trials to evaluate new and innovative therapeutic approaches should be facilitated.

TIERS OF CARE

ALTHOUGH THERE WILL BE SOME VARIATION AMONG SERVICES, WHICH SHOULD BE CONFIGURED TO BEST MEET LOCAL NEEDS, THE WELL-FUNCTIONING SERVICE WILL HAVE LEVELS OF SERVICE DELIVERY CORRESPONDING TO THE FOLLOWING:

- HIGH VOLUME INTERVENTIONS

Aimed at those experiencing stress or other forms of psychological distress, and may include provision of information, psycho-education, prescribed exercise, counselling or the use of psychological principles within another healthcare context.

These do not fall within the scope of the HEAT target, but some measurement of the volume of activity within this tier should be made.

- 'LOW INTENSITY' EVIDENCE-BASED TREATMENTS

Protocol-driven interventions aimed at less complex mental illness and disorder and normally lasting between two and six sessions.

Waiting times for Low Intensity treatments will be counted under the PTs HEAT Access target if those treatments are delivered to people with a mental illness or disorder, person-to-person (or in group settings), in protected time, to protocol, by properly trained staff under appropriate supervision.

SUMMARY GUIDANCE ON 'WELL-FUNCTIONING PSYCHOLOGICAL THERAPIES SERVICES'

Both High Volume interventions and Low Intensity treatments should be highly valued as essential elements of the well-functioning system, recognising their potential to deliver effective care to a significant number of patients, thereby reducing the pressure on the higher tiers and enabling the delivery of the HEAT Access target.

- PSYCHOLOGICAL THERAPIES-'HIGH INTENSITY' AND 'SPECIALIST' INTERVENTIONS.

Traditional, standardised psychological therapies (Cognitive Behavioural Therapy (CBT), Interpersonal Psychotherapy (IPT), Short-term, focused Psychodynamic Psychotherapy etc) aimed at moderate to severe mental illness and disorder with significant complexity, sometimes within a specialist service, and normally lasting between six and 20 sessions.

- HIGHLY SPECIALIST PSYCHOLOGICAL THERAPIES AND INTERVENTIONS

Individually tailored interventions based on case formulations drawn from a range of psychological models, aimed at service users with highly complex ad/or enduring mental illness and disorder, and normally lasting for 16 sessions and above.

Waiting times for 'High Intensity', 'Specialist' and 'Highly Specialist' psychological therapies and interventions will be measured under the Psychological Therapies HEAT Access target.

TARGETS, STANDARDS AND COMMITMENTS

THE PROVISION OF EFFECTIVE PSYCHOLOGICAL INTERVENTIONS AT SUFFICIENT VOLUME IS ESSENTIAL TO ENSURE THAT NHS BOARDS ACHIEVE THE AMBITIOUS TARGETS THE SCOTTISH GOVERNMENT HAS SET FOR IMPROVING MENTAL HEALTH OUTCOMES IN SCOTLAND.

PSYCHOLOGICAL THERAPIES HEAT TARGET

THE TARGET FOR PSYCHOLOGICAL THERAPIES IS CONSTITUTED AS AN ACCESS TARGET FOR MENTAL HEALTH SERVICES.

‘Deliver faster access to mental health services by delivering 18 weeks referral to treatment for Psychological Therapies from December 2014’

There are no exclusions from the target, which will be applied across the age range, and to all patient groups.

Timely access to safe and effective Psychological Therapies continues to be a priority for the Scottish Government, and the target will carry forward as an LDP standard in 2015-16.

TARGETS, STANDARDS AND COMMITMENTS

RELATED TARGETS AND STANDARDS

IN ADDITION TO THE PSYCHOLOGICAL THERAPIES ACCESS TARGET, THE TIMELY PROVISION OF EFFECTIVE PSYCHOLOGICAL INTERVENTIONS WILL BE NECESSARY TO SUPPORT BOARDS IN MEETING A NUMBER OF CURRENT HEAT TARGETS AND STANDARDS, AND COMMITMENTS IN THE MENTAL HEALTH STRATEGY FOR SCOTLAND (2012-2015):

■ DRUG AND ALCOHOL TREATMENT WAITING TIMES STANDARD

'90% of clients will wait no longer than three weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.'

■ DEMENTIA POST-DIAGNOSTIC SUPPORT TARGET

'By 2015/16, all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan.'

■ COMMITMENT 20 OF THE MENTAL HEALTH STRATEGY FOR SCOTLAND

'We will take forward the recommendations of the Psychological Therapies for Older People report with NHS Boards and their statutory and voluntary sector partners, and in the context of the integration agenda'

■ COMMITMENT 22 OF THE MENTAL HEALTH STRATEGY FOR SCOTLAND

'We will work with the Royal College of GPs and other partners to increase the number of people with Long Term Conditions with a co-morbidity of depression or anxiety who are receiving appropriate care and treatment for their mental illness.'

TARGETS, STANDARDS AND COMMITMENTS

CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH: TARGETS AND COMMITMENTS

IN ADDITION TO THE PSYCHOLOGICAL THERAPIES HEAT TARGET, CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) ARE ALSO WORKING TO MEET AN ACCESS TARGET FOR SPECIALIST SERVICES:

'Deliver faster access to mental health services by delivering 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) from December 2014'

and a number of other commitments:

- Commitment 7 of the Mental Health Strategy for Scotland (2012-2015):
'In 2012 we will begin a national roll-out of Triple P and Incredible Years parenting programmes to the parents of all 3-4 year olds with severely disruptive behaviour.
- To implement The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care by 2015

- To make basic infant mental health training more widely available to professionals in the children's service workforce.
- To provide training for child psychotherapy through NHS Education for Scotland.

A significant increase in access to appropriate evidence-based therapies, delivered to the highest standards, within well governed and quality-assured local structures, will be essential if NHS Boards are to deliver the targets and commitments listed above.

THE INTEGRATION OF HEALTH AND SOCIAL CARE

THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014 PROVIDES A FRAMEWORK TO SUPPORT IMPROVEMENTS IN THE QUALITY AND CONSISTENCY OF HEALTH AND SOCIAL CARE SERVICES THROUGH THE INTEGRATION OF HEALTH AND SOCIAL CARE IN SCOTLAND.

All Integration arrangements must be in place by April 2016, and services are in the process of creating the structures and processes which will underpin the envisioned paradigm shift in the delivery of health and social care.

The prescribed national health and wellbeing outcomes become 'live' in December 2014, and it is against these outcomes, and the indicators which sit beneath them, that the performance of the new integration authorities will be measured. In relation to the measurement of outcomes, the Scottish Government has stressed that the underlying principle of the proposals is to provide national leadership in relation to what is required – the outcomes that must be delivered – and to leave to local determination how best to achieve those outcomes – the delivery mechanisms that will best suit different local needs.

At the time of writing it is not clear where the existing targets and standards will sit within the new system, however the delivery of timely and effective psychological therapy remains a Scottish Government priority.

THE PURPOSE AND STRUCTURE OF THIS PAPER

THE PURPOSE OF THIS GUIDANCE IS TO SUPPORT NHS BOARDS ACROSS SCOTLAND TO DELIVER AN INCREASE IN ACCESS TO EFFECTIVE PSYCHOLOGICAL THERAPIES BY OFFERING CLEAR AND EASILY ACCESSIBLE GUIDANCE ON:

- the evidence base for the effectiveness of psychological interventions for specific patient groups.
- how these interventions should be delivered in practice to ensure maximum impact on services.

NHS Boards will be able to assess the capacity of local services to deliver these therapies as part of their strategic planning for mental health and long term conditions.

MAIN AIMS

- To summarise preferred options for commissioning psychological interventions for specific patient groups based on evidence of efficacy.
- Thereby guiding NHS Boards in determining which interventions they should consider providing in their area.
- To aid NHS Boards in identifying gaps in the provision of psychological therapies.
- To support NHS Boards in developing strategic plans for increasing local capacity to deliver Psychological Therapies.
- To provide an indication of the associated staff training requirements.
- To provide advice on other important governance issues.

THE PURPOSE AND STRUCTURE OF THIS PAPER

Psychological interventions will be embedded in specific models of service delivery. These may vary in the fine detail, but in general a matched/stepped care approach is assumed. It is important to bear in mind that the standards for the delivery of Psychological Therapies within a stepped care system will be based around the competence framework developed by 'Skills for Health' (see Chapter 3).

Services will be expected to work towards complying with these standards.

Priority is given, in the first instance, to delivering psychological interventions to help NHS Boards move towards:

- Meeting the Psychological Therapies HEAT Access target
- Improving services for the common mental health problems - depression and anxiety
- Building capacity in clinical priority areas

IN LINE WITH THE STRATEGIC AIMS OF THE EXERCISE, THE DOCUMENT IS DIVIDED INTO TWO PARTS:

PART ONE

> CHAPTER 1:
DELIVERING PSYCHOLOGICAL THERAPIES - THE FUNDAMENTALS

> CHAPTER 2:
SERVICE STRUCTURES AND PROCESSES

> CHAPTER 3:
TRAINING, SUPERVISION AND GOVERNANCE

> CHAPTER 4:
SUPPORT FOR CHANGES

> CHAPTER 5:
KEY DEVELOPMENTAL QUESTIONS FOR SERVICES

PART TWO

CHAPTER 1

DELIVERING PSYCHOLOGICAL THERAPIES: THE FUNDAMENTALS

VALUE-BASED CARE AND A RECOVERY FOCUS

ANY PSYCHOTHERAPEUTIC INTERVENTION MUST BE VALUES BASED AND RECOVERY FOCUSED, AND ROOTED IN RESPECT FOR THE PERSON, ETHICAL PRACTICE, PERSON-CENTRED CARE AND RESPECTING DIVERSITY AND PROMOTING EQUALITY.

The 10 Essential Shared Capabilities (ESC) for Mental Health Practice provides the baseline capabilities on which other interventions are built.

NES launched the first version of the Scottish materials in 2007 and also commissioned a “training for trainers” programme that prepared and supported individuals drawn from across mental health services in Scotland to further disseminate and cascade the 10 ESC training within their organisations. The 10 ESC training and learning has been widely disseminated in Scotland and is now embedded in the undergraduate preparation of health professionals. [An updated version of the mental health materials](#) was produced in 2011.

In 2012 NES produced another learning resource: The 10 Essential Shared Capabilities – Promoting Person Centred Approaches. [This version of the learning resource](#) builds on the successes of the original mental health learning resource. It was developed to reflect the evolving policy and legislative context driving improvements in person centred care in Scotland, and the increasing influence of values, rights based and personal outcomes approaches to practice.

There has also been an increasing emphasis in Scotland on Recovery focused practice, led by the Scottish Recovery Network (SRN). The SRN, in partnership with NHS Education for Scotland, published a [framework for learning and training in Recovery focused practice, and a set of national learning materials](#) which will help support all staff to operate from a recovery-based perspective.

VALUE-BASED CARE AND A RECOVERY FOCUS

The modules in 'Realising Recovery' (which comprise 'Understanding Recovery', 'Using Self to Develop Recovery-focused practice', 'Enabling self-direction', 'Sharing Responsibility for Risks and Risk-taking' and 'Connecting with Communities') build on the sound foundations laid down in the 10 ESCs.

Combined, these materials offer all mental health workers opportunities to develop their knowledge, skills and values in ways that maximise the involvement of service users, embrace the belief that recovery is possible and facilitate new relationships between people who use services and the communities they live in.

[The Scottish Recovery Network website](#) contains a wealth of other materials to support further developments in our understanding of recovery and recovery focused practice.

Increasingly multi-disciplinary teams are working together to review and develop the recovery orientation of their services and practices using the Scottish Recovery Indicator (SRI2) tool and process. The Scottish Recovery Indicator (SRI) is a service development tool that can be used by anyone interested in developing recovery focused services. SRI was developed by the Scottish Recovery Network (SRN) to provide services with a practical tool to review, develop and improve how they are supporting recovery.

SRI 2 is a revised and improved version of the original SRI tool. Since it was first introduced in 2011, SRI 2 has been used by a wide range of services to help them review their existing practices against a range of recovery indicators. Completing an SRI 2 helps services to highlight existing strengths, that can be built upon and identify actions that would improve the recovery focus of the service.

WORKING WITH CHILDREN AND YOUNG PEOPLE

MUCH OF WHAT HAS BEEN SAID ABOUT VALUES AND A RECOVERY FOCUS WILL APPLY EQUALLY IN WORK WITH YOUNG PEOPLE. BUT AS WELL AS THIS, POLICY DEVELOPED IN THIS AREA OVER RECENT YEARS HAS ARTICULATED A NUMBER OF ADDITIONAL VALUES AND PRINCIPLES WHICH ARE REITERATED HERE.

Mental health promotion for children and young people should be an underpinning principle for all who come into contact with children and young people, whether they are well or unwell.

Mental health promotion, illness prevention, treatment and care for children and young people should have the rights of children and young people as a core value. Services must recognise the right of children and young people to be heard, and their capacity to play a full part in thinking about mental health and in influencing the arrangements that we make to improve mental health.

Interventions must be designed and delivered in a way that recognises the developmental stage of the children's lives and the social and relationship contexts in which they live. Particular attention has to be paid to the experience of, and the quality of, family and other care-giving relationships.

WHAT ARE PSYCHOLOGICAL THERAPIES?

THERE IS A RECOGNITION THAT THE PHRASE 'PSYCHOLOGICAL THERAPIES' IS USED TO DESCRIBE A WIDE RANGE OF PRACTICES, AND THAT THERE IS A DEGREE OF CONFUSION OVER THE MEANING OF THE TERM.

At the higher tiers of the matched/stepped-care system (see below), staff may be accredited to a specialist level in one of the major therapeutic approaches. Further down the pyramid they may simply be required to use circumscribed elements of any particular approach under appropriate supervision.

For the purposes of this paper, the term 'Psychological Therapies' refers to a range of interventions, based on psychological concepts and theory, which are designed to help people understand and make changes to their thinking, behaviour and relationships in order to relieve distress and to improve functioning. The skills and competences required to deliver these interventions effectively are acquired through training, and maintained through clinical supervision and practice.

A range of different psychological models have been applied to mental health problems, and different 'schools' or modalities of therapy have grown up around these models. The modalities of therapy most commonly provided within the Health Service in Scotland are Cognitive Behavioural Therapy (CBT), Behaviour Therapy (BT), Systemic and Family Therapy, Psychoanalytic/Psychodynamic Psychotherapy, Inter-Personal Therapy (IPT) and Humanistic Therapy.

There are a range of other therapies on offer, many of which are offshoots or developments from the main modalities, some of which offer an integrative approach.

WHAT ARE PSYCHOLOGICAL THERAPIES

Effective psychological interventions tend to share the following key characteristics:

- A clear underlying model/structure for the treatment being offered.
- A focus on current problems of relevance to the service user.
- Recognition of the importance of a good therapeutic alliance between patient and therapist.

For any particular patient population it is possible to review the scientific evidence, based on published research trials, for the effectiveness of any particular therapy. The Matrix evidence tables (Chapter 6) set out to summarise this evidence.

Different levels of skills and competences are required at the various tiers of patient care, and these need to be clearly articulated for each therapeutic modality to ensure that appropriate care is delivered at each stage of the patient journey. The description of these competences will inform the training agenda (See Chapter 3).

PSYCHOLOGICAL THERAPIES AND THE HEAT ACCESS TARGET

THE OBJECTIVE OF THE TARGET IS TO:

‘DELIVER FASTER ACCESS TO MENTAL HEALTH SERVICES BY DELIVERING 18 WEEKS REFERRAL TO TREATMENT FOR PSYCHOLOGICAL THERAPIES FROM DECEMBER 2014’

The target is intended to improve access to the evidence based psychological therapies for people who have a mental illness or disorder.

There are no exclusions from the target, which applies across the age range and in inpatient as well as community settings. It will also apply in physical health, learning disability and substance misuse settings where there is associated mental illness or disorder.

The target will be part of the HEAT performance management system and will require NHS Boards to make monthly data submissions to ISD. Progress against the delivery of the target will be monitored through the existing six-monthly review visits which the Mental Health and Protection of Rights Division has with NHS Boards.

PSYCHOLOGICAL THERAPIES AND THE HEAT ACCESS TARGET

DATA TO BE COLLECTED NATIONALLY

In order to monitor progress towards the target the key information to be collected on every patient to enable monitoring of waiting times is:

- Date of receipt of the referral.
- Date psychological therapy commences as planned.

As a balancing measure the waiting time between assessment and commencement of therapy will also be recorded by collecting:

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

Waiting times should be measured and adjusted for patient unavailability in line with national waiting times guidance. In order to ensure that information is collected consistently ISD worked with key stakeholders to develop data standards and guidance on the application of national waiting times guidance to psychological therapies.

DATA TO BE COLLECTED LOCALLY

■ BALANCING MEASURES

The setting of a HEAT target for any part of the system can have repercussions for other areas of service. It is expected that NHS Boards will collect data locally on a number of additional balancing measures. This will help to ensure that the existence of the target does not impact negatively on other parts of the system, or on the quality of patient care.

Patient outcomes are an important balancing measure. These need to be monitored closely to ensure that any changes made to achieve the target do not impact adversely on clinical effectiveness. The Mental Health and Protection of Rights Division is currently consulting on the possibility of standardising outcome measures across Scotland, and on what will be monitored nationally in this regard.

The monitoring of the target should also include a balancing measure capturing the percentage of people assessed as not suitable for psychological therapy.

Further information on key measurement points and other guidance can be found on the [ISD website](#)

PSYCHOLOGICAL THERAPIES AND THE HEAT ACCESS TARGET

- MEASURES AROUND EVIDENCE-BASED PRACTICE

For the purposes of the HEAT target, 'Psychological Therapies' will be defined as evidence-based interventions (as recommended in the evidence tables in Section 6 of this document), delivered to patients experiencing a mental illness or disorder. In the vast majority of cases these interventions will be delivered to people with depression and anxiety.

However, during development of the target, representatives from NHS Boards made the case that there are circumstances where a psychological therapy is delivered that is not included in The Matrix in order to meet the needs of a particular patient. At the moment there is no clear picture of what therapies are delivered across Scotland, and what proportion of them are delivered in line with the evidence-base. For this reason, data will be collected nationally on all psychological therapies being delivered to people with a mental illness or disorder.

Collecting information locally about the level of variance – how often therapies are delivered outwith the evidence base – will provide an overview, both locally and nationally, of where there might be gaps in The Matrix, as well as where there might be barriers to delivering evidence-based therapies e.g. due to a lack of trained staff.

In order for a Board to be able to determine whether a psychological therapy is being delivered in line with the evidence base, it will need to know that the therapy being delivered is:

- a therapy which has an evidence base for that particular diagnosis

and that it is being delivered:

- by appropriately trained staff
- in dedicated/focused sessions within protected time
- with recommended levels of psychological therapies supervision.

This will include interventions delivered by telephone or direct video link. There are also situations in which psychological therapy is delivered through family members, carers and health or care staff, who are being trained or supported to deliver a particular intervention. This may happen, for example, in Child, Learning Disabilities and Dementia services. In these circumstances the therapist will be involved in face-to-face sessions with third parties as described. Although the named patient may not be present, these interventions should be counted under the target.

PSYCHOLOGICAL THERAPIES AND THE HEAT ACCESS TARGET

ISD have developed standards and definitions around the key information requirements for the target, to enable Boards to develop their own local datasets for the collection of information on diagnosis, type of therapy delivered and clinical outcomes, in addition to the information required around access. Ensuring the competence of therapists, the provision of adequate psychological therapies supervision and the availability of protected time for delivery is a local governance issue.

It is recognised that the current evidence tables in The Matrix do not cover all diagnostic groups, and it is assumed that Boards will take advice from local experts on the status of current evidence and best practice where national guidance is not available.

- WHAT SHOULD BE COUNTED?

The target is focused on mental health services, and on patients who would meet diagnostic criteria for mental illness and disorder, and consequently the waiting times measures will primarily focus on therapies delivered at higher tiers of service, and on those Low Intensity interventions which meet the criteria listed above.

This is not to suggest that other higher volume, low intensity interventions are unimportant. The evidence is that a substantial proportion of those with mild/moderate mental illness and disorder can be treated effectively at this level, reducing demand for service at higher tiers.

Indeed it is envisaged that NHS Boards will only be able to meet the target if they provide a substantial volume of high quality 'Low Intensity' interventions as part of an integrated service. It is expected that NHS Boards will put in place some measure of volume of care delivered within the lower tiers.

PSYCHOLOGICAL THERAPIES AND THE HEAT ACCESS TARGET

Examples of what should and should not be counted under the target:

Everything listed below is desirable, and should happen in a well-functioning service, but not everything should be counted under the target.

(Note: The list does not attempt to cover every possible intervention, but to provide helpful exemplars)

- All staff should be delivering psychologically-informed care, which may involve formulating a patient's difficulties in psychological terms. Although this is an essential element of holistic care, it should not be counted under this particular target.
- Staff delivering open access, large scale psycho-educational groups should not count this under the target, although some measure of volume of care should be in place.
- Staff delivering counselling for psychological distress at lower tiers of the service should not count this under the target, although, again, some measure of volume of care delivered should be in place. Counselling should only be counted under the target where it is recommended in The Matrix as an evidence-based intervention for a specific condition.
- Staff delivering CBT-based guided self-help to protocol, or standardised small-scale anxiety management groups, should count this under the target.

- Staff delivering 'High Intensity' Therapy and 'High Intensity Specialist' Therapy for mental illness or disorders should count this under the target.
- Staff delivering 'Highly Specialist' Therapy should count this under the target.

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

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

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

PSYCHOLOGICAL THERAPIES AND THE HEAT ACCESS TARGET

■ ASSESSMENTS

Where assessments are quite clearly for the purpose of establishing suitability for psychological therapy, and/or triage to appropriate levels of service, they will be captured as a 'balancing' measure for the HEAT target as outlined above.

However, there are more complex assessments which are not necessarily linked to the delivery of psychological therapies, but which may require a number of sessions to complete. These may include general diagnostic assessments, neuro-psychological assessments, assessments to establish the presence of a learning disability etc.

- If these assessments are purely investigative or diagnostic, or for the purpose of general care planning, and do not involve or lead on to the delivery of psychological therapy (as defined for the purposes of the target), they should not be counted under the target.
- However, during the course of such an assessment it may be appropriate to deliver a formal psychological intervention. This psychological intervention should be counted under the target if it meets the criteria for an evidence-based psychological therapy as defined for the purposes of the target. The clock would stop at the point at which therapy commences, which may be during the assessment phase.

- If, following the assessment, the patient is referred on for a psychological intervention or therapy for a mental illness or disorder, the waiting time should be measured in line with national waiting times guidance.

Further information on what is to be counted can be found in the [ISD Frequently Asked Questions \(FAQ\) document](#).

This will be updated on an ongoing basis.

PSYCHOLOGICAL THERAPIES AND THE HEAT ACCESS TARGET

■ APPROACH TO DATA COLLECTION

Psychological therapies waiting times data has been collected nationally, using a phased approach, since April 2011. Boards were not in a position to provide complete, high quality data from the outset. In the first two years of the target the focus locally was on identifying the wide range of services and workforce delivering psychological interventions, and making changes to IT systems to enable comprehensive collection of good quality waiting times data. The existence of the target has acted as a catalyst for improvement in a number of areas, the development of information systems in particular, and significant progress has been made using the phased approach around data quality.

The target is due for delivery from December 2014, and, despite the considerable progress made, there is still some way to go in relation to data quality and completeness. As at October 2014 some Health Boards are still working on development of IT systems, and as a result the data are not yet complete. Boards are now accelerating their development work in order to provide assurances to the Government that plans are in place to improve performance, and to produce nationally consistent and comparable data, including the capacity to capture adjusted waits (where patients were unavailable or did not attend an appointment).

Issues around the delivery of evidence-based therapy, the role of clinical supervision, the definition of High and Low Intensity

interventions and the specification of appropriate training levels are discussed further below.

DELIVERING EVIDENCE-BASED PSYCHOLOGICAL THERAPIES

THE COMMITMENT TO DELIVER 'EVIDENCE-BASED' INTERVENTIONS HAS A NUMBER OF IMPLICATIONS FOR ANY SERVICE.

The evidence base is derived from the results of key therapeutic research trials, and to deliver an 'evidence-based' therapy we must be able to demonstrate that we are replicating the conditions operating within those trials as closely as possible.

In practice this means having therapists:

- trained to recognised standards and having the competences necessary to deliver psychological interventions effectively to the tier of service within which they work.
- delivering a therapy which has a strong evidence base with respect to the patient's diagnosis.
- delivering well-articulated therapy, and adhering to the appropriate model.
- operating within a well-governed system which offers regular high quality, model-specific psychological therapies supervision, support and relevant Continuing Professional Development (CPD).

NHS Education for Scotland (NES) has been working in partnership with UCL and the UK-wide organisation 'Skills for Health' to articulate the competences necessary both to deliver Psychological Therapies, and to supervise others who are in training or delivering within the service (see Chapter 3).

It is important to bear in mind that the standards for the delivery and supervision of Psychological Therapies within a matched/stepped-care system will be based around these competences, and services will be expected to work towards complying with these standards to demonstrate that they are providing evidence-based care. All NHS Boards are currently being encouraged to review their service provision, staff training and supervision arrangements in the light of these developments.

DELIVERING EVIDENCE-BASED PSYCHOLOGICAL THERAPIES

The NES/ISD/SGHD Psychological Therapies Workforce Survey provides a template for the collection of data on the numbers of staff delivering Psychological Therapies, their level of training, their access to PTs supervision, and the time protected for systematic delivery. It will be rolled out on a recurrent basis to help SGHD and Health Boards understand the characteristics of the workforce and the capacity within the system, and to assist Boards in identifying issues around the delivery of evidence-based care. It will also allow NES to further refine and target a needs-led training programme.



THE KEY ROLE OF PSYCHOLOGICAL THERAPIES SUPERVISION

AS WITH ALL OTHER HEALTH SERVICE TREATMENTS, PSYCHOLOGICAL THERAPIES MUST, IN LINE WITH THE AMBITIONS OF THE HEALTHCARE QUALITY STRATEGY AND THE 20:20 VISION, BE DELIVERED IN A WAY WHICH IS SAFE, EFFECTIVE AND EFFICIENT.

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

The best available evidence suggests that regular Psychological Therapies supervision covering all active cases, and focusing on ethical practice, adherence to protocol, progress in treatment and elements of the therapeutic relationship, is the best mechanism for reducing potentially harmful variations in practice, and for ensuring the safe, effective and efficient delivery of therapy.

At the outset, it is important to distinguish between traditional clinical or work-related supervision - which may cover a range of clinical, managerial and related issues- and the term 'Psychological Therapies supervision'.

Psychological Therapies supervision focuses on the delivery of a particular therapy in a specific context. It is essential to the provision of effective Psychological Therapies services, both during training and to ensure the safety and quality of subsequent practice. It is a requirement of all professional bodies accrediting psychological therapists.

THE KEY ROLE OF PSYCHOLOGICAL THERAPIES SUPERVISION

Psychological Therapies Supervision:

- ensures that the supervisee practices in a manner which conforms to ethical and professional standards.
- promotes fidelity to the evidence base (the therapeutic trials from which the evidence base is derived routinely insist on close supervision of individual cases and outcomes).
- promotes adherence to the therapeutic model.
- provides support and advice in dealing with individual cases where the therapy may be stuck, or where there are elements of risk.
- acts as a vehicle for training and skills development in practice.
- may improve treatment effectiveness and efficiency when it is outcome focused.

In order to deliver safe and effective Psychological Therapies, NHS Boards will have to ensure that there are enough adequately trained psychological therapies supervisors within the system and the capacity for regular supervision of both trainees and practising staff (see Chapter 3).

PSYCHOLOGICAL THERAPIES - A ROLE FOR ALL DISCIPLINES

ALL CLINICAL STAFF WORKING IN THE NHS IN SCOTLAND SHOULD HAVE THE BASIC LEVEL OF KNOWLEDGE AND UNDERSTANDING NECESSARY TO COMMUNICATE EFFECTIVELY WITH PATIENTS AND DELIVER HOLISTIC CARE WHICH TAKES ACCOUNT OF THE PATIENT'S PSYCHOLOGICAL AND EMOTIONAL PRESENTATION AND NEEDS.

Beyond that, staff from all disciplines have a role in the identification of psychological problems, and many will be involved in the delivery of specific evidence-based psychological interventions and therapies at different tiers of the service. Within primary care and mental health services in particular, it will be necessary to maximise the contribution of the various disciplines to the delivery of Psychological Therapies in order to meet the HEAT access target.

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

APPLIED PSYCHOLOGY

THE BULK OF PSYCHOLOGICAL INTERVENTIONS DELIVERED WITHIN THE NHS WERE TRADITIONALLY CARRIED OUT BY CLINICAL PSYCHOLOGISTS FROM WITHIN PSYCHOLOGY SERVICES AND DEPARTMENTS.

However in recent years the emphasis has been on expanding capacity through skill mix, and psychologists have increasingly been involved in the development and quality assurance of psychological competence in the existing multi-professional workforce.

Skill mix has happened within many psychology services, with the addition of Assistant Psychologists, Clinical Associates in Applied Psychology, Counselling Psychologists, Cognitive Behaviour Therapists and Self-help Workers. In addition there has been an increase in the number of staff from other disciplines trained in particular psychotherapeutic approaches.

PSYCHOLOGICAL THERAPIES - A ROLE FOR ALL DISCIPLINES

This expansion of the skill mix, and the demand for greater access to psychological interventions, has led to an increase in the requests for Applied Psychologists to provide training and supervision.

The 2011 document 'Applied Psychology and Psychologists in NHS Scotland' recommends that Applied Psychologists, the staff group with the highest level of psychological expertise within the workforce by virtue of their 7-year full-time academic and Doctoral level clinical training, maintain and develop extended roles aimed at increasing the availability of psychological interventions, whilst retaining a central role in psychological governance, ensuring the quality of interventions offered. It is also recommended that Applied Psychologists concentrate their direct clinical work on those with the most complex presentations.

NURSING

AS THE LARGEST PROFESSION IN THE NHS, THE INPUT OF NURSES WILL BE CRITICAL IN ENABLING NHS BOARDS TO DELIVER GOOD PSYCHOLOGICALLY-BASED CARE, AND TO MEET THE HEAT ACCESS TARGET.

Mental health nurses' role in delivering Psychological Therapies will be progressed using a stepped approach to competence development. Achieving this will require the provision of accredited training, ongoing psychological therapies supervision for nurses practicing Psychological Therapies, and pro-active management activity to ensure nurses have protected time to deliver psychological interventions and therapies in practice.

PSYCHOLOGICAL THERAPIES - A ROLE FOR ALL DISCIPLINES

ALLIED HEALTH PROFESSIONALS (AHPs)

AHPs HAVE CONTACT WITH PATIENTS IN A RANGE OF SETTINGS, AND ARE IN A GOOD POSITION BOTH TO IDENTIFY PSYCHOLOGICAL DISTRESS, AND TO OFFER APPROPRIATE INTERVENTIONS.

Appropriately trained AHPs can also deliver a range of evidence-based interventions as described in the psychological therapies Matrix while continuing to provide specialist AHP rehabilitation interventions.

All AHPs will acquire some psychological knowledge and skills within their basic training, and can integrate recognised psychological approaches into their core practice. Some professionals, particularly Occupational Therapists who work in Mental Health, and Speech and Language Therapists, will have significant exposure to psychological ideas and techniques. Occupational Therapists are the majority AHP group working in Mental Health alongside Mental Health Nursing, and are in a good position to undergo further training, and to deliver a range of psychological interventions at Low and High Intensity level.

Art Psychotherapists and Dance Movement Psychotherapists have a very specific Masters level psychotherapy training, and can provide high intensity psychological therapy (such as individual and group psychotherapeutic interventions for Trauma) within specialist services.

RECOMMENDATION 7 from '[Realising Potential: an action plan for allied health professionals in mental health 2010](#)' states that:

'NHS Boards should ensure the delivery of evidence-based psychological interventions by appropriately trained AHPs to support rehabilitation, self-management and recovery approaches as part of local delivery strategies.'

The challenge for services is to utilise the AHP staffing resources at their disposal to deliver a range of evidence-based psychological interventions and maximise AHPs potential to promote better outcomes for service users and carers. The challenge for AHPs is to clearly articulate their contribution to delivering psychological interventions and actively engage in local psychological forums and strategy groups, working in partnership with NES Psychological Therapies Training Co-ordinators.

Realising Potential: an action plan for allied health professionals in mental health' can be found at <http://www.scotland.gov.uk/Publications/2010/06/15133341/0>.

An [update on the implementation of the action plan 'Driving Improvement: Implementing Realising Potential'](#) is available.

* Allied Health Professionals registered with the Health and Care Professions Council include: Art Therapy / Art Psychotherapy, Dance Movement Psychotherapy, Dieticians, Drama Therapy, Music Therapy, Occupational Therapy, Podiatry, Physiotherapy, and Speech and Language Therapy.

PSYCHOLOGICAL THERAPIES - A ROLE FOR ALL DISCIPLINES

PSYCHIATRY

THE ROYAL COLLEGE OF PSYCHIATRISTS HAS RECOMMENDED THAT PSYCHOLOGICAL THERAPY SERVICES ARE EXPANDED NATIONALLY SO THAT THEY ARE AVAILABLE IN ALL AREAS.

All psychiatrists working in the NHS have some basic training in the different forms of psychological therapy, and may deliver low intensity psychological therapies – as well as more supportive psychological interventions for people with long-term problems – as part of their role within the general psychiatric services.

Psychiatrists from a range of specialties may have additional training in psychological interventions and therapies which are relevant to their areas of work.

A smaller number of psychiatrists will have completed a higher specialist training in psychotherapy, which included intensive training in one psychotherapeutic modality (CBT, Psychodynamic or systemic therapy), and training in the other two approaches. They are then designated 'Consultant Psychiatrists in Psychotherapy'. As such Consultant Psychiatrists in Psychotherapy are able to train specialty registrars in psychotherapy, and staff from other disciplines.

In their role as psychological therapies trainers and supervisors, and Consultant Psychiatrists in Psychotherapy, psychiatrists have an important role in the governance of the psychological treatment services within NHSScotland.

PRIMARY CARE STAFF

THE MAJORITY OF PSYCHOLOGICAL DISTRESS AND MENTAL HEALTH PROBLEMS ARE DEALT WITH IN THE PRIMARY CARE SETTING.

With reference to psychological interventions, GPs and other Primary care staff who are working closely with patients and families in the general health context have a key role in identifying psychological problems, offering advice and low level interventions as appropriate, and referring on to mental health services where this is indicated. Within some GP practices staff may be trained to deliver psycho-educational packages and guided self-help interventions.

CHAPTER 2

SERVICE STRUCTURES AND PROCESSES

SERVICE STRUCTURES AND PROCESSES

IT IS RECOGNISED THAT, ALTHOUGH CONSIDERABLE PROGRESS HAS BEEN MADE, THERE IS STILL A GAP IN SOME AREAS BETWEEN WHAT IS CURRENTLY AVAILABLE AND THE LEVEL OF SERVICE REQUIRED TO MEET THE ASPIRATIONS OF THE SCOTTISH GOVERNMENT.

Where there is such a discrepancy, up-skilling of staff alone will not be enough to produce the necessary increase in capacity. Organisational change and service re-design will be essential, and some re-configuration of resources may well be required. One of the functions of the Mental Health Quality and Efficiency Support Team will be to facilitate such change (see Chapter 4).

In relation to mental health services for children and young people, alongside training and re-design, the SGHD recognises that, in many NHS Boards, CAMHS staffing levels will have to increase to bridge this discrepancy. In recent years there has been significant investment to support and accelerate development of specialist CAMHS services. There are additional psychologists and Child and Adolescent Psychotherapists in training, and there has been an overall increase of 45% in the size of the specialist CAMHS workforce since 2008. This increase, together with the training in evidence-based Psychological Therapies and parenting interventions commissioned through NHS Education for Scotland, will help provide the increase in capacity required to deliver the Psychological Therapies target.

STRATEGIC PLANNING

AT A STRATEGIC LEVEL IT IS EXPECTED THAT THERE WILL BE AN IDENTIFIED NHS BOARD LEAD FOR THE PSYCHOLOGICAL THERAPIES HEAT TARGET AT EXECUTIVE DIRECTOR LEVEL.

Direct accountability for Psychological Therapies at NHS Board level, will ensure meaningful engagement with the local Psychological Therapies strategic planning mechanisms, facilitating negotiation around service re-design and the allocation of resource.

There will be an identified project lead/team for the implementation of the target.

An appropriate mechanism - for example a local multi-professional and multi-agency Psychological Therapies strategic planning and management group - comprised of senior clinicians and managers- will exist to ensure comprehensive Psychological Therapies planning across a NHS Board area. This group should have formal links with local service users and carers to ensure meaningful engagement in the planning process.

The remit of this grouping should include:

- Planning the sustainable development of the Psychological Therapy services to meet published targets and commitments, in line with Scottish Government priorities;
- Auditing availability of appropriately trained Psychological Therapy practitioners and supervisors;
- Prioritising and commissioning training based on service need, available evidence of effectiveness of treatment approaches for particular service user groups, cost-effectiveness and issues of equity and accessibility;
- Facilitating and contributing to local service re-design to support the implementation of the strategic plan;

STRATEGIC PLANNING

- Consistent linking with work on the implementation of the local ICPs, work of the Mental Health Quality and Efficiency Support Team, work of the NES Psychological Therapies Training Co-ordinators in local areas, and work of the local CAMHS waits reporting leads;
- Putting in place appropriate governance to ensure safe service delivery, including ensuring necessary clinical supervision and CPD both for those in training and those practicing in the service;
- Promoting service-based research and audit to advance the evidence base and audit effectiveness of local delivery models, including appropriate activity and outcome measures. This includes acting to alter systems based on the result of audit exercises; and
- Facilitating the implementation of properly funded research trials to evaluate new and innovative therapeutic approaches.

SERVICE DELIVERY

THE EXPECTATION IS THAT A MATCHED/ STEPPED-CARE MODEL WILL BE ADOPTED AS THE MOST COST-EFFECTIVE WAY OF DELIVERING THE SERVICE.

MATCHED/STEPPEd CARE MODELS OF SERVICE DELIVERY

MATCHED/STEPPEd-CARE MODELS WERE DEVELOPEd TO ENHANCE THE CAPACITY OF MENTAL HEALTH SERVICES AND TO INCREASE ACCESS TO EVIDENCE-BASED PSYCHOLOGICAL INTERVENTIONS IN THE FACE OF ESCALATING DEMAND AND DIMINISHING RESOURCES.

They build on the development of a range of 'Low Intensity' psychological interventions which are less restrictive and resource intensive than traditional approaches. It is now accepted that many patients who present to the mental health services can achieve good outcomes from these less resource-intensive interventions, freeing up capacity at the higher tiers of service to provide effective treatments for those with more complex difficulties

Matched/stepped-care services adopt a tiered approach to service provision, best described as pyramidal in structure, with high-volume, low intensity interventions being provided at the base of the pyramid to service users with the least complex difficulties. Subsequent 'steps' are usually defined by increasing levels of case complexity, and increasingly intensive forms of treatment. An allocation process seeks to predict how patients will respond to the different levels of therapy available, and to match them with the least resource-intensive treatment likely to be effective.

There are a number of features common to effective matched/stepped care systems:

SERVICE DELIVERY

- Matched/stepped care requires a range of treatments of differing intensity to be available.
- The least intrusive treatment available that will provide significant health gain should be offered first, and services should have 'drivers' that strongly encourage clinicians to match to the least intensive interventions.
- The system should be 'self-correcting', i.e. provide feedback and allow for the intensity of the interventions to be adjusted.
- A range of systematic mechanisms must be in place to aid clinical decision making e.g. referral criteria, rank ordering or consensus on hierarchies of interventions, allocation guidelines, and subjective and objective measures of patient outcome.

Click [here](#) for a more detailed review of the issues around the provision of effective matched/stepped care services.

The tiered approach to delivering mental health services in Scotland is laid out in the Framework for Mental Health Services (1997), and in the CAMH SNAP report (2003). Historically, however, a variety of matched/stepped care models have been developed to deliver Psychological Therapies, based on a number of different conceptual frameworks.

This has given rise to a range of definitions of the tiers of service and of

the skills needed at each level. Some models are described in terms of the severity of problem and its impact on functioning, some in terms of the level of expertise of the professional involved, some in terms of the nature of the service delivered in that tier, or the likely duration of input etc.

However, most service-level based PT models would have levels of service delivery corresponding to:

HIGH VOLUME INTERVENTIONS

■ INFORMATION

Use of information and evidence-based 'health technologies' is the least resource intensive level of intervention. It is generally initiated by the individual and accessed directly, does not involve one-to-one contact with mental health staff, and does not require GP referral. It would include information available on mental health issues in general, on common mental health problems, and on different treatment approaches.

The dissemination mechanisms would include information leaflets available through GPs surgeries or other health and social care agencies, library/reading schemes, relevant television programming, large-scale psycho-educational groups, and direction to high quality Psychological Therapy websites.

■ STRUCTURED EXERCISE

This can be initiated by the patient and accessed directly, or 'prescribed' by healthcare staff who can refer motivated individuals for appropriate exercise advice and activities in local communities.

■ COUNSELLING

It is recognised that counselling is one of a range of interventions which NHS Boards may choose to make available at lower tiers of the service. These will meet the need of a significant number of people experiencing psychological distress, thereby contributing to a well-functioning system overall.

'LOW INTENSITY' EVIDENCE-BASED TREATMENTS

THESE ARE MOST COMMONLY ACCESSED THROUGH GPs, AND WOULD COVER DOING WELL ADVISORS/SELF-HELP COACHING, PROBLEM SOLVING THERAPY, GUIDED SELF-HELP, BEHAVIOURAL ACTIVATION, SOME COMPUTERISED CBT PACKAGES, STRUCTURED ANXIETY MANAGEMENT GROUPS ETC.

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

'HIGH INTENSITY' INTERVENTIONS-PSYCHOLOGICAL THERAPIES

THESE ARE NORMALLY BASED IN SECONDARY CARE, AND COMPRISE TRADITIONAL, STANDARDISED PSYCHOLOGICAL THERAPIES (CBT, IPT, ETC), DELIVERED TO PROTOCOL.

The therapies are aimed at moderate/severe common mental health problems with significant complexity and effect on functioning, and normally last between 6 and 16 sessions.

SPECIALIST PSYCHOLOGICAL THERAPIES

THESE ARE MOST COMMONLY ACCESSED THROUGH SECONDARY CARE AND SPECIALIST SERVICES.

Essentially they are standardised high intensity psychological therapies developed and modified for specific patient groups.

They are delivered at the same level as 'High Intensity' therapies, but in a specialist context.

Specialist therapies are aimed at moderate/severe mental health problems with significant complexity and effect on functioning e.g. substance misuse, eating disorders, bi-polar disorder and normally last between 10 and 20 sessions.

HIGHLY SPECIALIST PSYCHOLOGICAL THERAPIES AND INTERVENTIONS

HIGHLY SPECIALIST, INDIVIDUALLY TAILORED INTERVENTIONS BASED ON CASE FORMULATIONS DRAWN FROM A RANGE OF PSYCHOLOGICAL MODELS.

These are normally accessed through secondary, tertiary and specialist services. Aimed at service users with highly complex and/or enduring problems, and usually lasting 16 sessions and above.

It is expected that a range of evidence-based therapeutic approaches would be available within each 'step'-particularly at the lower levels-as it is recognised that no one therapeutic modality produces significant change for all patients.

The outcomes from well-designed research trials would predict a response rate of around 60% for most evidence-based therapies, leaving 40% of patients who may well respond better to an alternative evidence-based approach. The aim would be to try to match patients with the treatment which is most likely to be effective, and considerations of patient preference are important here.

SERVICE DELIVERY

Users and carers should be informed of the available options, and be fully engaged in the process of decision making around their care.

There are also significant numbers of service users experiencing more than one problem, often with very complex presentations, who do not fit neatly into traditional diagnostic categories. It is important that a range of therapeutic approaches are available for this group, and there is evidence that experienced and highly skilled therapists able to work flexibly using a range of models are more successful in engaging these patients in psychological therapy.

The full range of 'steps' are required within any Psychological Therapies service, although the proportions of care delivered within each step may vary according to the context. In IAPT services in England, which currently cover mild/moderate populations, a ratio of 60% High Intensity Psychological Therapists to 40% Low Intensity workers is emerging as the optimum staffing configuration. Services focusing on more complex patients would require a higher proportion of High Intensity and Highly Specialist Therapists. Careful thought needs to be given to this aspect of service design in order to balance the availability of care at each level with the aspiration to maximise access to the service as a whole.

DESIGNING AND DELIVERING SUSTAINABLE SERVICES AND MAXIMISING SERVICE IMPACT

TO ENSURE SUSTAINABILITY OF THIS APPROACH AND MAXIMUM SERVICE IMPACT:

- Services should be designed based on consultation with all stakeholders, including service users and carers.
- There should be investment at system level to foster change.
- Appropriate training should be provided to enable staff to deliver psychological care and therapy at each tier of the service.
- There should be an educational infrastructure to support training and supervision.
- The service should be structured in such a way as to support and enable trained staff to deliver Psychological Therapies safely and effectively.
- Staff should have protected time in which to make use of their skills.
- There should be access to, and protected time for, regular Psychological Therapies supervision and CPD appropriate to level of service delivery.

SERVICE DELIVERY

Good access to the service depends on well-defined care pathways to psychological therapy, on the effective functioning of all tiers of the service, and on efficient communication between tiers.

To operate matched/stepped care systems effectively, to design appropriate training for staff, and to ensure sustainability in the long-term, it is essential to have:

- Clarity around the services which are providing the different tiers of care, and well-defined communication and referral pathways between those services in a particular geographical area.
- Clarity around thresholds for accessing the Psychological Therapies service.
- Clarity about the most effective way of describing the various 'steps' or tiers.
- Clearly defined inclusion criteria for each 'step' and well-defined pathways from one step to the next.
- Clear patient pathways based on explicit mechanisms for allocation to particular therapies or tiers of the service, taking into account issues of patient preference.
- Robust measures of complexity for allocating service users to levels of the system.

- Collection of valid and reliable outcome measures both to determine the appropriate pathway for individual service users and to monitor the effectiveness of the service.
- Clear understanding of the knowledge and competences necessary for staff to operate safely and effectively at each tier of the system.
- Well-defined career pathways for staff.

The aim is to match the level of intervention as far as possible to the level of service user need, taking into account such factors as risk, problem severity, chronicity, co-morbidity, social complexity, history of previous treatments and service user's preference.

As part of supporting the development of the HEAT target, the NES Psychological Interventions Team has carried out [a review of current literature and of services delivering psychological therapies and interventions](#)

Regular review of service user's progress should be built into the system to compensate for any shortcomings in the assessment and allocation process, so that individuals requiring a higher level of intervention, are 'stepped-up' speedily and efficiently.

To facilitate this process health and social outcomes should be routinely and regularly recorded. There is emerging evidence that regular psychological therapies supervision informed by routine outcome measures, collected on a session-by-session basis, provides the level of information necessary to ensure timely step-up, and can improve the effectiveness of therapy.

Local matched/stepped-care models should be designed to maximise the capacity of the system, and to make best use of available expertise and resources. Tools developed previously by the Mental Health Collaborative and resources emerging from the MH QuEST early implementer sites can be accessed to support re-design work around demand and capacity (see Chapter 4).

To increase access we must look across all tiers, and focus training efforts and resources where they will have maximum impact on the service user experience.

SERVICES FOR CHILDREN AND YOUNG PEOPLE

IN ADDITION TO THE ABOVE, THERE ARE SOME FURTHER CONSIDERATIONS NECESSARY WHEN DESIGNING SYSTEMS FOR DELIVERING STEPPED CARE INTERVENTIONS FOR CHILDREN AND YOUNG PEOPLE:

Recognition of the relationship between contextual factors, such as family relationships, and the effectiveness of psychological therapies for children and young people;

Clear arrangements to ensure that these contextual factors are identified during assessment; and

Attention to the steps (such as concomitant family work, parent training, sibling group work) which are necessary to achieve and sustain a robust and supportive context for the young person engaging in psychological therapy.

Safe and effective service delivery also requires to be underpinned by appropriate governance and educational infrastructure in the service.

ISSUES AROUND ACCESS TO SERVICES

WHEN THINKING ABOUT ACCESS TO PSYCHOLOGICAL THERAPIES IT IS IMPORTANT TO BEAR IN MIND THAT ACCESS IS NOT SIMPLY A FUNCTION OF AVAILABILITY OR SERVICE CAPACITY. ISSUES OF DIFFERENTIAL UTILISATION ARE CENTRAL HERE.

We know that there are groups within the community who do not access services in proportion to the level of mental health problems and distress they experience.

There are issues around social deprivation, life circumstances, ethnicity, gender and age which influence people's decision as to whether or not to make contact with the services available.

Emerging evidence from the Increasing Access to Psychological Therapies (IAPT) initiative in England suggests that having a 'direct access' option within the service i.e. one where referrals are not filtered through the GP-increases uptake by disadvantaged groups. The English Department of Health has been so convinced by the evidence accumulating through the ongoing evaluation, that all IAPT services have now been directed to create 'direct access' options.

It is not acceptable simply to set up services and expect that they will be equally acceptable to and accessible by all. The onus is on NHS Boards to identify groups which are having difficulty engaging with services as currently configured, and support innovative approaches to deliver care which are acceptable and accessible by the target populations.

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CHAPTER 3
TRAINING, SUPERVISIONS AND GOVERNANCE

TRAINING, SUPERVISIONS AND GOVERNANCE

TRAINING AND SUPERVISION, AND SKILLS DEVELOPMENT IN BOTH, ARE KEY TO THE PSYCHOLOGICAL THERAPIES STRATEGY OUTLINED PREVIOUSLY, WHICH IS BASED ON INCREASING THE CAPACITY OF THE CURRENT WORKFORCE TO DELIVER SAFE AND EFFECTIVE INTERVENTIONS AT THE VOLUME REQUIRED TO ACHIEVE THE WAITING TIMES TARGET.

There are a number of training and governance issues which need to be addressed, however, before we can have confidence that we are operating in a safe, effective and sustainable system.

In order to achieve outcomes similar to those described in the treatment literature, levels of training and supervision should replicate, as far as possible, those described in the research papers from which the evidence base is drawn. In order to guarantee that therapists and supervisors are trained to the appropriate level there needs to be:

- clarity around the competences necessary for safe and effective practice at each level of tiered care.
- commissioning of good quality training.
- evidence that the relevant competences have been acquired by the staff delivering the interventions.
- ongoing quality assurance in practice.

NES has focused therefore, on the development of competence frameworks, the quality assurance of training including the assessment of competence, and training in psychological therapies supervision to support quality assurance of service delivery.

Knowledge of the skills and competences necessary for therapists and supervisors will allow service managers to plan appropriate training for staff, and ensure the educational and clinical governance of services.

PSYCHOLOGICAL THERAPY COMPETENCE FRAMEWORKS

OVER RECENT YEARS, NHS EDUCATION FOR SCOTLAND, WHICH HAS A ROLE IN SETTING THE STANDARDS FOR TRAINING WITHIN THE NHS, HAS WORKED IN PARTNERSHIP WITH 'SKILLS FOR HEALTH' (THE SECTOR SKILLS COUNCIL FOR THE UK HEALTH SECTOR), UCL AND OTHER PARTNERS IN ENGLAND TO ARTICULATE THE COMPETENCES NECESSARY TO DELIVER A RANGE OF PSYCHOLOGICAL THERAPIES SAFELY AND EFFECTIVELY AT DIFFERENT LEVELS OF MATCHED/STEPPEd CARE SYSTEMS.

A number of evidence-based Competence Frameworks have been produced, including:

Cognitive and Behavioural Therapy for Depression and Anxiety (which differentiates between the competences needed at the 'Low Intensity' and 'High Intensity' levels within stepped care)

- Psychoanalytic/Psychodynamic Competences
- Systemic Competences
- Humanistic Competences
- Psychological Therapies Supervision Competences

Further competence frameworks have been produced which have a broader, services-based focus, including:

- Competence Framework for Child and Adolescent Mental Health Services, commissioned by NES, which includes the competences needed to deliver psychological interventions with children and young people.
- Competence frameworks for psychological interventions for serious mental illness (psychosis, bipolar disorder and personality disorder).

These, and others, can be accessed [here](#).

Given that therapist competence is developed through training and supervision, the importance of the frameworks cannot be overestimated. NES has been working with psychological therapies trainers in Scotland to benchmark the content of their training courses against the relevant competence framework.

QUALITY OF TRAINING AND ACCREDITATION

BENCHMARKING PSYCHOLOGICAL THERAPIES TRAINING AGAINST THE EVIDENCE-BASED COMPETENCE FRAMEWORKS IS NECESSARY AS THE FIRST STEP IN GOVERNING THE QUALITY OF TRAINING, BUT IS NOT IN ITSELF SUFFICIENT TO GUARANTEE THAT TRAINEES WILL EMERGE AS COMPETENT PRACTITIONERS.

Other factors which need to be considered in the commissioning of training include:

- The baseline knowledge and skills of the group targeted for training.
- A curriculum designed and evaluated on sound educational principles.
- The opportunity, as an integral part of the training, for skills development over time through supervised clinical practice or coaching.
- The knowledge, skills and experience of the trainers and supervisors in the particular psychological intervention.
- The competence of the trainers to deliver training effectively.
- Systematic assessment of knowledge and skills acquired during training.

In the case of courses which aim to equip trainees to deliver one-to-one Psychological Therapy, it is the view of NES that:

- Trainers should be properly trained in the therapy in question, and should have significant experience in delivering the intervention in practice.
- Direct observation of practice (whether in-vivo, or by recorded practice samples) is an essential element of assessment of competence.

There are many potential training providers in this area, and it is not always easy for service managers, who may not themselves have experience in the delivery of psychological therapies, to determine the quality of any particular training course. It is for this reason that NES encourages all training providers to pursue external and objective accreditation at the appropriate level. This may be with one of the Higher Education Institutions, national credit and qualifications frameworks, or widely recognised professional bodies.

PSYCHOLOGICAL THERAPIES SUPERVISION TRAINING

THE QUALITY OF TREATMENT PROVIDED WILL BE ENHANCED BY PSYCHOLOGICAL THERAPIES SUPERVISION WHICH, AS PREVIOUSLY STATED (CHAPTER 1-THE KEY ROLE OF PSYCHOLOGICAL THERAPIES SUPERVISION), WILL REDUCE POTENTIALLY HARMFUL VARIATIONS IN PRACTICE AND ENSURE DELIVERY OF THERAPY IN LINE WITH THE AMBITIONS OF THE HEALTHCARE QUALITY STRATEGY AND THE EVIDENCE BASE.

There is a particular knowledge and skills set necessary for the delivery of good quality psychological therapies supervision, and being a competent therapist does not in itself equip a practitioner to be a competent supervisor.

As stated earlier, NHS Education for Scotland has worked in partnership with Skills for Health to develop a competence framework for Psychological Therapies supervision.

For the standard 'High Intensity' psychological therapies the aspiration is that anyone delivering supervision will be:

- A qualified psychological therapist with a working knowledge of, and substantial experience in, the delivery of the intervention in which they are providing supervision.

And

- will have training which equips them with the 'Skills for Health' supervision competences.

A Psychological Therapist who is not a psychologist (for example a CBT Therapist) would normally be expected to have two or three years of experience of delivering the therapy under supervision (after having completed their therapy training), plus support from management for their application, before putting themselves forward for supervisor training.

The NES position on Clinical Psychologists is that they complete the equivalent of a formal psychological therapies training during the first year of the Doctoral course. Their clinical practice in the subsequent two years of their training qualifies them to apply for psychological therapies supervision training on graduation.

PSYCHOLOGICAL THERAPIES SUPERVISION TRAINING

To support NHS Boards to realise the psychological therapies supervision capacity necessary to deliver on the HEAT target, NES has developed a training curriculum and course materials which cover the essential Skills for Health competences - the NES Generic Psychological Therapies Supervision Course (known as the GSC). This is currently being rolled out using 'Training for Trainers' model which will enable Boards to deliver high quality training in line with local need.

Some modality-specific supervision modules which cover the content specific to supervision within the main psychotherapeutic approaches (including CBT, IPT and Mindfulness-based CBT) are now also available.

Staff delivering Psychological Therapies should receive regular supervision, in line with existing guidelines for the particular therapeutic modality. This supervision should address all ongoing clinical cases, and be informed by the patient's routine outcome measures. If supervision takes place in a group format, the time devoted to it should be appropriately extended.

Until now the expectation has been that, where possible, all staff will receive supervision from a more senior practitioner working at a higher level of the tiered system. (At the highest tier staff receive supervision from peers). In practice this means that staff delivering High Intensity therapy take on the supervision of staff delivering Low Intensity interventions. In many places this is the preferred model, and continues to be viable.

As the HEAT target drives an increase in the volume of psychological interventions and therapies delivered, however, so the demand for PTs supervision is increasing. Some Boards are already struggling to release the capacity to offer supervision to their 'Low Intensity' staff, and have taken the strategic decision to address this shortfall by developing supervision skills in their more experienced Low Intensity workers. Where Boards have chosen to pursue this option NES would strongly advise that the same governance considerations should apply to Low Intensity as to High Intensity supervisors. That is, Low Intensity workers experienced in a particular intervention should only offer supervision on that specific intervention; that the relevant service managers should support their application to train as supervisors; and that they should undertake the NES GSC training.

Finally, there should be support for, and governance of, the supervision process itself. As a minimum, supervisors should have the opportunity to discuss difficult situations which may arise during supervision, or seek advice on the assessment of risk, with a senior colleague or experienced peer. Supervisors should also have the opportunity to develop or refresh their supervision skills through CPD.

LEVELS OF PSYCHOLOGICAL THERAPIES TRAINING IN MATCHED/STEPPED CARE SYSTEMS

ULTIMATELY THE GOVERNANCE OF ANY PSYCHOLOGICAL THERAPIES SERVICE IS THE RESPONSIBILITY OF THE TERRITORIAL BOARD PROVIDING THAT SERVICE TO THE PUBLIC.

NHS Education for Scotland is, however, in a position to offer guidance on the level of training needed to operate effectively at different levels of the tiered care model. This guidance derives from the evidence base, from knowledge acquired through the process of developing the psychological therapies competence frameworks, from experience of commissioning and delivering a wide range of training options, and from an understanding of local conditions obtained through ongoing dialogue with the Boards around the challenges of delivering the PTs HEAT target.

PSYCHOLOGICAL THERAPIES AND TIERED CARE

PSYCHOLOGICAL THERAPIES ARE HIGHLY INDIVIDUAL AND VARIED, AND THEIR DEVELOPMENT PRE-DATES THE CONCEPT OF A TIERED CARE MODEL. THERE IS NO STRAIGHTFORWARD AND UNCONTENTIOUS WAY, THEREFORE, OF ALLOCATING INTERVENTIONS TO THE VARIOUS TIERS OF SERVICE WHICH MAY, IN ANY CASE, VARY FROM BOARD TO BOARD.

Feedback from the Boards has suggested, however, that an attempt to articulate the training pathways for a range of therapies in the context of a tiered-care service model would be useful in planning training for staff. Such an exercise is attempted below, with the caveat that it is for guidance only, and cannot hope to capture the full complexity of service delivery.

Although tiers may vary somewhat according to local circumstances, most tiered models for the delivery of psychological interventions and therapies will have levels of service delivery corresponding to those described below. (Table 1)

LEVELS OF PSYCHOLOGICAL THERAPIES TRAINING IN MATCHED/STEPPED CARE SYSTEMS

| LEVEL OF THERAPY | PATIENT GROUP / SEVERITY |
|-----------------------------|---|
| LOW INTENSITY | <p>PATIENT GROUP: Common Mental Health Problems – Stress/Anxiety/Depression</p> <p>SEVERITY: Mild/moderate, with little complexity and limited effect on functioning; Co morbid common mental health problem in client with complex needs</p> |
| HIGH INTENSITY | <p>PATIENT GROUP: Common Mental Health Problems</p> <p>SEVERITY: Moderate/severe with significant complexity and effect on functioning</p> |
| HIGH INTENSITY – SPECIALIST | <p>PATIENT GROUP: Specialist areas e.g. Schizophrenia, Personality Disorder, Bi-polar Disorder, Eating Disorders, Substance Misuse etc</p> <p>SEVERITY: Moderate/Severe with significant complexity and effect on functioning</p> |
| HIGHLY SPECIALIST | <p>PATIENT GROUP: Complex, enduring mental health problems with a high likelihood of co-morbidity, and beyond the scope of standardized treatments.</p> <p>SEVERITY: Highly Complex</p> |

The mapping of competences and levels of training against the tiers of the matched/stepped care system is currently best articulated for the Cognitive Behavioural Therapies in the context of common mental health problems. The table describing this appeared in the first edition of The Matrix. This original table is reprinted at the end of this chapter. (Table 9)

The principles of the stepped-care approach can be applied to different patient groups, and different therapeutic modalities. Within the Matrix evidence tables, evidence-based treatments are labelled as 'Low' or 'High' intensity. Within High Intensity there are also increasing levels of specialism.

The new suite of tables, which describe the training needed to operate effectively at different levels of the tiered care model for a range of therapeutic approaches, is set out below.

The tables include information on:

- Appropriate training to increase awareness and understanding of the therapeutic approach before embarking on formal training.
- The pre-requisites for formal training
- Options for formal training at various levels (including links).
- The additional requirements to practise as a supervisor and a trainer within each modality.

LEVELS OF PSYCHOLOGICAL THERAPIES TRAINING IN MATCHED/STEPPEd CARE SYSTEMS

These tables should be read in conjunction with the disorder based Evidence Tables.

As a pre-requisite to any psychological therapies training, staff will be operating within a values-based and Recovery-focused framework, and will possess basic levels of psychological awareness and literacy (see below).

VALUES BASE AND RECOVERY FOCUS

IT IS ASSUMED THROUGHOUT THIS SECTION THAT ALL STAFF WORKING IN MENTAL HEALTH SERVICES ARE OPERATING FROM THE VALUES BASE AS DESCRIBED IN THE 10 ESSENTIAL SHARED CAPABILITIES, AND HAVE A STRONG RECOVERY FOCUS (SEE CHAPTER 1).

It is also assumed that all staff working in child and adolescent mental health services are operating from the values base set out in the national policy document Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (2005).

LEVELS OF PSYCHOLOGICAL THERAPIES TRAINING IN MATCHED/STEPPEd CARE SYSTEMS

PSYCHOLOGICAL AWARENESS/BASIC PSYCHOLOGICAL LITERACY

IN ADDITION TO THE TRAINING IN VALUES BASED CARE AND RECOVERY, ALL MENTAL HEALTH STAFF SHOULD HAVE A BASIC LEVEL OF PSYCHOLOGICAL 'AWARENESS' AND 'LITERACY'.

This should include:

- Training in a basic psychological model to run in tandem with the medical model, and within which they can construct a simple, psychologically-informed formulation of the service user's problems;
- Training in listening and communication skills;
- Training in basic counselling skills;
- Training in responding to people in severe distress; and
- Training in self-awareness, and assessing the impact of their own thinking and behaviour on inter-personal interactions.

For staff working in CAMHS this should also include:

- training in a developmental approach which equips them to understand the developmental stages of childhood, adolescence and the family life-cycle; and
- training in the key elements of systemic thinking, such that they can understand:
 - i. The importance of, and likely significance of, family relationships in relation to mental health problems;
 - ii. The importance and potential impact of other contextual factors on the lives of children; and
 - iii. The need to attend to these contextual factors when designing any psychological therapy intervention.

The aim is that as well as being covered by pre-registration courses, these will now be covered in [Essential CAMHS](#), an online resource, created by NES. This learning will then be reviewed and reflected upon in the clinical supervision setting.

LEVELS OF PSYCHOLOGICAL THERAPIES TRAINING IN MATCHED/STEPED CARE SYSTEMS

TO FUNCTION AS SUPERVISOR OR TRAINER

IT IS EXPECTED THAN ANYONE SEEKING TO SUPERVISE OTHER STAFF WILL UNDERTAKE THE NES GSC TRAINING AND ADDITIONAL NES SPECIALIST MODULES IN ADDITION TO ANY FURTHER TRAINING REQUIRED BY RELEVANT PROFESSIONAL BODIES.

NES strongly advises that anyone delivering training in psychological therapies undertakes the NES 'Facilitating Learning' course or some equivalent training in educational theory and practice.

TRAINING PATHWAY TABLES

IT IS HOPED THAT THE TABLES BELOW WILL BE OF BENEFIT BOTH TO SERVICE MANAGERS MAKING DECISIONS ABOUT STAFF TRAINING, AND TO STAFF WHO ARE THINKING OF EMBARKING ON TRAINING IN PSYCHOLOGICAL THERAPIES.

Much information is necessarily truncated or lost in the production of such summary tables, but the intention is to create a more detailed and nuanced training appendix over time.

The 'pre-requisites for formal training' are those normally required by the various training organisations, but there may be some flexibility around this. Individuals should contact the trainers directly to discuss any queries.

Specific courses mentioned should be taken as examples of training programmes which would meet the standards required. This is intended as indicative, and not as an exhaustive or exclusive list. Managers and clinicians should ensure specific courses achieve the skills appropriate to their service needs.

LEVELS OF PSYCHOLOGICAL THERAPIES TRAINING IN MATCHED/STEPPEd CARE SYSTEMS

BEHAVIOURAL ACTIVATION

Low Intensity

(The training route can apply to both Hopko & Martell's Models for BA)

TABLE 1

| Pre-requisites for formal training | Formal Training | Further experience and training necessary to deliver supervision | Delivering formal, accreditable training |
|---|---|--|--|
| Mental health / social care professional / COSCA accredited | BA training Two-day course - delivered by NES certified BA trainers within local NHS Boards with agreed supervision structure in place | Supervised CBT practitioner with two years experience plus NES GSC | Senior CBT practitioner plus experience of training including NES Facilitating Learning Course |

BEHAVIOURAL FAMILY THERAPY

TABLE 2

| Increasing Awareness | Pre-requisites for formal training | Formal Training | Further experience and training necessary to deliver supervision | Delivering formal, accreditable training |
|--------------------------------------|------------------------------------|---|---|---|
| ½ to three-day informational session | Mental Health/ social care worker | Five-day training course(delivered locally by accredited trainers or by Meriden Family Programme) | Five-day BFT 'training for trainers and supervisors' course delivered by Meriden plus NES GSC | Five-day 'training for trainers and supervisors' course delivered by Meriden. |

LEVELS OF PSYCHOLOGICAL THERAPIES TRAINING IN MATCHED/STEPED CARE SYSTEMS

COGNITIVE BEHAVIOURAL THERAPY (CBT)

Low Intensity, High Intensity and High Intensity-Specialist

TABLE 3

| Increasing Awareness | Pre-requisites for formal training | Formal Training Low Intensity | Formal Training High Intensity and High Intensity Specialist | Further experience and training necessary to deliver supervision | Delivering formal, accreditable training |
|--|--|--|--|---|---|
| <p>Two five-day training courses</p> <p>NES e-learning CBTcourse for anxiety</p> | Health or social care/educational professional with previous experience of delivering one-to-one psychologically based care in a mental health setting | <p>Formal accredited training course e.g.</p> <ul style="list-style-type: none"> ■ Dundee CBP Certificate ■ SoS CBT Certificate ■ UWS CBT PG Cert | <ul style="list-style-type: none"> ■ Dip/Masters in CBT <p>Examples in Scotland</p> <p>DundeeCBP</p> <p>SoSCBT</p> <p>UWS CBT</p> <p>MSc Applied Psychology</p> <ul style="list-style-type: none"> ■ Doctorate in Clinical or Counselling Psychology | <p>Normally two years experience following completion of CBT training</p> <p>NES GSC plus at least one</p> <ul style="list-style-type: none"> ■ CBT bolt on ■ accredited CBT course supn training <p>OR as defined by BABCP</p> | As defined by accredited training institutions or BABCP |

LEVELS OF PSYCHOLOGICAL THERAPIES TRAINING IN MATCHED/STEPPEd CARE SYSTEMS

GUIDED/SUPPORTED SELF HELP

Low Intensity

TABLE 4

| Pre-requisites for formal training | Formal Training | Further experience and training necessary to deliver supervision | Delivering formal, accreditable training |
|--|---|--|--|
| <p>Posts generally developed and managed locally to support local training pathways.</p> <p>Criteria set for role include active listening skills, ability to manage conflict, ability to develop rapport quickly, self awareness and ability to reflect on own practice</p> | <p>Usually 5-10 days training plus intensive ongoing support</p> <p>Examples in Scotland: Guided self help workers(Lothian); D&G Self help coaches; SPIRIT training GG&C; Cert level on accredited CBT training</p> | <p>Clinical Associate/Psychological practitioner with CBT expertise</p> <p>NES GSC</p> | <p>Clinical Associate/Experienced Psychological Practitioner</p> <p>NES 'Facilitating Learning' Course</p> |

LEVELS OF PSYCHOLOGICAL THERAPIES TRAINING IN MATCHED/STEPED CARE SYSTEMS

INTERPERSONAL THERAPY (IPT)

High Intensity

TABLE 5

| Increasing Awareness | Pre-requisites for formal training | Formal Training | Further experience and training necessary to deliver supervision | Delivering formal, accreditable training. |
|---|--|--|---|--|
| <p>Brief training events</p> <p>Examples in Scotland:</p> <p>½-1 day events by UofEd/IPT Scotland</p> | <p>Mental health/social care professional with previous experience of delivering psychological therapy</p> | <ul style="list-style-type: none"> ▪ IPT Scotland ▪ UofEd PG Cert Psych Ther(IPT) <p>PLUS specified no of written submissions and supervised cases</p> | <p>GSC plus IPT bolt on</p> <p>As approved by recommended training course e.g.</p> <ul style="list-style-type: none"> ▪ IPT Scotland ▪ IPT UK | <p>As defined by IPT Scotland/IPT UK</p> <p>NES 'Facilitating Learning' Course</p> |

LEVELS OF PSYCHOLOGICAL THERAPIES TRAINING IN MATCHED/STEPED CARE SYSTEMS

MENTALISATION-BASED THERAPY

TABLE 6

| Increasing Awareness | Pre-requisites for formal training | Formal Training | Advanced Therapist Training | Further experience and training necessary to deliver supervision |
|--|---|---|---|--|
| Level A 2 day MBT INTEREST/ SKILLS training course | Mental health professional with previous experience of delivering psychological therapy | Level B Three-day introductory course, read manual. Four patients with reflective statements and supervised by level D | Level C At least two cases per year under supervision and attendance at advanced MBT training event annually | NES GSC plus level C Six MBT cases completed (minimum) Supervisors report. Level C must be ongoing |

LEVELS OF PSYCHOLOGICAL THERAPIES TRAINING IN MATCHED/STEPED CARE SYSTEMS

MINDFULNESS-BASED COGNITIVE THERAPY

High Intensity

TABLE 7

| Increasing Awareness | Pre-requisites for formal training | Formal Training | Further experience and training necessary to deliver supervision | Delivering formal, accreditable training |
|---|---|--|--|--|
| Attendance as participant at eight week MBCT course. Reading core texts | <p>Mental health professional with previous experience of delivering psychological therapy</p> <p>Sustained personal mindfulness practice, including attending supervision practice groups, for 12 months prior to teacher development training</p> | <p>Teacher(therapist) development course – two x two days</p> <p>Deliver courses with experienced teacher(therapist)</p> | <p>Experienced practitioner.</p> <p>Has delivered eight-nine courses with a minimum of half with clients as opposed to staff</p> <p>NES GSC plus two-day MBCT supervision bolt-on course</p> | <p>Has delivered eight-nine courses with a minimum of half with clients as opposed to staff</p> <p>Helps to run a four day teacher development course led by qualified trainer</p> |

LEVELS OF PSYCHOLOGICAL THERAPIES TRAINING IN MATCHED/STEPED CARE SYSTEMS

MOTIVATIONAL INTERVIEWING

Low Intensity

TABLE 8

| Increasing awareness | Pre-requisites for formal training | Formal Training | Further experience and training necessary to deliver supervision | Delivering formal, accreditable training |
|---|--|---|---|--|
| NES/NHS Lothian e-learning module or a formal two day training introduction | Mental health/social care professional | Further training incorporating taped casework and specific supervisor feedback on ratings of skills and fidelity to model | GSC plus coaching training (currently available through National MI Coaching Group) Supervisors should continue with clinical practice which is being supervised | Supervision training and practice, meeting standards such as those established by MINT |

LEVELS OF PSYCHOLOGICAL THERAPIES TRAINING IN MATCHED/STEPPED CARE SYSTEMS

NOTES:

1. With regard to training at the 'Low Intensity' level, some is available centrally (e.g. SPIRIT training and training provided at post-graduate certificate level by the CBT courses), but it is anticipated that much will be commissioned and delivered locally.

It is important that local training schemes are structured around the relevant Skills for Health competences, and that those delivering the training have the appropriate level of expertise as described earlier in this chapter.

In the light of the recommendations of the SGHD Applied Psychology Review, it is expected that NHS Boards will look to local Psychology Departments, working in partnership with Nurse and AHP Consultants and other local specialist services such as Psychotherapy Departments, to develop, deliver and quality assure such training in the first instance.

NHS Education for Scotland has developed [a 'toolkit' to support NHS Boards in the commissioning of education and training locally](#).

2. It is recognised that the outline above does not adequately reflect the complexity of the delivery of Psychological Therapies within the service.

Staff may, for example, be involved in the delivery of a specific 'low intensity' intervention to patients with complex problems-for example an Occupational Therapist delivering a structured, time limited anxiety management group within an inpatient setting. Good governance would demand that all the relevant factors be taken into consideration.

3. As above, matched/stepped care approaches are not exclusive to Cognitive Behavioural Therapy or Adult Mental Health, and there are, for example, a number of levels of intervention based on Psychodynamic Psychotherapy which would fit well with this approach.

Consultant Psychotherapists would function both at 'high intensity' and 'highly specialist' tiers, and a number of local training initiatives seek to equip staff with knowledge and skills which would fit at a 'low intensity' level. NHS Education for Scotland is supporting the scoping of currently available psychodynamic training with a view to articulating a matched/stepped care approach within this modality, structured around the 'Skills for Health' Psychoanalytic/Psychodynamic competence framework.

4. This cannot be an exhaustive overview of available training or a prescriptive approach to an inflexible structure. Over time individuals may have pursued idiosyncratic training pathways which have equipped them with high-level competences even though they have not completed recognised training courses. It is the responsibility of Boards

LEVELS OF PSYCHOLOGICAL THERAPIES TRAINING IN MATCHED/STEPPEd CARE SYSTEMS

to satisfy themselves that any member of staff has the competences necessary to take on a particular role. NES would advise consulting psychologists and other local experts in psychological therapies to formalise and oversee any 'grand parenting' arrangements. Given the increase in availability and accessibility of formal training provided by NES and other providers over recent years, however, the expectation is that individualised training routes for established therapies will decrease in frequency.



LEVELS OF PSYCHOLOGICAL THERAPIES TRAINING IN MATCHED/STEPPED CARE SYSTEMS

TABLE 9

| Level of Therapy | Patient Group / Severity | Treatment delivered | Training required / competences | Examples in Scotland |
|------------------|---|--|--|---|
| Low Intensity | <p>PATIENT GROUP: Common Mental Health Problems – Stress/ Anxiety/Depression</p> <p>SEVERITY: Mild/moderate, with little complexity and limited effect on functioning</p> | <p>Supported self-help, solution-focused problem solving, structured anxiety management groups, self-help coaching</p> | <p>MINIMUM TRAINING REQUIRED: generally 5-10 day training plus intensive, ongoing clinical supervision</p> <p>LEVEL OF COMPETENCE: must meet the 'Skills for Health' 'Low Intensity' competences</p> | <ul style="list-style-type: none"> ■ SPIRIT training as developed and delivered by Chris Williams and his team at Glasgow University ■ Dumfries and Galloway training for 'Self-Help Coaches' ■ Borders training for 'Doing Well Advisors' ■ 'Certificate' level training on the Dundee and South of Scotland CBT courses (60 'scotcat' points) |
| High Intensity | <p>PATIENT GROUP: Common Mental Health Problems</p> <p>SEVERITY: Moderate/severe with significant complexity and effect on functioning</p> | <p>Standardised psychological therapies – delivered to protocol and normally lasting between six and 16 sessions</p> | <p>TRAINING REQUIRED: Diploma level Normally at least 24 days formal teaching, 24 days of CBT in the workplace, plus intensive supervision over at least 1 year of training</p> <p>LEVEL OF COMPETENCE: must meet the 'Skills for Health' 'High Intensity' competences</p> | <ul style="list-style-type: none"> ■ South of Scotland CBT Course: Diploma Level Training ■ Dundee CBT course: Diploma Level Training (120 'scotcat' points) ■ Clinical Associate in Applied Psychology MSc training ■ Doctoral level Clinical and Counselling Psychology training |

LEVELS OF PSYCHOLOGICAL THERAPIES TRAINING IN MATCHED/STEPPED CARE SYSTEMS

| Level of Therapy | Patient Group / Severity | Treatment delivered | Training required / competences | Examples in Scotland |
|-----------------------------|---|---|---|--|
| High Intensity - Specialist | <p>PATIENT GROUP: Moderate/Severe mental health problems with significant effect on functioning-Specialist areas e.g. Schizophrenia, Personality Disorder, Bi- polar Disorder, Eating Disorders, Substance Misuse etc</p> <p>SEVERITY: Moderate/ Severe with significant complexity and effect on functioning</p> | Standardised psychological therapy, developed and modified for specific patient groups. 16 to 20 sessions | <p>TRAINING REQUIRED: Diploma level CBT training plus supervised placement in specialist service.</p> <p>LEVEL OF COMPETENCE: must meet the 'Skills for Health' 'High Intensity' competences</p> | <ul style="list-style-type: none"> ■ Dundee CBT Course Masters level options in Trauma, Chronic Anxiety/ OCD etc ■ South of Scotland CBT Course Masters level options in Personality Disorder, Eating Disorder etc ■ Diploma level CBT training plus supervised placement in specialist service. ■ Clinical Associate in Applied Psychology MSc training plus supervised placement |
| Highly Specialist | <p>PATIENT GROUP: Complex, enduring mental health problems with a high likelihood of co-morbidity, and beyond the scope of standardized treatments.</p> <p>SEVERITY: Highly Complex</p> | High specialist, individually tailored, interventions, drawing creatively on the theoretical knowledge base of the discipline of psychology. Normally lasting 16 sessions and above | COMPETENCES: Specialist knowledge of a range of theoretical and therapeutic models Ability to formulate complex problems using a range of psychological models, taking into account historical, developmental, systemic and neuropsychological processes | <ul style="list-style-type: none"> ■ Doctoral level Clinical Psychology or Counselling Psychology Training ■ Individual clinicians with a highly developed special interest, normally including involvement in research, and identified by colleagues as having the requisite knowledge and skills |

CHAPTER 4

SUPPORT FOR CHANGES

CHAPTER 4: SUPPORT FOR CHANGES

THERE ARE A NUMBER OF SCOTTISH GOVERNMENT INITIATIVES WHICH HAVE BEEN PUT IN PLACE TO SUPPORT NHS BOARDS IN THE DELIVERY OF EFFICIENT AND EFFECTIVE MENTAL HEALTH SERVICES, AND WHICH INCLUDE PSYCHOLOGICAL THERAPIES WITHIN THEIR REMIT.

Every effort has been made to promote coherent

strategic planning by ensuring that these initiatives are aligned at national level, and that the various elements dovetail to provide NHS Boards with complementary advice within a clear direction of travel.

NHS EDUCATION FOR SCOTLAND

NES IS WORKING IN PARTNERSHIP WITH SCOTTISH GOVERNMENT AND NHS BOARDS TO HELP BUILD EFFECTIVE, EQUITABLE AND ACCESSIBLE PSYCHOLOGICAL THERAPIES SERVICES ACROSS SCOTLAND THROUGH EDUCATION, TRAINING AND WORKFORCE DEVELOPMENT.

NES develops and supports sustainable training in the evidence-based interventions required to allow NHS Boards to meet the HEAT target

In collaboration with the Mental Health and Protection of Rights Division, and other key stakeholders, NES has supported quality improvement in psychological therapies services by producing this document-The Matrix- which offers guidance on the safe and efficient delivery of effective, evidence based care.

IMPROVING QUALITY BY ESTABLISHING TRAINING STANDARDS

- As detailed in earlier sections, NES worked with 'Skills for Health' to produce Competence Frameworks which set standards for staff training and performance in both psychological therapies and clinical supervision.
- Working with current psychodynamic training providers (including CBT, Psychodynamic Psychotherapy, Mindfulness-Based Cognitive Therapy, IPT etc) to re-structure Psychological Therapies training based on the competence frameworks and future service needs;
- Developing innovative ways of assessing competence in CBT and Supervision.
- Producing a competence-based curriculum for Psychological Therapies supervision training, and rolling this out using a 'training for trainers' model.
- Producing an 'Educational and Development 'Toolkit '- Testing for the Best in Educational Development' - to aid NHS Boards in commissioning education and training locally.

TRAINING AND WORKFORCE DEVELOPMENT

■ THE PSYCHOLOGICAL INTERVENTIONS TEAM (PIT)

The Psychological Interventions Team is funded by the Mental Health and Protection of Rights Division and hosted within NES. The team has contributed to the development of the HEAT target, and now focuses on organising and delivering the training required to improve general access to psychological interventions and therapies in SGHD priority areas – Older People's Services, Forensic Services, Alcohol and Substance Misuse, PTSD and Trauma and Low Intensity Treatments.

Further details of the work of the Psychological Interventions Team, including details of forthcoming training events, can be found on the [NES website](#).

In addition to the work of the PIT, NES:

- Is supporting the training of frontline staff and 'cascade' trainers in a range of therapeutic approaches recommended in The Matrix.
- Is training psychologists at Doctoral and Masters level in support of the psychological therapies agenda, and is aligning training plans and building capacity in key Government priority areas such as CAMHS and Older People's services.
- Is developing, through the Psychology of Parenting initiative within NES, a workforce capacity-building plan to support early intervention and improved outcomes for three and four year old children with early-onset behaviour problems. The dissemination plan outlines the educational infrastructure required to ensure that these parenting programmes are delivered with fidelity, in sustainable ways.
- Is working with AHPs to develop and deliver psychological training opportunities for all AHPs to consolidate and develop their current skills and respond to the training needs identified in Realising Potential.
- Has produced a Knowledge and Skills framework in support of the National Dementia Strategy, and a Dementia Workforce Development Plan based on that framework, and will be undertaking a range of activities to support implementation of the workforce development plan.
- Is taking forward the actions from Rights, Relationships and Recovery - the report of the National Review of Mental Health nursing in Scotland. These include rolling out the 10 ESC and Recovery Training (as detailed in Chapter 1-Values-based Care), and progressing the role of the Mental Health Nurse in delivering psychosocial interventions and psychological therapies.

DEVELOPING INNOVATIVE EDUCATIONAL INFRASTRUCTURE

NES IS DEVELOPING THE EDUCATIONAL INFRASTRUCTURE NECESSARY TO SUPPORT TRAINING AND SUPERVISION IN LOCAL AREAS BY FUNDING PSYCHOLOGICAL THERAPIES TRAINING CO-ORDINATORS (PTTC) POSTS IN EACH NHS BOARD.

The role of the Psychological Therapies Training Coordinator is to support the territorial NHS Boards in meeting the HEAT Access target by increasing the capacity within the current workforce to deliver Psychological Therapies and supporting service change to ensure that the available resource is used most effectively in practice.

Although detail varies according to local circumstances their functions include:

- Working with Psychological Therapies strategic planning groups to support the increase in access to psychological therapies by identifying service gaps and workforce training needs.
- Advising on and organising the appropriate evidence-based training taking into account quality, cost, timing, and reliability.
- Providing the educational infrastructure needed to ensure that training is sustainable, and establishing clinical supervision structures to ensure safe and effective practice.

NES/ISD/SGHD PSYCHOLOGICAL THERAPIES WORKFORCE SURVEY

THE PSYCHOLOGICAL THERAPIES WORKFORCE SURVEY HAS BEEN DESIGNED TO COLLECT WORKFORCE DATA IN SUPPORT OF THE PTs HEAT TARGET.

It will provide information on the number of staff in the workforce who are delivering Psychological Therapies, the approaches they are using, their level of training, their access to PTs supervision, and the time protected for systematic delivery. It provides valuable information to SGHD and to Boards on the characteristics of the workforce, the capacity in the system, and particular challenges to evidence-based practice.

NES will use intelligence gathered to further refine its needs-led Psychological Therapies and PTs Supervision training programme.

IMPROVEMENT SUPPORT FOR PSYCHOLOGICAL THERAPIES

HEAT TARGET DELIVERY

REDESIGNING SYSTEMS TO MAKE BEST USE OF CURRENT RESOURCES

INCREASING ACCESS IS NOT ONLY ABOUT TRAINING INCREASED NUMBERS OF STAFF TO DELIVER HIGH QUALITY CARE, IT IS ALSO ABOUT DELIVERING THIS CARE IN THE MOST EFFICIENT WAY POSSIBLE IN ORDER TO PRODUCE THE MAXIMUM IMPACT WITHIN THE RESOURCE AVAILABLE.

The Matrix presents the evidence base for the

effectiveness of treatments, but there is also a need for services to apply a different evidence base - the evidence base in relation to systems improvement methodology. This will support NHS Boards in designing efficient and effective processes and systems.

IDENTIFYING OPPORTUNITIES FOR DESIGNING MORE EFFECTIVE AND EFFICIENT PROCESSES AND SYSTEMS

WORK HAS BEEN COMPLETED TO HIGHLIGHT THE KEY PARTS OF THE MENTAL HEALTH SYSTEM THAT NEED TO BE IMPROVED IN ORDER TO DELIVER THE PSYCHOLOGICAL THERAPIES HEAT TARGET AND THEN, FOR EACH PART OF THE SYSTEM, TO IDENTIFY THE SPECIFIC CHANGES THAT CAN BE MADE TO IMPROVE THAT ASPECT OF THE SYSTEM.

This is referred to as a Driver Diagram. Effectively a Driver Diagram, is a cause and effect diagram that shows how actual changes at a service level feed into the delivery of a wider organisational aim.

NHS Boards can continue to self-assess against this driver diagram to identify further opportunities for improving their local systems on an on-going basis.

SUPPORT FOR IMPLEMENTING CHANGES TO SYSTEMS AND PROCESSES.

THERE IS NOW CONSIDERABLE EXPERIENCE WITHIN NHS BOARDS ON USING SYSTEMS IMPROVEMENT METHODOLOGY AND MOST NHS BOARDS HAVE CENTRALISED IMPROVEMENT TEAMS WHO CAN WORK WITH SPECIFIC SERVICES ON ORGANISATIONAL PRIORITIES.

Further there are now a range of individuals working in mental health services with the knowledge and experience of using service improvement methodologies.

The Quality and Efficiency Support Team at the Scottish Government (QuEST), has worked in partnership with two NHS Boards to demonstrate how these approaches could be used to improve access to psychological therapies within current resources, whilst delivering the same or better clinical outcomes. The work with these 'early implementer' sites, as well as work with other NHS Boards, has helped generate this guidance, resources and tools that support the application of systems improvement methodologies to deliver improved access to Psychological Therapies.

This guidance, the driver diagram and other resources can be accessed at: <http://www.qihub.scot.nhs.uk/quality-and-efficiency/mental-health.aspx>

INFORMATION SERVICES DIVISION (ISD)

NHS NATIONAL SERVICES SCOTLAND'S INFORMATION SERVICES (ISD) IS SCOTLAND'S NATIONAL ORGANISATION FOR HEALTH INFORMATION, STATISTICS AND IT SERVICES.

NES, ISD (NSS), NHS QIS, the Mental Health Collaborative and NHS Board clinical leads worked together in 2010 as 'The Information Systems, Referral Criteria and Patient Pathways Group' and 'Stakeholder Reference Group' to take forward the various strands of work to develop the Psychological Therapies HEAT target. ISD's [Mental Health Programme](#) worked with NHS Boards to gather information to help set and measure the target. An information review was carried out with territorial NHS Boards in May and July 2010 to capture key information on the current structure, management, monitoring and waiting times for psychological therapies. This information enabled the Scottish Government to set a sensible informed target.

ISD and NES ran a series of workshops across a number of NHS Boards in October 2010 to define and agree key measurement points for the target. Based on the feedback from these workshops it was decided that the waiting time will be measured between the date referral received and the date psychological therapy commences as planned.

ISD have worked with key stakeholders to develop and refine a reporting template (an Excel document) to monitor progress against the HEAT target. NHS Boards have been required to submit an NHS Board level return of aggregated data to ISD on a monthly basis from May 2011. It is important that the information collected by NHS Boards is consistent to enable it to be used at national level. ISD is working with key stakeholders to develop data standards and definitions in order to support NHS Boards in this challenge.

INFORMATION SERVICES DIVISION (ISD)

ISD have been working with NHS Boards and the Scottish Government Mental Health and Protection of Rights Division to help develop and embed national waiting times guidance and scenarios to ensure information collected is in line with the key waiting times measurement stages.

ISD issue regular email newsletters to keep customers and colleagues informed.

Further information on the HEAT Target can be found on the [ISD website](#).

CHAPTER 5

KEY DEVELOPMENTAL QUESTIONS FOR SERVICES

KEY DEVELOPMENTAL QUESTIONS FOR SERVICES

ALTHOUGH PSYCHOLOGICAL THERAPY IS THE EXPLICIT FOCUS OF THE HEAT ACCESS TARGET, IT HAS ALWAYS BEEN VIEWED AS A PROXY MEASURE FOR GOOD CARE ACROSS THE MENTAL HEALTH SERVICES, AND AS A CATALYST FOR IMPROVEMENTS IN DATA COLLECTION AND ANALYSIS, EFFICIENCY OF SERVICE DELIVERY, TRAINING AND SUPERVISION OF STAFF, AND PATIENT OUTCOMES.

Over the lifetime of the target there have been considerable improvements in all of these areas, with more people seen by services, and seen more quickly. More and better quality data is being collected and used to improve services, and more staff have been trained to deliver evidence-based interventions and to deliver psychological therapies supervision.

There is still some way to go, however, before we reach the point where we can say with confidence that all patients are being offered safe, effective and timely psychological interventions, and that Boards are achieving the best possible outcomes within a sustainable service delivery framework.

SUSTAINABLE DELIVERY OF HIGH QUALITY CARE

THE MATRIX TABLES, TAKEN TOGETHER WITH THE ADVICE ON SERVICE STRUCTURES AND GOVERNANCE SET OUT IN THE EARLIER SECTIONS OF THIS DOCUMENT, FORM A TEMPLATE AGAINST WHICH SERVICE PLANNERS IN NHS BOARDS CAN MAP THEIR CURRENT SERVICES.

IN THIS CHAPTER A NUMBER OF KEY AREAS ARE DRAWN OUT AND HIGHLIGHTED AS ESSENTIAL TO FURTHER PROGRESS TOWARDS THE SUSTAINABLE DELIVERY OF HIGH QUALITY CARE.

DATA COLLECTION, ANALYSIS AND FEEDBACK.

EFFICIENT COLLECTION AND ANALYSIS OF DATA FROM ALL SERVICES DELIVERING PSYCHOLOGICAL THERAPIES IS ESSENTIAL NOT ONLY FOR MONITORING OF PROGRESS TOWARDS THE HEAT TARGET AND OTHER TARGETS AND STANDARDS, BUT FOR THE WIDER GOVERNANCE AND CONTINUOUS IMPROVEMENT OF PATIENT CARE.

In order to monitor progress towards the PTs HEAT target specifically, 'date of receipt of referral' and 'date psychological therapy commences as planned' should be collected for every patient. As a balancing measure the 'date of start of initial assessment for suitability for psychological therapy' should also be recorded. Waiting times should be measured and adjusted for patient unavailability in line with national waiting times guidance.

Key questions for efficiency and sustainability:

- Have all services which deliver Psychological Therapies been identified, and are arrangements in place to collect data from these services?
- Are there effective data capture systems in place to monitor waiting times, and to provide both adjusted and unadjusted data?
- Is there dedicated IT support to configure data collection and analysis?
- Is there training and support in place for staff to enable them to collect the data routinely, and to use it to improve patient care?
- Is the patient information system easy to use in clinical practice, based on electronic recording of data, and can it feed meaningful and clinically relevant information back to staff to inform both direct patient care and service audit and re-design?

SUSTAINABLE DELIVERY OF HIGH QUALITY CARE

SERVICE DEVELOPMENT AND DESIGN

IN ORDER TO MAXIMISE ACCESS TO PSYCHOLOGICAL THERAPIES, BOARDS MUST DELIVER HIGH QUALITY CARE IN THE MOST EFFICIENT WAY POSSIBLE. SYSTEMS IMPROVEMENT METHODOLOGY CAN BE USED TO DESIGN EFFICIENT AND EFFECTIVE PROCESSES AND SYSTEMS.

To ensure equity of provision across the country, Boards must also ensure that there is adequate service provision for those with mental illness or disorder within their local population.

Key questions for efficiency and sustainability:

- Is there a multi-disciplinary, multi-agency Psychological Therapies strategic planning group with the authority and remit to plan, commission, re-design and de-commission services (as described in Chapter 2)?
- Is there investment at system level to foster change? Have links been made with the generic improvement structures within the organisation?
- Can the Boards provide meaningful data on which to base re-design and subsequently audit outcomes?
- Is there a mechanism for involving service users, carers and other key stakeholders in service re-design?
- Has there been an audit of local need, based on the local

incidence and prevalence of particular mental illnesses or disorders, and has this informed service development, design and capacity?

- In any particular service, what percentage of the potential patient population is accessing the service?
- How will increased access be demonstrated for the spectrum of service users, including 'hard to reach' groups?

SUSTAINABLE DELIVERY OF HIGH QUALITY CARE

EFFICIENT AND EFFECTIVE TIERED CARE

WELL-FUNCTIONING PSYCHOLOGICAL THERAPIES SERVICES SHOULD OPERATE WITHIN THE FRAMEWORK OF A CLEARLY ARTICULATED AND WELL-GOVERNED TIERED CARE SYSTEM. EACH SERVICE SHOULD BE AUDITED AND MANAGED PROACTIVELY TO MANAGE DEMAND AND CAPACITY, AND TO MAXIMISE EFFECTIVENESS, EFFICIENCY, COST-EFFECTIVENESS AND PATIENT SAFETY.

Key questions for efficiency and sustainability:

- Is there a process for developing and refining comprehensive stepped/matched care systems which have a) clearly defined and explicitly linked tiers of care, b) clear access thresholds and criteria for allocation to different levels of treatment, c) self-correcting mechanisms, and d) can demonstrate effective delivery through clinical outcomes?
- Are there systems in place to use data to effectively manage demand, capacity and queues (waiting lists)?

TRAINING AND SUPERVISION OF STAFF

THE COMMISSIONING OF STAFF TRAINING SHOULD TAKE INTO ACCOUNT THE PATIENT POPULATION AND THE NEEDS AND STRUCTURE OF THE SERVICE; THE EVIDENCE BASE FOR EFFECTIVE INTERVENTIONS (AS LAID OUT IN THE MATRIX EVIDENCE TABLES); THE QUALITY, COST, TIMING AND SUSTAINABILITY OF ANY TRAINING OPTIONS; THE LEVEL OF SUPERVISION REQUIRED TO MAINTAIN SKILLS; THE CAPACITY OF THE STAFF TO DELIVER THE THERAPY IN PRACTICE ONCE TRAINING IS COMPLETE.

Key questions for efficiency and sustainability:

- Is there a process for determining what training will be necessary to enable staff to deliver psychological care and therapy at each tier of the service?
- Is effective use being made of the data from the NES/SGHD/ISD Psychological Therapies Workforce Survey in planning staff training?
- Is there an educational infrastructure to support training?
- Will the re-designed services be structured in such a way as to support and enable trained staff to deliver PTs safely and effectively?
- Is there access to, and protected time for, regular supervision and CPD appropriate to level of service delivery?
- Do staff have protected time in which to make use of their skills?

SUSTAINABLE DELIVERY OF HIGH QUALITY CARE

MONITORING OF CLINICAL OUTCOMES

MONITORING OF CLINICAL OUTCOMES IS NECESSARY NOT ONLY TO ASSURE QUALITY OF SERVICE IN THE BROADEST SENSE, BUT AS A BALANCING MEASURE FOR THE PTs HEAT ACCESS TARGET.

Any target can distort the provision of services and produce unintended consequences, and ensuring that outcomes for patients are not adversely affected by the target is an essential aspect of governance. Monitoring clinical outcomes will provide Boards with an assurance that as they provide faster access to psychological therapies, clinical outcomes are being maintained or improved.

Routine session-by-session outcome monitoring will improve data completeness, thereby allowing a more accurate estimate of the effectiveness of the service. There is also some evidence that session-by-session monitoring can improve patient outcomes and service efficiency if used to inform supervision.

Key questions for efficiency and sustainability:

- Is there routine monitoring of outcomes using reliable and validated outcome measures?
- Are outcomes being monitored on a session-by-session basis?
- Are outcome measures being analysed and reported, and used to drive service improvement?

DELIVERY AND GOVERNANCE OF PSYCHOLOGICAL THERAPIES UNDER HEALTH AND SOCIAL CARE INTEGRATION

AT THE TIME OF WRITING IT IS NOT CLEAR WHERE THE EXISTING STANDARDS AND TARGETS WILL SIT WITHIN THE GOVERNANCE STRUCTURES FOLLOWING HEALTH AND SOCIAL CARE INTEGRATION.

The Government is clear, however, that consideration will have to be given as to where psychological therapy services will sit, and how they will be governed under the new arrangements.

Functions which will have to be in place include:

- Planning and auditing the coverage, effectiveness and efficiency of psychological therapies services.
- Systems for data capture and analysis which enable monitoring of all aspects of the services, including access times and clinical outcomes, and feed into continuous service improvement.
- Continuous review of training and supervision requirements.

Regardless of the future status of the Psychological Therapies HEAT Access Target, the Scottish Government continues to view this as a priority area for healthcare delivery, will continue to monitor service data, and expects improvement on an ongoing basis. The Government will be particularly interested in how this area of service is effectively delegated within Health and Social Care Partnerships, and sustained progress will be viewed as one indication of how the partnerships are working in practice to deliver effective mental health services.



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NESD0366 | Designed and typeset by the NES Design Service.