PWP Best Practice Guide

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1. Introduction

The Improving Access to Psychological Therapies (IAPT) programme was established in 2008 to enable people with common mental health problems to access evidence based psychological therapies, as recommended by the National Institute for Health and Care Excellence (NICE). Psychological therapies should be delivered within a stepped care system. Stepped care operates on the principle of offering the least intrusive most effective treatment in the first instance; patients can then be 'stepped up' to a more intensive treatment if required. Crucial to the effective operation of a stepped care model is the Psychological Wellbeing Practitioner (PWP) who provides care at 'step 2'. This is sometimes referred to as Low Intensity (LI) work. PWPs should work alongside High Intensity Therapists (HITs) and other clinicians providing evidence based treatment across the therapeutic modalities.

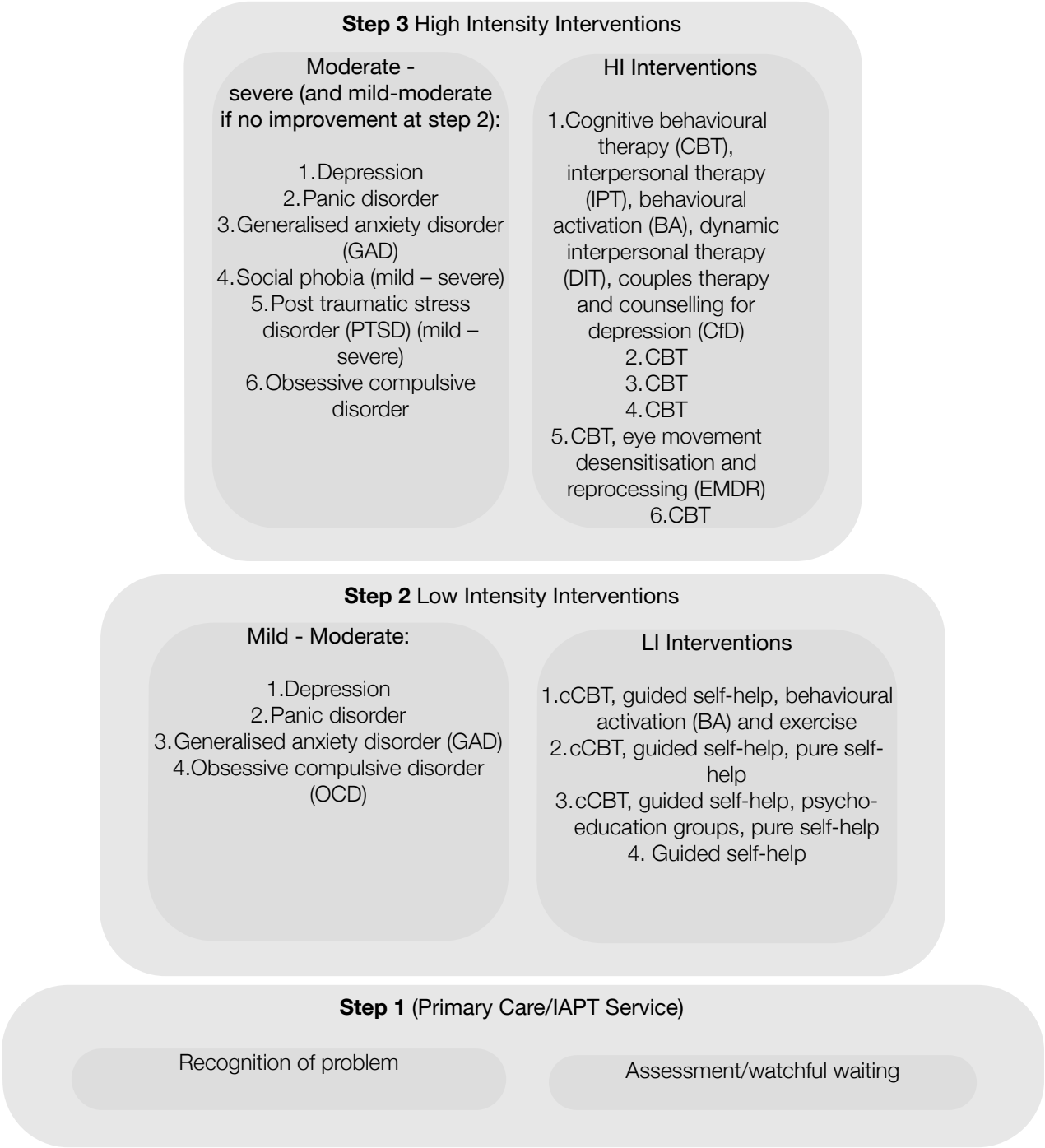
PWPs work with people with mild to moderate depression and anxiety problems. Treatments at step 2 are brief and can be delivered in different ways, such as face-to-face or over the telephone. The focus is on a self-management approach. Low intensity interventions include guided self help via booklets or computerised CBT programmes, behavioural activation and psychoeducation groups, as recommended by NICE for the treatment of mild to moderate common mental health problems.

PWPs working at step 2 are fundamental to the effective delivery of IAPT as many patients can be seen at step 2 and require no further treatment. The IAPT workforce as a whole is a relatively new development but it is the establishment of the PWP role and training which is the substantive innovation in the delivery of effective and efficient psychological care for the wider population.

2. What is an IAPT Service?

An IAPT service provides NICE-approved psychological therapies within a stepped care model. Figure 1 shows the elements that make up a stepped care model.

Figure 1. The Stepped Care Model.



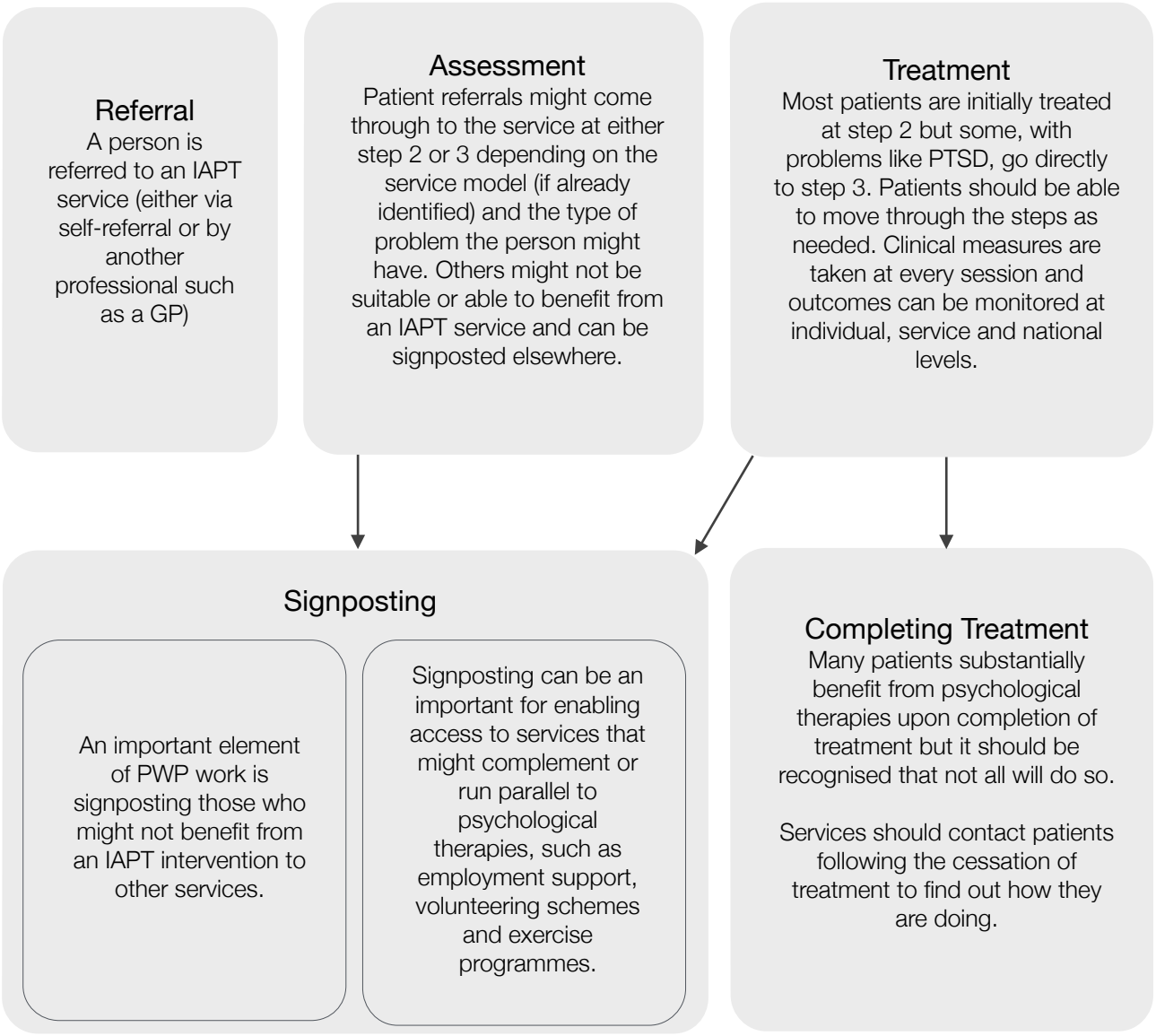
Most IAPT services provide treatment at steps 2 and 3. Step 4 and above is usually considered to be secondary care, although there are some IAPT services specifically commissioned to deliver elements of this. It is important to recognise that no IAPT service should operate in isolation. Good links should be maintained with primary care, other mental health services, voluntary sector services and employment agencies

IAPT services collect data and information about all patients accessing the service. This enables IAPT staff to monitor the progress of their patients and IAPT services, commissioners and NHS England to evaluate the impact that IAPT services are having against the outcomes achieved in clinical trial settings, numbers accessing the service and whether the service is reaching diverse populations in the local area. The national expectation is that at least 15% of people with a common mental health problem in England should be able to access an IAPT service with at least 50% of those completing treatment moving towards recovery.

Accessing psychological therapy services can still have a stigma attached to it and many people do not feel comfortable discussing this with their GP. One way of addressing this is via self-referral - IAPT services should offer self referral routes so that patients can access the service directly and do not have to be referred to the service by another health professional.

IAPT services are commissioned and funded by the NHS and are provided by a range of organisations. These might include NHS Trusts, charities, social enterprises and private providers. Whilst the employing organisation might differ from locality to locality (sometimes within a single area) the model for how care is provided should be broadly similar. An example of what this might look like for a patient is shown in Figure 2.

Figure 2: Example of a Patient Journey through IAPT:



IAPT services are primarily designed, and IAPT staff trained, to treat common mental health problems, namely anxiety and depression at step 2 and 3. IAPT services should not treat people with serious and enduring complex mental health problems, such as psychosis or very severe and recurrent depression, whose needs may be better met by other services. This is one of the reasons it is important to see IAPT services as one element of a wider system.

3. The PWP Role

PWPs see a high volume of patients. NICE commissioning guidance suggests that a trained PWP might see 213 patients in a year (fewer in the training year). This is a significantly higher number than their HI colleagues (at 72 a year). The low intensity nature of step 2 work and the high volume of patients means that PWPs typically have relatively few contacts with individual patients, with an average number of contacts being around 5 sessions (compared with a HI average of around 12). This is a crucial aspect of a properly functioning stepped care model and is intrinsic to the underlying principle of stepped care: that the least intrusive, most effective therapy should be offered in the first instance. In addition to holding a caseload, PWPs are often the first point of contact for people accessing the service and may offer a brief assessment including assessment of a patient's suitability for the service, often called a triage.

Many PWPs have a substantial administrative burden as a result of the high volume of patients they are expected to see. Every service is different and administrative tasks will be allocated differently by services, but it is important that this is taken in to account alongside clinical duties.

PWPs can be seen more as 'coaches' or facilitators of treatment rather than therapists – supporting, enabling and motivating the patient to use evidence based low intensity interventions and materials to work towards recovery. The main focus of the treatment is on supporting the patient to use published manuals, self-help guides or other CBT self-help materials (sometimes this can be computerised CBT self-help). This is a different method to that of HITs who typically deliver traditional Cognitive Behavioural Therapy (CBT), Interpersonal Therapy (IPT), Couples Therapy, Counselling for Depression (CfD) or Brief Dynamic Interpersonal Therapy (DIT).

PWPs are trained and skilled in 'common' as well as 'specific' therapeutic factors. This allows them to develop supportive therapeutic relationships with patients to help the patient to follow the treatment through including problem solving difficulties with any aspects of the treatment.

Although PWPs are skilled in face-to-face work with patients, they often deliver their treatment through a range of alternative delivery systems such as the telephone or web-based support. Telephone delivery can be the main contact method in some services. In many services, PWPs do much of their work through psychoeducational groups.

PWPs work in a variety of different settings. A key element of IAPT is of course 'improving access' and PWPs are central to this. As such, PWPs often work in GP surgeries, children's centres, community centres and a variety of other settings and may offer evening appointments

PWPs primarily work with people with mild to moderate mental health problems but can also provide support for people with long term conditions (LTC) and medically unexplained symptoms (MUS). PWPs usually work with adults aged 18 and above with no upper age limit. PWPs are trained to work with patients from a variety of backgrounds across age, gender, race and culture, spirituality and sexuality. Guided self-help materials have been translated

into a range of languages and many PWPs work with interpreters. This is important to help make IAPT services accessible to all.

The support PWPs provide is designed to support those with mild to moderate mental health difficulties. This means that PWPs should not be working with people with serious and enduring mental health problems nor should they be working with patients with high levels of risk to self or others who need a higher level of care. For all patient work it is important that a PWP is suitably supervised and managed.

What should PWPs be doing?	
PWPs should	PWPs should not
Assess and treat people with common mental health problems	Assess and triage patients for secondary mental health services or treat people with severe, complex and enduring mental health problems
Signpost people to other services when appropriate	Treat people with high levels of risk or needing a higher level of care
Work through a variety of media such as telephone, internet and face-to-face and in a range of settings working with the local community to improve access	Work in isolation including from step 3 colleagues e.g. if in other organisations
Offer brief protocolised step 2 interventions	Carry out high intensity treatment or support non evidence based treatments at step 2
Work with people with LTC and MUS within step 2 model	Hold high intensity or other waiting lists
Monitor patients progress through regular outcome monitoring and be able to step patients up easily and quickly when appropriate	Operate without appropriate supervision
Be valued for the important role they provide including continuing professional development	

All IAPT staff should administer standard questionnaires at every session with patients. This enables individual and service outcomes to be collected and monitored. These measures are used in a variety of ways, from monitoring patient progress in treatment, to service development and outcome monitoring. These measures and the collection of data are integral to the IAPT model.

PWP trainees are usually employed at NHS agenda for change (AFC) band 4 or equivalent.

The PWP role is both challenging and rewarding. The high volume nature of the role can be stressful and pressured but also allows for a variety of ways of working and with a range of patients, many of whom will show good recovery. It is important to understand the nature of the role and to acknowledge both the benefits and challenges that this can bring. PWPs have contributed to the table below.

PWP Challenges and Benefits	
Challenges	Benefits
Expectation of high caseloads and number of clinical contacts	Range of experiences of working with different common mental health disorders: Depression, Generalised Anxiety Disorder, Obsessive Compulsive Disorder, Panic Disorder and sleep problems.
Ratio of face-to-face work to telephone work can very across services	Opportunity to work with clients from a diverse range ages, cultures, backgrounds
High volume of administrative duties linked to high volume case load	Attending training alongside working allows for development within the role
Short duration of treatment sessions	Large amount of clinical contact with patients
Learning to conduct sessions with assistance from interpreters	Experience in providing self-guided therapy through a range of media including: one-to-one, group, workshops and computerised
Working to targets	Collaboration with external agencies and secondary care services
Needing to explain the PWP role to other therapists and clinicians	Seeing real improvements in peoples mood and mental health through outcome measures
Balance of assessment/triage versus treatment	Close supervision for case management and clinical skills

The PWP role is a new and developing one and PWPs can come from a wide range of backgrounds in both the public and private sector.

IAPT services should actively seek to make sure that staff groups are as representative as possible of the population they serve.

PWP Case Study

A PWP in the London borough of Lambeth
I currently work as a qualified PWP in Lambeth IAPT service. My role involves a diverse set of responsibilities and positions. Currently most of my clinical time is spent delivering one-to-one step 2 interventions with clients. One and half days a week these are delivered within a GP surgery and hospital in the borough. However, twice a week I deliver step 2 LI interventions to prisoners within Brixton Prison. This responsibility is only a small part of my involvement in Brixton Prison and I am involved in a number of other areas including developing and co-facilitating psychoeducation workshops, conducting triages and service development including service promotion and clinical audits. My other time is spent acting as a triage facilitator at one of our team bases. This involves managing a team of other PWPs to conduct telephone triages with clients. Within this post I provide brief supervision advising clinicians which stepped care treatment is appropriate to the client's needs or signposting/referring to alternative services. The role also requires liaising with GPs regarding referrals, administrative tasks and managing risk. On a day to day basis my clinical work is done with the use of self-help materials and guides that follow the NICE guidelines. These are delivered generally through-face to-face sessions; however there is the option for telephone working if the client prefers. I also run a recovery support group for those who have had treatment within the service. To help manage my caseload and support me clinically I have supervision once a week with a high intensity therapist/Clinical Psychologist and for CPD and clinical reflection I attend group supervision with my fellow PWPs. Working as a PWP I manage a high case load of clients seeing on average 8 patients a day. This provides me with a diverse range of experience working with a variety of clients with varying diagnoses. The role is exciting and ever changing. It has many areas in which to develop professionally, gaining a wide portfolio of skills and qualities and allows for you to specialise in personal areas of interest.

4. PWP Training

There are multiple routes in to PWP training and this can vary from area to area. Some courses offer undergraduate entry as part of a degree programme, but the majority of PWP courses are at postgraduate level. Most trainees will be working as an employee of a service through the training year and working within a service is an important component of the delivery of the training. Universities should provide a non-graduate entry route enabling prospective trainees without degrees to undertake training. Training places are usually NHS funded but self-funding arrangements are possible in some areas.

To become a qualified PWP, trainees attend a university course, usually run over an academic year. The training consists of 45 days - 25 days are university based and 20 practice based learning days are within the workplace. The courses are usually designed to deliver intensive training at university at the beginning of the course, moving to a day a week in university and 4 days within the service for the remainder of the course.

Trainees do not see patients at the beginning of the training; instead they spend time shadowing staff, practicing skills in role play and clinical skills supervision and learning their service protocols and self-help materials. Following this, trainee caseloads should gradually build over the course of the training year, moving up to around 80% of a trained PWP caseload by the end of the training course.

Training requires trainees to demonstrate competence across a range of well specified skills; covering assessment, treatment, diversity and working within a service. PWP trainees are specifically required to demonstrate competence in undertaking patient-centred interviews, in supporting a range of low-intensity CBT interventions and to work within an inclusive values base that promotes recovery and respects diversity. All modules are assessed by the university. In addition, clinical supervisors in IAPT services sign off practice based outcomes for which trainees will collect evidence of developing competence within the workplace across a number of areas. Once the course has been successfully completed PWPs should receive a PWP qualification, usually a postgraduate certificate or undergraduate award and move from NHS AFC band 4 to band 5 or equivalent.

Training is provided both by the university and the IAPT service and should be seen as partnership between the two. Universities and services should work together closely to provide the best training experience possible for trainees. This collaborative training is delivered through practice based outcomes, university specified practice based learning days in service and by assessing and treating a caseload of patients under supervision.

PWP courses are accredited by the British Psychological Society (BPS). Courses and education commissioners should ensure that services taking in trainees are appropriate environments for training.

An appropriate training environment for a trainee should include the following:

- The service should operate a stepped care system, with coherent integrated care pathways and clear protocols for initial allocation and stepping up/down in place.
- The service should deliver interventions that are provided in line with NICE guidance.

- Suitable office and clinical accommodation should be available.
- Trainee caseloads must be compatible with an effective training experience (e.g. gradual build-up of caseload, type of patients seen) and services should commit to agreeing appropriate caseloads with the relevant courses.
- Trainees should have access to the full range of presentations and modes of assessment and treatment that are required for completion of the course.
- Services should work with courses to address identified problems by making relevant adjustments to individual support, supervision and training/development.
- Supervisors should have demonstrable knowledge and experience of delivering LI interventions.
- Supervisors should have attended an LI supervisor training and be conversant with GSH/cCBT materials and site protocols.
- Regular case management and clinical skills supervision should be provided.
- Trainees must be able to access the required number of practice based learning days, and these should not be used for routine clinical work.
- Services' GSH materials/cCBT packages should be available for trainees.
- Equipment for the routine audio and video taping of sessions should be available.

Supervision

Supervision is crucial for the safe and effective practice of PWPs and their skills development, both during training and post-qualification. PWPs should receive at least one hour a week of clinical case management supervision in which all patients on their caseload are reviewed as new patients where risk or scores on measures are above a predetermined threshold, where appointments are overdue. All patients should be reviewed at least every four weeks. PWPs should receive one hour every two weeks of clinical skills supervision which could be provided on an individual basis or as part of a group. Supervisors should have a good understanding of the PWP role and be skilled in delivering PWP interventions themselves. Supervisors should attend a low intensity supervisor training programme provided by an accredited training provider. Receiving supervision from an appropriately trained supervisor is one of the criteria PWPs need to meet for individual practitioner accreditation.

In addition, PWPs should receive appropriate management supervision, regular appraisals and opportunities for their continuing professional development needs to be met. The elements of supervision may be provided by a number of different members of staff with good communication between supervisors essential.

It is important to recognise that the high volume of patients that PWPs see can be stressful and PWPs should have access to emotional support in the workplace and on the course.

5. Developments within the role

The PWP role is incredibly valuable, and unique. The opportunities for PWPs to develop and continue learning within it are very important in maintaining and retaining an effective step 2 workforce. In addition, PWPs can look at specialising in different clinical areas, for example long term conditions, to further increase their skills and experience. Services and education commissioners should ensure that there are training opportunities for PWPs beyond the training year. This type of training is often referred to as continuing professional development (CPD) training. PWPs may also develop specialisations in areas such as community engagement or working with specific groups of the population such as deaf people.

Increasingly, services are acknowledging and expanding the role of PWPs and in a number of areas the role of the senior PWP (usually at NHS AFC band 6 or equivalent) is being developed (see below). A number of universities employ PWPs and senior PWPs as Clinical Educators on PWP courses. PWPs can provide a valuable part of low intensity teaching by providing trainees with access to their own experience

Some PWPs might want to move into other roles such as IAPT high intensity training. PWPs who wish to look at high intensity training should bear in mind that HI courses look for at least two years post PWP qualification experience for PWPs (see www.babcp.com for more details[1])

It is important for services to ensure that PWPs are properly supported in the role and provided with the same opportunities for development as other staff. PWPs who are properly supported and valued stay in the role longer and are more effective.

Senior PWP Roles

Senior PWP positions are increasingly becoming available to provide further opportunities for those who wish to develop within the role. Typically the PWP role includes supervision, management and service development responsibilities. For example, a senior PWP may attend supervision training and provide case management or clinical skills supervision for qualified PWPs whilst supporting service managers through service evaluation or specific responsibilities such as overseeing team training. Senior PWPs are also able to draw on their experience as a practising PWP to feed into management decisions in the service.

[1] The British Association for Behavioural and Cognitive Psychotherapies (BABCP) is the accrediting body for High Intensity training

A senior PWP in Sheffield

My IAPT journey began in 2008 in the first cohort of Sheffield IAPT Psychological Wellbeing Practitioners (PWPs), ever since I have been dedicated and passionate about the PWP role. In 2011, I was thrilled to be successful in becoming one of four Senior PWPs in Sheffield IAPT.

My role as a Senior PWP is fast pace and varied, being part of an evolving role is exciting and motivating. I am currently working with several colleagues leading on a number of projects within the IAPT service such as Stress Control, Healthy Living Workshops and the Physical Activity Group. I am also one of the lead PWPs for the LTC/MUS Pathfinder, working with Health Psychologists and colleagues to develop and deliver workshops and courses, which have been a great success. I have played an active role in recruitment and training new members of staff, which has been an invaluable and rewarding experience.

Leadership is a key part of my role. I believe it is essential to work together effectively in order to develop and empower others. I was delighted to embark on an NHS leadership course as part of my development, which has given me an opportunity to develop my leadership skills and equip me with innovative ways of working. An integral part of my role is supervision: providing high quality supervision is something I am committed to, delivering NICE-recommended evidence based interventions and adhering to the Stepped Care model.

I have a keen interest in research. Recent projects I have played a key role in are a study about providing Cognitive Analytical Therapy (CAT) self-help at Step 2. I presented these findings along with the researcher at the PWP conference in York. I am also currently involved in the Practice Research Network, which is looking at combining data from a number of IAPT sites and using the learning from this. I believe it's important that we are curious, learn from data and share good practice to make improvements and ultimately improve patient care.
The Senior PWP role together with the PWP role is forever evolving and I feel privileged to be apart of this exciting and enthusiastic workforce. The Senior PWP is such a dynamic and diverse role, with many opportunities and I am looking forward to continuing on this career path.

A Senior PWP in Essex and the Clinical Tutor Role

I began as a Trainee Psychological Wellbeing Practitioner (PWP) in 2009,qualifying in 2010. In April 2011 I was promoted to Senior PWP within the North East Essex service, a change which saw me taking on a range of additional responsibilities including case management supervision. In September of the same year I was asked to deliver a brief talk to the trainee PWPs at the University of Essex about the work of a step 2 practitioner and my involvement with the course has gradually increased from that point onwards.

Alongside my Senior PWP role, I am now employed as a Clinical Lecturer for two and a half days a week with the University of Essex. My main responsibilities include all the activities you would expect of an academic role, such as lecturing, marking and researching into the low intensity knowledge base. As well as these more obvious duties, I also assist with trainee interviews and conduct visits to services across the region. Working in an academic environment has also given me the opportunity to engage in further study and attend relevant conferences to further my subject knowledge which is an aspect of the job I really enjoy.

The use of trained and experienced PWPs in low intensity training courses is a mutually beneficial model; the training provider can draw upon the knowledge of people who have actually been doing the role (an aspect of the course which students also find beneficial) and it opens up a career development pathway for PWPs who are looking to expand into wider roles.

From PWP to Team Manager

I started my IAPT journey in 2008 and have worked in a number of different clinical and leadership roles since this time. I began as a trainee Psychological Wellbeing Practitioner teaching patients new skills to manage their anxiety and depression related problems. I went on to successfully gain a Postgraduate Certificate in delivering Low Intensity interventions based on Cognitive Behavioural Therapy. During this role I developed a desire for supporting other PWPs in their roles and went on to become a supervisor. I moved in to a Senior Psychological Wellbeing Practitioner role where I became heavily involved in supervising trainee and qualified staff and large scale pieces of service development. Part of this involved setting up and delivering group interventions for the Sheffield IAPT service. I then became the lead for Sheffield IAPT for Healthy Living Workshops.

I moved in to a team leader role in the service which gave me prime opportunity to become more involved in service improvement and support a team of therapists in their roles. What was becoming apparent to me was just how rewarding and valuable it felt to lead and support staff in their roles to achieve their potential. I applied for a team manager role and was successful. A key motivator for me is ensuring that patients access the right therapy at the right time. My IAPT journey has led to a position in management where I can now lead a whole team of clinicians from different professions to hopefully make a difference in the NHS. I hope to continue to develop my skills to find ways to improve the quality of patient care creating positive ripple effects for staff and patients.