

## **Psychological Wellbeing Practitioners- Not just a supplement for IAPT!**

### **Introduction**

The national programme to Improve Access to Psychological Therapies (IAPT) was funded to enable 800,000 additional people to access NICE recommended therapies for anxiety and depression between 2008 and 2011. Cognitive Behaviour Therapy (CBT) was selected as the first therapy to deliver and a target of 3600 extra therapists was set to develop an enhanced and to some extent an entirely new workforce. As both step 2 and step 3 interventions were required, the role of a case manager/ low intensity therapist or coach, as tested in the Doncaster Demonstration site, was used as the prototype for the practitioner who would deliver step 2, low intensity, CBT based, interventions: subsequently to be called the Psychological Wellbeing Practitioner (PWP). It was judged that as this role was relatively less evidenced based at the time, that the balance of PWP to High Intensity Therapist should be a 40:60 split of that 3600. The overall target of 3600 extra staff is likely to be exceeded by March 2011.

### **The growing importance of the PWP role**

The PWP role was captured nationally in a job description and person specification with recommended banding for trainees and qualified PWPs. A training curriculum and learning materials were developed by Richards and Whyte and courses were commissioned by Strategic Health Authorities to deliver them. It is perhaps true to say that the first year of IAPT saw a greater emphasis on High Intensity CBT training, including top up training and accreditation. However, 2009/10 has seen a greater focus on the PWP role, including guidance on case management supervision, a Good Practice Guide to Self-help, greater clarity on what top-up training should be addressed and most importantly, the accreditation of PWP training courses. Top-up training has been necessary, since in wave 1 services, PWPs were employed although they had not been formally trained: many of these practitioners had been experienced graduate mental health workers.

National conferences, bringing together new PWPs, together with service and university representatives in 2009 and 2010, have highlighted the difference that PWPs are making to services and some SHAs are looking to commission a greater ratio of PWPs to high intensity therapists. The reasons for this are complex, however, some state that local outcomes are very encouraging and they want to increase capacity; for others there has been a higher level of turnover of PWPs in services as they seek to progress in their careers, requiring more therefore to be trained to fill the gaps.

### **The risks to the PWP Workforce**

This raises a key challenge for the future sustainability of the PWP role. Any new roles, which are not professionally affiliated, are vulnerable as they don't fit the traditional workforce planning, education commissioning and governance processes. This is particularly the case if the role is filled by ambitious graduates who see it mainly as a stepping stone to another career; we saw this happen with the Graduate Worker in Primary Care, where many went on to train as Clinical Psychologists. We, in IAPT, see the PWP as a career in its own right and although there is a place for high flying

graduates, we are keen to help build a stable PWP workforce. This can be achieved by developing career progression options in the role at a band 6 (some sites have even identified a band 7 role) PWP manager and by enriching the role to include specialist interests. Equally, we have been keen to spread the message of the importance of bringing a broader group of people into that workforce in the first place, thereby increasing the likelihood of employing a workforce more representative of the local communities. One way to enable this to happen is to provide an undergraduate option for training as well as the current post graduate certificate; some universities are doing this already and others are baulking at the idea and it remains to be seen how this will materialise in 2010/11.

There are host of important issues that need to be addressed to maximise the retention of the PWP role and workforce, not least being that of communication to key players such as commissioners and people who use services. To that end, IAPT recently published on its website ([www.IAPT.nhs.uk](http://www.IAPT.nhs.uk)) a **PWP Best Practice Guide** the contents of which cover the following:

*The role of a PWP; Stepped Care; What made me become a PWP?; What do PWPs Do?; The Impact PWPs are making; Establishing this new role; What did I do before becoming a PWP?; Training Programme; Accreditation; My work with PWPs; Enriching the PWP role; Progressing my role as a PWP; How a PWP has helped me; Career Progression; What action can you take now?*

## **Conclusions**

The BABCP has already opened an individual accreditation route for new PWPs and the BPS, having led the course accreditation process, is also looking to offer an equivalent route; all of which will support this new group of practitioners in being recognised as a professional grouping in the future.

The announcement in the Comprehensive Spending Review in October 2010 indicated that increasing access to psychological therapies would be a priority, even in these difficult financial times. Although at the time of writing the detail is not clear, there is every reason to hope that PWPs will figure importantly in this continuing process.

## **References**

Turpin, G. (Ed.) (2010): *IAPT Good Practice Guide to using Self-help Materials*. NMHDU/IAPT, 1 - 40.

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Roslyn Hope & Graham Turpin

IAPT National Advisors on Workforce, Education and Training

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