Health Education England

Identifying the competences of High-Intensity CBT therapists and Clinical Psychologists

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Contents

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Executive summary

Background

This report was commissioned by Health Education England with a brief to identify similarities and differences in the competences and working practices of High Intensity CBT Therapists and Clinical Psychologists.

Structure of the report

This report is in three parts, reflecting the methods we adopted to address the question we were posed.

The first part of the report asks a simple question: are High Intensity CBT therapists and Clinical Psychologists employed in the same services? By definition the former are employed in IAPT Adult Mental Health Services; what is less clear is where clinical psychologists are located. The second part is a mapping of the training curricula for High-Intensity CBT therapists and Clinical Psychologists. Being clear about the knowledge and skills each group is expected to acquire through their training is an obvious way to identify and delineate their competences. But how someone is trained may not always reflect what they do in practice, and so the final section of the report comprises an analysis of interviews with service leads who employ High-Intensity CBT therapists and Clinical Psychologists, and with course directors of High-Intensity CBT and Clinical Psychology training programmes.

Summaries of each section

Part 1 – Identifying the services within which clinical psychologists are employed.
A clear and consistent pattern emerged from our workforce surveys: only a very small proportion of the clinical psychology workforce is employed in IAPT services: even within an Adult Mental Health context most work in primary, secondary or tertiary contexts in a range of specialities that have little overlap with IAPT (particularly in child and adolescent and paediatric services, as well as in physical health, forensic, learning disabilities, older adult, neurology/neurorehabilitation and substance misuse).

A clear conclusion is that High Intensity CBT therapists and clinical psychologists are employed to meet different service requirements (because they are employed at different levels of the system) as well as meeting the needs of different client populations).

Part 2: Results of the mapping of training curricula.
The mapping exercise indicated areas of overlap but also identified distinctive differences in the expectations of, and outputs from, training.

i) High Intensity CBT programmes focus specifically on knowledge of CBT and this unitary focus is reflected in the structure and extent of teaching. High Intensity practitioners are trained for a specialist role that equips them to intervene effectively and competently with adults presenting with depression and anxiety disorders, using well-defined and well- developed CBT skills.

ii) Clinical Psychologists are also trained to implement CBT interventions to a high standard of competence (with around one third of their training focussed on CBT), but programmes include other evidence based therapeutic modalities and prepare practitioners for versatile working in work in a wide range of clinical contexts. A particular feature of clinical psychology training is that it encompasses an understanding of fundamental psychological processes (just as training in medicine is underpinned by an understanding of human biology) which enables clinical psychologists to work flexibly in response to different problems and to keep updated with developments in science and practice. They gain experience with clients across the age range (from infants and children to adults of working age and older adults), working in primary, secondary and tertiary settings, with presentations encompassing the complete spectrum of mental health difficulties as well as helping individuals with learning disabilities, neurodevelopmental disorders and psychological difficulties arising in the context of physical health and trauma. They commonly work with co-morbidity and multiple morbidity, applying psychological knowledge to assess, formulate and intervene in contexts where innovative practice is required.

iii) Clinical Psychologists have extensive training in research skills, making a significant contribution to treatment development, and indeed to the evidence-based approaches which underpin the IAPT curricula.

iv) The training of Clinical Psychologists makes it possible for them todeliver interventions based on organisational and system change, drawing on their psychological expertise to analyse existing provision and to formulate and implement changes to the ways in which services are delivered.

v) Supervision, consultation and leadership are increasingly emphasised within clinical psychology training, such that these are roles that can be undertaken soon after qualification.

To summarise, HI and Clinical Psychology programmes overlap in that CBT is taught and practised to a good standard in both, but there is a critical difference in ‘bandwidth’; clinical psychology training has a much broader remit, and (in a sense) equips practitioners to be
‘psychological problem solvers’ with a wider reach and clinical application.

Part 3: Results of interviews with service managers and course directors.
Interviews with trainers and employers of clinical psychologists and High Intensity therapists yielded a consensual view: although there are some similarities between the two groups, there are also distinctive differences.

Participants were clear that there was an important distinction between the roles of

High Intensity therapists and Clinical Psychologists. The former was seen as well-

trained specialist workers with specific expertise in delivering CBT, primarily (but increasingly not exclusively) to adults presenting with anxiety disorders or depression. Clinical Psychologists were identified as having a much broader range of skills that usually encompassed CBT but included a broader range of therapeutic models applied to a broader set of clients and presentations.

High Intensity therapists were seen as working almost solely face-to-face, delivering psychological therapy through direct client contact. For clinical psychologists, therapy was seen as only part of their work, especially as they became more senior, with the proportion of direct work decreasing as they took on more 'indirect' roles, supporting other staff (through training, supervision and consultation) and contributing to service delivery and design. This shift of role with greater experience was not seen as characteristic of High Intensity therapists; for the most part the main focus of their role continued to be face to face therapy.

A further point of difference is that clinical psychologists were seen as working not only within primary care, but also across a range of other services and settings (including secondary care mental health services and physical health settings). In relation to client groups their range extends beyond adults to include older adults and children and adolescents, as well as people who present with acquired or developmental cognitive difficulties.

Participants noted that clinical psychologists were well placed to contribute to operational and corporate aspects of health services, able to lead and advise on service provision and delivery. They also noted that clinical psychologists were well placed to develop the psychological skills of the wider healthcare workforce, helping to create more responsive systems and services in the context of limited direct psychological therapy resources within the NHS.

To summarise, interviews with course directors and service managers echoed the conclusions of the curriculum mapping exercise, confirming the areas of overlap between High Intensity therapists and Clinical Psychologists, but also foregrounding the significantly broader remit and reach associated with Clinical Psychologists.

Part 1. Identifying patterns of employment of Clinical Psychologists: Summary of method and findings.

Background

One indicator of the roles and responsibilities of HI CBT therapists and clinical psychologists is the locations in which they work. By definition High Intensity CBT therapists are employed in IAPT services, but Clinical Psychologists work in a diverse range of services. As such, the aim of this section is to identify the services where they are employed.

How patterns of work were identified
There were three sources of information:

a. 'First destination' data from clinical psychology Doctoral programmes

b. 'First destination' data from the national clearing house for clinical psychology programmes

c. A national survey of service heads.

Results

A clear and consistent pattern emerged indicating that only a very small proportion of the clinical psychology workforce is employed in IAPT services – estimates from the three sources of data were 4.35%, 1.9% and 3.1%.

Even within an Adult Mental Health context most work in primary, secondary or tertiary contexts outside IAPT. Outside Adult Mental Health, clinical psychologists are working in a range of specialities that have little overlap with IAPT, particularly in child and adolescent and paediatric services, as well as in physical health, forensic, learning disabilities, older adult, neurology/neurorehabilitation and substance misuse.

Conclusions

A clear conclusion is that High Intensity CBT therapists and clinical psychologists are employed to meet different service requirements (because they are employed at different levels of the system) as well as meeting the needs of different client populations.

Identifying patterns of employment of Clinical Psychologists

Background
One indicator of the roles and responsibilities of HI CBT therapists and clinical psychologists is the locations in which they work. By definition High Intensity CBT therapists are employed in IAPT services, but Clinical Psychologists work in a diverse range of services. If we are seeking to understand the contributions of each group, then knowing where they work is important, as is identifying the relative numbers of clinical psychologists working within and outside IAPT.

Although the NHS collects census data on all professions, the current occupational codes are not a reliable source of data for clinical psychologists: the code under which they are subsumed also includes a variety of other psychological practitioners (a problem that has only recently been identified and is currently being rectified through revisions to the Electronic Staff Record coding structure.

Method
Given that no accurate national data is available, two methods were used to identify where clinical psychologists are employed:

First destination data: All clinical psychology training programmes collate data on the first employment destinations of their students, yielding information about the services in which they are working.

A survey was sent to the 26 English Doctoral programmes in Clinical Psychology, requesting information about the first destinations of cohorts leaving the programme between 2013 and 2016. In order to maintain consistency in the data they were asked to use the template shown in Table 1. As can be seen, this distinguishes adult IAPT from adult mental health services outwith IAPT settings, and adult mental health settings where the focus is on working with psychosis, rehabilitation or early intervention.

Table 1. Service locations for first destination data

Adult Mental Health (AMH)
AMH IAPT service
AMH
AMH psychosis/rehabilitation/Early Intervention
Child/Adolescent/Paediatric services
Forensic services (e.g. working in ‘medium secure’ or prison services)
Physical Health (e.g. working with people with diabetes, cardiac problems or chronic fatigue)
Learning Disabilities services
Older Adult services
Services for people with neurological problems (e.g. stroke or head injury)
Drugs/Alcohol services

Data was returned from just under half the programmes – 10 courses. Because this relatively small sample may not be representative of the national picture, data from the Clearing House for Courses in Clinical Psychology (which collects information on first destinations from all UK courses) was collated for 2014 and 2015 in order to cross-check and supplement returns from individual courses.

Service locations as indicated by service managers**:** Using a list of managers held by the British Psychological Society, 123 clinical psychologists who act as NHS service managers in England were sent a survey requesting information about the service locations of clinical psychologists for whom they had management responsibility (using the same template as in Table 1). Returns were received from 41 managers, a response rate of 33%.

Results

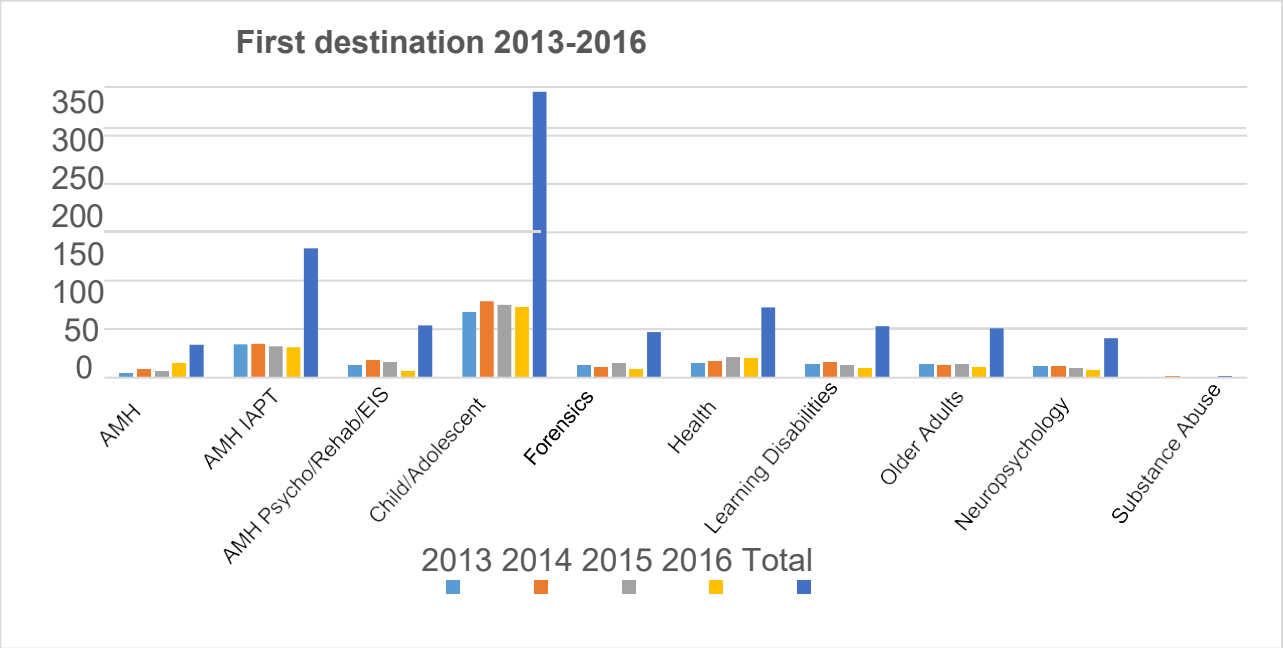
First destination data

Data from training programmes: Table 2 and Figure 1 show collated data from the 10 English clinical psychology programmes for leavers between 2013 and 2016; this yields information about the first employment destinations of 782 qualifiers. A clear finding is that only a small proportion of qualifiers enter adult IAPT services – 4.35%. The greatest proportion (37.7%) work with children/adolescents/paediatrics, with around 24% working with adults in non- IAPT contexts.

Table 2: Collated first return data from 10 English clinical psychology programmes for graduates 2013 and 2016.

Year of qualification	AMH IAPT	Adult Mental Health	AMH psychosis/ Rehab/ EIS	Child/Adolescent/ Paediatric	Forensic	Health	Learning Disability	Older Adult	Neuropsychology	Substance abuse
2013	4	34.5	13	68	13	15	14	13.5	12	0
2014	9	35	18	79	10.5	17	16	13	11.5	1
2015	6	32.5	16	75	14.5	20.5	13	14	9.5	0.5
2016	15	31.5	7	73	9	20	10	10.5	8	0
Total (N)	**34**	**133.5**	**54**	**295**	**47**	**72.5**	**53**	**51**	**41**	**1.5**
As % of total	**4.35**	**17.06**	**6.9**	**37.7**	**6.0**	**9.27**	**6.77**	**6.5**	**5.24**	**0.19**

Figure 1. Collated first destination returns from 10 English Clinical Psychology programmes.



Data from the Clearing House in Clinical Psychology: Returns for 2014 and 2015 (Table 3) mirror this pattern. Information was available for 767 qualifiers; a small percentage (1.9%) entered adult IAPT services.

Table 3. Collated first return data for English programmes in clinical psychology for graduates in 2014 and 2015.

Qualifying Year	AMH IAPT	Adult Mental Health	AMH Psychosis	Child and Adolescent	Forensic	Health	Learning Disabilities	Older Adults	Neuropsychology	Substance Abuse	Eating Disorders	Research / academia	Other
2014	5.5	87	13	111	29	30	27	24	19.5	1	9	4	6
2015	9	91	13	128	18	41	39	25	19	1	10	3	4
Total	**14.5**	**178**	**26**	**239**	**47**	**71**	**66**	**49**	**38.5**	**2**	**19**	**7**	**10**
As %age	**1.9**	**23.2**	**3.38**	**31.1**	**6.12**	**9.25**	**8.6**	**6.38**	**5.01**	**0.26**	**2.47**	**0.91**	**1.30**

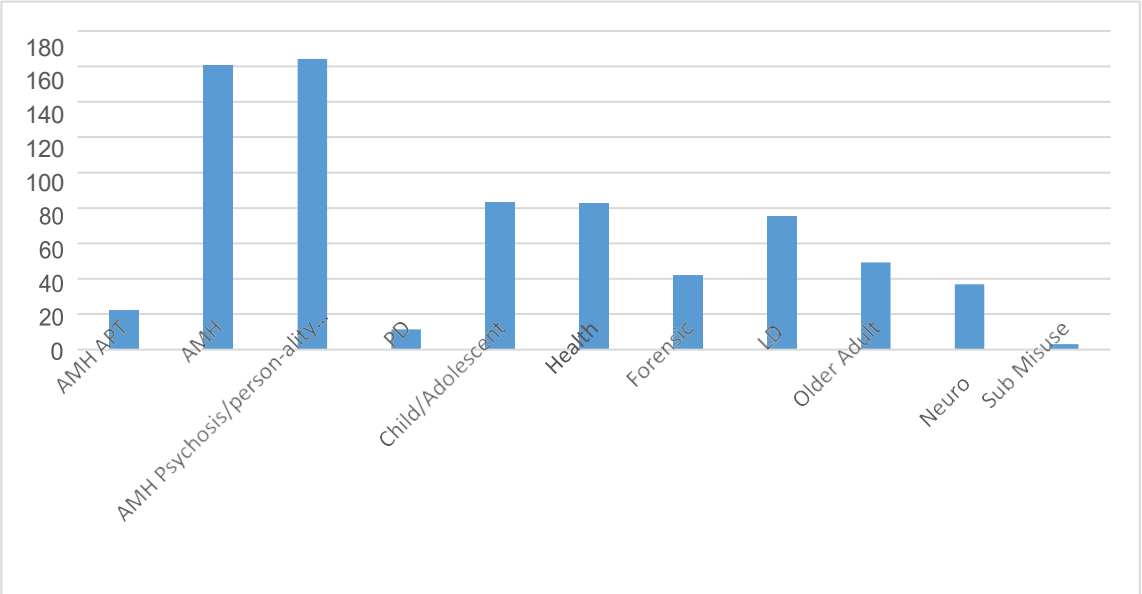
Service manager returns

Returns from service manager identified the service locations of 728 Whole Time Equivalent posts (Table 4 and Figure 2). Although the pattern of posts across services is slightly different from the first destination data, the proportion employed in Adult IAPT is very similar (at 3.1%).

Table 4. Area of employment of clinical psychology staff

	AMH APT	AMH	AMH Psychosis	PD	Child/Adolescent	Health	Forensic	Learning Disability	Older Adult	Neuro	Sub Misuse
Total WTE	22.3	161	164.1	11.3	83.5	82.6	41.7	75.5	49.2	36.8	3
As %age	3.1	22.1	22.5	1.5	11.4	11.3	5.7	10.3	6.7	5.1	0.4

Figure 2. Service locations of clinical psychology staff



Discussion

Estimates of the number of clinical psychologists working within IAPT were derived from first destination data supplied by English Doctoral programmes, from the Clearing House in Clinical Psychology and from service manager returns. Notwithstanding the variation in these estimates (with a range from 1.9% to 4.3%), it is safe to conclude that relatively few clinical psychologists are based in IAPT services. Even within an Adult Mental Health context most work in primary, secondary or tertiary contexts outside IAPT. Outside Adult Mental Health, clinical psychologists are working in a range of specialities that have little overlap with IAPT, particularly in child and adolescent and paediatric services, as well as in physical health, forensic, learning disabilities, older adult, neurology/neurorehabilitation and substance misuse.

Summary

A clear conclusion is that High Intensity CBT therapists and clinical psychologists are employed to meet different service requirements (because they are employed at different levels of the system) as well as meeting the needs of different client populations.

Part 2: Mapping the curricula for training in High-Intensity CBT Therapy and Clinical Psychology

Summary of method and findings

How the mapping was done
Training for HI CBT therapists is focused on work in a specific therapeutic modality delivered to a specific set of patients (those with common mental health problems); Clinical Psychologists are given a professional training that includes (but is not restricted to) CBT. This means that the standards and curricula that underpin these trainings have a different focus. To overcome this and 'triangulate' data, mapping was undertaken in the following ways:

a. A contrast of the national standards for Doctoral training in Clinical Psychology (as published by the British Psychological Society (BPS) and the Health and Care Professions Council (HCPC) Standards of Proficiency) against the national curriculum for High Intensity CBT training.

b. A contrast of the CBT content of doctoral clinical psychology programmes and that delivered on HI therapy courses.

c. A comparison of CBT experience gained during training, and the methods used for evidencing competence on doctoral clinical psychology programmes and on HI therapy courses.

Results of the mapping

Mapping indicates areas of overlap but also identifies distinctive differences in the expectations of, and outputs from, training.

i) HI programmes focus specifically on knowledge of CBT and this unitary focus is reflected in the structure and extent of teaching. HI practitioners are trained for a specialist role that equips them to intervene effectively and competently with adults presenting with depression and anxiety disorders, using well-defined and well-developed CBT skills.

ii) Clinical Psychologists are also trained to implement CBT interventions to a high standard of competence, but programmes include other evidence based therapeutic modalities and prepare practitioners for versatile working in work in a wide range of clinical contexts. A particular feature of clinical psychology training is that it encompasses an understanding of fundamental psychological processes (just as training in medicine is underpinned by an understanding of human biology)

which enables clinical psychologists to work flexibly in response to different

problems and to keep updated with developments in science and practice. They gain experience with clients across the age range (from infants and children to adults of working age and older adults), working in primary, secondary and tertiary settings, with presentations encompassing the complete spectrum of mental health difficulties as well as helping individuals with learning disabilities, neurodevelopmental disorders and psychological difficulties arising in the context of physical health and trauma. They commonly work with co-morbidity and multiple morbidity, applying psychological knowledge to assess, formulate and intervene in contexts where innovative practice is required.

iii) Clinical Psychologists have extensive training in research skills, making a significant contribution to treatment development, and indeed to the evidence-based approaches which underpin the IAPT curricula.

iv) The training of Clinical Psychologists makes it possible for them to deliver interventions based on organisational and system change, drawing on their psychological expertise to analyse existing provision and to formulate and implement changes to the ways in which services are delivered.

v) Supervision, consultation and leadership are increasingly emphasised within clinical psychology training, such that these are roles that can be undertaken soon after qualification.

To summarise, HI and Clinical Psychology programmes overlap in that CBT is taught and practised to a good standard in both, but there is a critical difference in ‘bandwidth’; clinical psychology training has a much broader remit, and (in a sense) equips practitioners to be
‘psychological problem solvers’ with a wider reach and clinical application.

High-Intensity (CBT) Therapists and Clinical Psychologists – a resumé

The role of high intensity CBT therapists was developed within the Improving Access to Psychological Therapies (IAPT) programme. This programme was originally conceived with a specific purpose: to increase access to evidence-based NICE-concordant therapies for people with anxiety or depression. Although other therapeutic modalities have since been accommodated within IAPT, these high-intensity workers were to be focussed on the delivery of CBT. Given the ambitions of the programme, it was clear that a new cadre of workers would be required in order to meet workforce needs, along with new dedicated training programmes. This being the case a competence (rather than profession)-based specification of their role was identified, based on the competence framework for CBT commissioned by the IAPT programme (Roth & Pilling, 2008), and a curriculum for training developed (Department of Health, 2008, 2011). In practice many programmes have adapted one-year Postgraduate Diploma courses in CBT, making a critical modification in their entry requirements to include a broader range of professions and prior experience. As such, HI workers are defined not by membership of a single profession, but by their CBTskill set.

Clinical psychology can be broadly defined as the integration and application of science, theory and clinical knowledge, aimed at understanding, preventing and relieving psychologically based distress or dysfunction, and promoting subjective well-being and personal development. Clinical psychologists work in many different clinical fields, in both mental and physical health settings, working with children, adults and older adults, as well as individuals with developmental and acquired cognitive difficulties. Their role includes the assessment and formulation of a person's presentation using a range of psychological techniques and models and the design, implementation and evaluation of interventions that are tailored to the individual client. Their training helps them to be psychological problem- solvers, able to draw on psychological knowledge in order to assess and understand complex clinical situations. Because they have a high level of research knowledge and expertise the profession has made an extremely significant contribution to the development of novel psychological therapies (including those applied in IAPT) and to the development of ways of effecting psychological change in individuals (for example, in the management of challenging behaviour) and in understanding and facilitating behavioural change in the context of physical health.

The context for the curricula

High-Intensity CBT for adults with depression or anxiety disorders: The curriculum for HI therapists is set nationally, and was developed specifically for the IAPT programme; since its original publication it has been subject to some revision (Department of Health, 2008, Department of Health, 2011).
– Appendices 1 and 2). It reflects the skills and knowledge set out in the CBT competence framework (Roth and Pilling, 2007), which is rooted in evidence-based practice and congruent with NICE guidance. All HI programmes are required to map

their teaching and training to the curriculum, and are accredited by the British Association for Behavioural and Cognitive Psychotherapies (BABCP), which sets out minimum training standards that specify the required academic and clinical experience required for accreditation as a CBT- practitioner.

Clinical Psychology: Regulation of Clinical Psychology is the responsibility of the Health and Care Professions Council (HCPC); professional governance rests with the British Psychological Society (BPS). Accreditation of programmes is carried out by both bodies independently. The HCPC approves programmes against minimum threshold Standards of Proficiency (SoPs) and Standards of Education and Training (SETs), and the BPS accreditation process considers specific professional standards and quality enhancement. The accreditation process allows for some variation in emphasis from course to course, but the standards set out a coherent framework that closely regulates course content.

Both HCPC and BPS requirements are relevant to the current mapping exercise, but for pragmatic reasons there is considerable advantage to using the BPS standards as the primary source of data:

a) the content of the SoPS for practitioner psychologists were informed by the BPS standards, making it relatively easy to ensure that the specifications included in the SoPs are appropriately represented
b) the SoPS are less detailed than the BPS standards in terms of their specificity and range

Course level and Course length

All High Intensity CBT training programmes are at Postgraduate Diploma/Masters level, and last for one year. All Clinical Psychology programmes are at Doctoral level, and the course length is three years full-time.

The difference in level influences the criteria for course admissions and the expected level at which coursework is undertaken.

Entry criteria for admission

HI therapy: Candidates usually need to hold an undergraduate degree (or equivalent) and have an HCPC/professional registered clinical qualification in one of a range of relevant areas (for example, mental health nursing, clinical/counselling psychology, psychiatry, psychotherapy, counselling, social work or psychological well-being practitioners).
Applicants without these qualifications can also apply but need to demonstrate a minimum of two years post-qualification clinical experience and evidence their competency via a portfolio of evidence that meets the Knowledge Skills and Attitude (KSA) requirements of the BABCP.

Clinical Psychology: All courses require candidates to hold the BPS 'Graduate Basis for Chartered Membership of the BPS (GBC). GBC is conferred on the basis of an undergraduate-level programme of academic study in psychology, or

a BPS-accredited conversion course. This has a direct influence on the curriculum because programmes assume that candidates enter training with a good knowledge of psychological theory and models and are familiar with research methodology.

Most courses will only consider applicants with a minimum of a mid- to high 2.1 degree. In addition, all courses require evidence of clinical experience in settings that are relevant to the practise of clinical psychology, and some also expect additional evidence of direct involvement in research.

Mapping

The content of the tables below is drawn from the HCPC and BPS accreditation standards and the HI curriculum (with some editing in the cause of legibility). The standards and the HI curriculum are included as appendices to this report. To set the scene this section is prefaced by a resumé of course aims and objectives, and of the clinical experience gained during training.

Resumé of course aims and objectives and clinical experience

HI Therapy: Courses have a focus on cognitive behavioural theories and models and provide practical intensive and detailed skills training aimed at facilitating skill development, increasing students' knowledge base regarding theory and research in CBT and promoting a critical approach to the subject. The intent is to enable students to become skilled and creative independent CBT practitioners, in accordance with BABCP guidelines for good practice, and to contribute to the further development of CBT. Courses provide opportunities for students to develop and demonstrate knowledge, understanding and skills in the following areas:

i) Practical competency in Cognitive Behaviour Therapy for common psychiatric disorders such as depression and anxiety disorders
ii) Critical knowledge of the theoretical and research literature relating to CBT
iii) Knowledge of studies of human development, psychopathology, psychology, the influence of social context and evidence-based practice

Trainees complete academic assignments (such as essays and case reports) and clinical skills assessments (CBT assessment and therapy sessions). They need to pass all components of the programme in order to qualify.

Clinical experience: Students are in college two days a week; when not in college for academic teaching they work under supervision in IAPT services, primarily gaining direct experience in CBT with adults with depression and anxiety disorders (including phobias, panic disorder, OCD, Generalised Anxiety Disorder and PTSD), and applying their academic learning to the clinical context.

Clinical Psychology: The aims and objectives of clinical psychology training are reflected in the BPS standards; Figure 1 is a simplified schematic illustrating the skills, knowledge and areas of application that students are expected to achieve by the end of training.

On the left of the 'map' are a set of generalisable and transferable competences applied in all settings, and which underpin clinical and professional work. This includes a capacity to draw on and apply psychological knowledge to a very diverse set of clinical and professional contexts. The way in which interventions are structured usually follows a cycle that starts by engaging with relevant individuals and services in order to assess the presenting problems or issues. This investigatory phase is followed by the development of a psychological formulation encompassing a careful analysis of the factors that led to and maintain the problem; the formulation acts to guide an intervention plan that is likely to result in change. Critically, an evaluation of the success of the intervention is an inherent part of this cycle.

There are further sets of skills that characterise a clinical psychologist's working practice. These include a capacity to communicate psychological ideas and information to clients and fellow professionals, to supervise and to train others, and to apply research skills to clinical and professional contexts. Taken together this set of skills underpin a capacity for organisational influence and leadership in relation (for example) to supporting service development and organisational change.

The attitudes and values which characterise the 'stance' taken by clinical psychologist is also relevant – notably an emphasis on working ethically and in accordance with organisational values, and an ability to work autonomously, taking professional responsibility for their input.

Taken together this describes a holistic set of skills, knowledge and values, applied in relation to clients across the lifespan, with a wide range of presentations (often characterised by complexity and comorbidity). Practitioners are expected to be able to draw on at least two distinct models of psychological therapy (one of which must be CBT), and be able to work with both individuals, families and groups. They are located in a range of service contexts (including primary care, secondary and specialist (tertiary) services), not only in mental health settings but also in physical health, rehabilitation and learning
disability services. They should also be able to work 'indirectly' by supporting others to effect change – for example, carers of service users, or fellow professionals - through a process of consultancy, supervision and training.

Alongside their clinical work trainees also complete academic assignments (such as examinations, essays and case reports) and undertake a doctoral–level research dissertation. In order to be awarded the qualification trainees need to pass the academic, research and clinical components of the programme.

Clinical experience: Although there are minor variations across courses, trainees on all UK programmes divide their time between academic teaching at the HEI (usually one or two days a week); the remaining three or four days are spent on a clinical placement where trainees are expected to carry a clinical caseload under

supervision. Over the three years they undertake a diverse set of six-month or one-year placements; these are organised in such a way as to ensure that they meet the required range and diversity specified in the BPS criteria. As such all trainees undertake placements in services for people across the age- range (children and their families, adults and older adults), in diverse settings (for example, including both outpatient and inpatient/residential contexts) and with a broad range of clinical presentations.

Background knowledge base

Clinical Psychology	High Intensity CBT
• Knowledge of fundamental concepts and research from discipline of psychology, including: o brain and behaviour o learning and memory o motivation and behaviour change o perception o language and cognition o emotion o developmental psychology o Statistics and research design • Knowledge of theoretical, research and clinical literature relating to the biological, intrapsychic and interpersonal processes that influence mental health and psychological well- being across the lifespan • Ability to apply psychological knowledge to facilitate change in individuals, groups, families, organisations and communities • Ability to generalise and synthesise prior knowledge and experience in order to apply them critically and creatively in different	• Knowledge of the theoretical and research literature relating to CBT • Systematic knowledge of the principles of CBT and the evidence base for the application of CBT techniques • Systematic knowledge of CBT for depression and anxiety disorders • Knowledge of phenomenology, diagnostic classification and epidemiological characteristics of common mental health disorders • Knowledge of studies of human development, psychopathology, psychology and the influence of social context

settings and novel situations	

Clinical populations with whom students will work

Clinical Psychology	High Intensity CBT
• Anxiety presentations • Depression (moderate to severe presentations)	Adults and Older Adults with: • Anxiety presentations • Depression (moderate to severe presentations)
• Severe and enduring mental health presentations (including psychosis and complex trauma) • Physical health presentations and issues related to adjustment and coping across the life span • Presentations of infancy and childhood (e.g. infant mental health, developmental, social, adjustment to adversity, physical health presentations, looked after children, conduct and mood difficulties) • Presentations of older adulthood (e.g. related to developmental changes and psychosocial adaptation, losses to cognitive functioning) • Neurological presentations of adult and childhood • Presentations of those with physical and intellectual disability • Specialist clinical presentations which present across the life span and in combination with other presentations (e.g. substance misuse, addictive behaviours, eating disorders, personality disorders and forensic presentations)	• Presentations in which anxiety/depression is comorbid with other mental health conditions or presents in the context of long-term health conditions

Application of theoretical models in clinical practice

Clinical Psychology	High Intensity CBT
• Able to implement therapeutic interventions based on knowledge and practice in at least two evidence-based models of formal psychological interventions, of which one must be cognitive-behaviour therapy. • Able to use multi-model interventions, as appropriate to the complexity and / or co-morbidity of the presentation, the clinical and social context and service user opinions, values and goals • Able to synthesise the knowledge base for any single presentation for transtheoretical application	• Able to implement CBT interventions based on knowledge and practice in: ○ two evidence-based CBT models of depression (Beck and Behavioural Activation) ○ evidence-based CBT models for all anxiety disorders • Able to demonstrate critical understanding of CBT theory and ability to evaluate evidence for application of CBT • Able to develop CBT formulations in order to work with more complex/comorbid presentations

Assessment skills

Clinical Psychology	High Intensity CBT

• Able to choose, use and interpret a broad range of assessment methods appropriate:
  ○ to the client and service delivery system in which the assessment takes place
  ○ to the type of intervention which is likely to be required.
• Able to employ:
  ○ performance based psychometric measures (e.g. of cognition and development)
  ○ self and other informant reported psychometrics (e.g. of symptoms, thoughts,
  ○ feelings, beliefs, behaviours)
  ○ systematic interviewing procedures
  ○ other structured methods of assessment (e.g. observation, or gathering information from others)
  ○ assessments of social context and organisations.
• Able to understand key elements of psychometric theory applicable to the interpretation of assessment (e.g. effect sizes, reliable change scores, sources of error and bias, base rates, etc.)
• Able to conduct risk assessment and use this to guide practice
• Able to use assessments to develop formulations which are informed by theory and evidence about relevant individual, systemic, cultural and biological factors
	• Able to conduct CBT assessment in relation to specific conditions (depression and anxiety disorders)
	• Able to assess suitability for CBT (guidelines, case applications and contra- indications (including assessment of alcohol/substance misuse))
	• Able to assess suitability for therapeutic interventions within the IAPT stepped-care model
	• Able to use other structured methods of assessment (e.g. observation, or gathering information from others)
	• Able to use assessments to develop formulations which are informed by theory and evidence
	• Able to conduct risk assessment, mental state examination, personal, medical history
	• Able to use standardised and idiosyncratic clinical measures to monitor CBT Process and outcome

Formulation skills

Clinical Psychology	High Intensity CBT
• Able to construct formulations of presentations informed by, but which are not premised on, formal diagnostic	• Able to construct maintenance and developmental CBT conceptualisations for depression and anxiety disorders
classification systems; developing formulation in an emergent transdiagnostic context • Able to construct formulations using a range of theoretical frameworks and/or with an integrative, multi- model, perspective (as appropriate and adapted to circumstance and context) • Able to develop a formulation collaboratively with service users, carers, teams and services • Able to adjust the format and complexity of a formulation so that it is appropriate and accessible to recipients • Able to use the formulation to guide appropriate interventions if appropriate. • Able to revise formulations in the light of on-going feedback and intervention	• Able to generate CBT formulations in relation to specific conditions (depression and anxiety disorders) • Able to develop a formulation collaboratively with service users • Able to deliver collaborative formulation driven interventions • Able to revise formulations in the light of on-going feedback and intervention • Able to adjust the format and complexity of formulations to accommodate complexity / physical health conditions • Able to develop CBT specific treatment plans

Psychological intervention

Clinical Psychology	High Intensity CBT
● Able to implement a range of psychological interventions appropriate to the presenting problem and to the psychological and social circumstances of the client(s) ● Able to implement CBT and (at least) one other psychological therapy ● Able to intervene in a collaborative manner with: ○ individuals ○ couples ○ families or groups ○ services / organisations ● Understanding application of therapeutic techniques and processes to work with a range of different presentations - for example: ○ anxiety ○ mood ○ adjustment to adverse circumstances or life events ○ trauma ○ eating difficulties ○ psychosis	● Able to implement specific evidence - based CBT interventions with individuals in relation to ○ specific conditions (depression and anxiety disorders) ○ more complex comorbid presentations ● Able to sensitively adapt CBT, and ensure equitable access considering cultural and social differences and values ● Able to adapt therapy to accommodate relevant factors (such as personality traits, or adverse life events)
● substance misuse ● physical health presentations ● somatoform presentations ● psychosexual difficulties ● developmental delay ● personality disorders ● cognitive and neurological presentations ● Understanding social approaches to intervention e.g. those informed by community, critical, and social ● constructionist perspectives	

'Indirect' interventions (working through others)

Clinical Psychology	High Intensity CBT

• Implementing monitoring and supervising interventions and care plans through, and with:
  ○ other professions
  ○ individuals who are formal (professional) carers
  ○ individuals who care for a client by virtue of partnership arrangements.	

Evaluation skills

Clinical Psychology	High Intensity CBT
• Able to evaluate practice by monitoring processes and outcomes across multiple dimensions of functioning • Able to devise innovate evaluative procedures where appropriate • Able to draw on knowledge of outcomes frameworks used in national healthcare systems • Understanding of relevant evidence bases • Understanding of theories of outcomes monitoring • Understanding strengths and limitations of different evaluative strategies, including psychometric theory and knowledge related to indices of change.	• Able to use IAPT national outcomes monitoring system (including session-by-session symptom measures • Use of standard and idiosyncratic clinical measurement to monitor CBT process and outcome • Able to use clinical measurement to inform the therapy and clinical decision-making and the IAPT initiative.
• Able to evaluate processes and outcomes at the organisational and systemic levels as well as the individual level.	

Organisational skills/ systemic influence

Clinical Psychology	High Intensity CBT
● Able to adapt practice to different organisational contexts for service delivery in a variety of settings (such as in-patient and community, primary, secondary and tertiary care, including work with providers outside of the NHS) ● Able to influence service delivery 'indirectly', including through consultancy, training and working in multidisciplinary and cross-professional teams ● Able to bring psychological influence to bear in the service delivery of others ● Able to use formulation to enhance multi-professional communication and psychological mindedness in services) ● Able to use research to influence and inform the practice of self and others ● Able to communicate clinical and non- clinical information from a psychological perspective, adapted to both professional colleagues and to users and their carers	• Knowledge of the IAPT stepped-care interface, and of other modality therapies available to enhance patient choice • Able to practise effectively at step 3 of the IAPT services stepped care system

Leadership and management

Clinical Psychology	High Intensity CBT
• Understanding of leadership theories and models, and their application to service development and delivery. • Able to demonstrate leadership qualities (e.g. being aware of (and working with) interpersonal processes, influencing the psychological mindedness of teams and organisations, contributing to and fostering collaborative working practices within teams)	
• Able to work with users and carers to facilitate their involvement in service planning and delivery. • Able to understand change processes in service delivery systems. • Able to understand and work with quality assurance principles and processes • Awareness of the legislative and national planning contexts for service delivery and clinical practice • Able to recognise malpractice or unethical practice in systems and organisations and respond to this (including being familiar with 'whistleblowing' policies and issues)	

Supervision and training of other professionals

Clinical Psychology	High Intensity CBT
• Providing supervision at an appropriate level within own sphere of competence • Preparing and delivering teaching and training which considers the needs and goals of the participants (e.g. by appropriate adaptations to methods and content) • Understanding of the supervision process for both supervisee and supervisor roles. • supporting others' learning in the application of psychological skills, knowledge, practices and procedures	• Providing CBT supervision at an appropriate level within own sphere of competence • Understanding of the supervision process for both supervisee and supervisor roles

Research skills

Clinical Psychology	High Intensity CBT
• Able to be a critical consumer, interpreter and disseminator of research evidence base relevant to clinical psychology practice • Able to design and conduct independent and original research that merits publication • Able to conduct service evaluations • Able to carry out small-scale (pilot) studies consistent with the ethos of both evidence-based practice and practice-based evidence.	• Knowledge of assessment methodology: clinical and research: clinical trials; outcome studies • Knowledge of theoretical and research evidence for cognitive models and methods and ability to evaluate the evidence

Expected level of autonomy

Clinical Psychology	High Intensity CBT
• Able to make informed judgments on complex issues in specialist fields, often in the absence of complete information • Able to communicate psychologically- informed ideas and conclusions to specialists and non- specialists in order to influence practice, facilitate problem solving and decision making • Able to exercise personal responsibility and largely autonomous initiative in complex and unpredictable situations in professional practice • Able to understand the process of providing expert psychological opinion and advice, including preparing and presenting evidence in formal settings	• Able to demonstrate self-direction and originality in tackling and solving therapeutic problems • Able to take personal responsibility for clinical decision making in straightforward and more complex situations

Mapping of CBT-specific content

The mapping exercise clearly indicates some areas of overlap but also many distinctive differences in the range of competences of High Intensity therapists and Clinical Psychologists. A subsidiary question is the degree of comparability in the area in which they clearly overlap; knowledge and application of CBT.

The BPS standards indicate that teaching and clinical experience should be benchmarked to the Roth and Pilling (2008) competence framework. This creates a direct parallel between clinical psychology and HI trainings, since both are benchmarked to the same framework, and so both should be operating to the same criterion. A small (but increasing) number of clinical psychology programmes have elected to gain Level 2 accreditation with the BABCP. This is an additional rather than a central form of regulation as all clinical psychology programmes are subject to common specified scrutiny processes determined by the HCPC and the professional body to ensure alignment in key educational outcomes across the discipline, including CBT.

Although these accreditation criteria do ensure some uniformity in delivery of CBT teaching, there is no *national* curriculum specifying the content of CBT on clinical psychology programmes, and the strategy adopted here is to take the content of CBT teaching on the UCL Clinical Psychology Doctoral programme as representative of UK training. This is an assumption, and caution is appropriate because the UCL Doctorate is accredited as a Level 2 BABCP programme, meaning that (as for IAPT HI CBT training) graduates are eligible for accreditation with BABCP as CBT therapists. Although other programmes are exploring BABCP accreditation, it is the case that there is some variation in specific CBT content across the 32 UK programmes. The ‘representativeness’ of the UCL curriculum has been ascertained by asking four Course Directors to contrast their own curricula with that of UCL. Their comments indicate a mixed picture: while some programmes offer equivalent CBT input, this may be less so for others, and so (in relation to CBT) the content and coverage of the UCL programme probably represents one end of a spectrum.

The mapping template is based on a synoptic version of the Roth and Pilling framework (prepared by BABCP and used for course accreditation), and the table indicates whether each content area is present in the curricula.

GENERIC THERAPEUTIC COMPETENCIES

	HI Curriculum	UCL curriculum
Knowledge and understanding of mental health problems	x	x
Knowledge of, and ability to operate within, professional and ethical guidelines	x	x
Knowledge of a model of therapy, and the ability to understand and employ the model in practice	x	x
Ability to engage the client	x	x
Ability to foster and maintain a good therapeutic alliance, and to grasp the client's perspective and 'world view'	x	x
Ability to deal with emotional content of session	x	x
Ability to manage endings	x	x
Ability to undertake generic assessment (relevant history and identifying suitability for intervention)	x	x
Ability to make use of supervision	x	x

BASIC CBT COMPETENCIES

	Hi Curriculum	UCL curriculum
Knowledge of basic principles of CBT and rationale for treatment	x	x
Knowledge of common cognitive biases relevant to CBT	x	x
Knowledge of the role of safety-seeking behaviours	x	x
Ability to explain and demonstrate rationale for CBT to client	x	x
Ability to agree goals for the intervention	x	x
Ability to structure session	x	x
Ability to use measures and self-monitoring to guide therapy and to monitor outcome	x	x
Ability to devise maintenance cycles and use this to set targets	x	x
Problem-solving	x	x
Ability to end therapy in a planned manner, and to plan for long-term maintenance of gains after treatment	x	x

SPECIFIC BT AND CT COMPETENCIES

	Hi Curriculum	UCL curriculum
Exposure techniques	x	x
Applied relaxation and applied tension	x	x
Activity monitoring and scheduling	x	x
Guided discovery & Socratic questioning	x	x
Ability to develop formulation and use this to develop treatment plan / case conceptualisation	x	x
Ability to understand client's inner world and response to therapy	x	x

CONDITION-SPECIFIC INTERVENTIONS

	Hi Curriculum	UCL curriculum
Specific Phobias	x	x
Social Phobia	x	x
Panic Disorder	x	x
OCD	x	x
GAD	x	x
PTSD	x	x
Depression - Beck - Cognitive Therapy	x	x
Depression - Behavioural Activation (High Intensity)	x	x
Depression - Behavioural Activation (Low Intensity)	x	
Sleep	x	

This mapping indicates that coverage of CBT in both curricula is essentially equivalent: the only variation is that the DClinPsy at UCL does not include teaching on low-intensity behavioural activation or offer discrete sessions on managing sleep disorders.

CBT Teaching hours

Although the HI CBT national curriculum sets clear parameters for teaching, how this is delivered varies from programme to programme. This next contrast takes the programme at the Institute of Psychiatry, Psychology and Neuroscience as representative, and contrasts it to the number of teaching hours on the UCL Doctorate.

HI curriculum

This is usually taught in four modules over one calendar year:

Module 1	Fundamentals of CBT	10 weeks 30 credits
Module 2	CBT For Anxiety Disorders	11 weeks 30 credits
Module 3	CBT for Depression	10 weeks 30 credits
Module 4	Accreditation Portfolio	30 credits

Overall hours of training are approximately 450 hours of which 200 hours is provided in the form of direct teaching. Students attend for lectures, workshops and supervision two days a week, and many programmes offer additional skills workshops to facilitate skill development to a defined standard of competency. Training days will usually comprise a mix of didactic teaching and experiential work focused on CBT skills training.

UCL curriculum

	Hours
CBT and Behaviour Therapy module (Adult)	119.5
CBT teaching in client-specific modules: Learning Disability Child and Adolescent Health Forensic Older Adult	28.5
CBT teaching in cross-modality workshops	8.25
'Generic' underpinning content within the Professional Issues module	16.75
'Generic' underpinning content with the Assessment and formulation module	30.25
'Generic' underpinning content within the Practice Based Evidence module	5.3
Clinical seminars with CBT-specific content	13.5
Total	213.5

Because the UCL programme is not modular, computing CBT teaching hours involves extracting this teaching from the timetable and expressing this input in hours rather than in terms of modules or credits. Nonetheless, it is clear that the number of direct teaching hours is equivalent to that offered by HI programmes, though the latter do include additional CBT-specific elements that do not feature in the Doctoral curriculum – notably in- house supervision and monitoring of CBT competence (both of these being areas that primarily reside with placement supervisors on the clinical psychology programme).

CBT experience gained during training and methods for evidencing competence

HI therapists

Number of clients and therapy hours
By the completion of the programme students will have delivered at least 200 hours of CBT assessment and treatment.

Assessment
Although there may be some minor variation across programmes, assessment is based on tutor and student self-rating of session recordings using the Cognitive Therapy Scale-Revised (CTS-R). Usually these will include two CBT assessments and at least four therapy sessions, illustrating work with clients with depression and anxiety presentations. Further assessment is undertaken through on-site reviews by placement supervisors, and a portfolio submitted by students (usually comprising reports of eight completed cases and an essay). There will usually be additional academic assignments throughout the programme (for example, reflective review of CBT literature and its application to practice with individual clients, or reflective analysis of a treatment session).

Supervision
Students receive weekly supervision both on the course and from their on-site supervisor, in both cases from a CBT therapist who is BABCP accredited or eligible for accreditation. In at least eight clinical cases supervisors will have listened to, and given feedback on, session recordings, or on sessions that they have sat-in on.

Clinical Psychologists Number of clients and therapy hours
Trainees will undertake an unspecified number of CBT interventions with a range of client groups, covering the age-span from children through to adults and older adults.

Programmes accredited with the BABCP will specify a minimum number of hours and cases, and this will be as for HI therapy programmes.

Assessment
There will be some variability between programmes, dependent on local programme requirements and local supervisory practice on placements. Nonetheless, all programmes will require trainees to submit clinical case reports (usually a minimum of 4-6), at least some of which will focus on the application of CBT.

Programmes will vary on the extent to which they mandate the summative/formative assessment of clinical recordings, but structured observation is required, using either the CTS-R or an equivalent scale. Programmes increasing specify that a minimum number of observations should be undertaken in each clinical placement.

Supervision
Programmes require a minimum of 1 to 1½ hours a week supervision, almost invariably from a clinical psychologist. Assuming 45 weeks of placement experience per annum trainees would have a *minimum* of between 135 and 202 supervision hours over the three years of training. Given the variation in models across training, not all this supervision will be of CBT practice.

Comparing the level of CBT experience in clinical psychology and HI programmes is complicated by the fact that clinical psychology trainees are required to demonstrate competence not only in CBT, but also in other intervention methods. The extent of CBT-specific experience is identified locally rather than nationally, and there is almost certainly variation in the amount of CBT experience that different programme expect and achieve. However, most (as mandated by the BPS) will make use of the Roth and Pilling (2007) framework in order to benchmark content. There is more certainty for those clinical psychology programmes that have (or are seeking) BABCP accreditation; trainees on these programmes will be required to demonstrate the same level of CBT experience that applies for HI programmes.

Drawing conclusions from the mapping
Mapping indicates areas of overlap but also identifies distinctive differences in the expectations of, and outputs from, training.

i) HI programmes focus specifically on knowledge of CBT and this unitary focus is reflected in the structure and extent of teaching. HI practitioners are trained for a

specialist role that equips them to intervene effectively and competently with adults presenting with depression and anxiety disorders, using well-defined and well-developed CBT skills.

ii) Clinical Psychologists are also trained to implement CBT interventions to a high standard of competence, but programmes include other evidence based therapeutic modalities and prepare practitioners for versatile working in work in a wide range of clinical contexts. A particular feature of clinical psychology training is that it encompasses an understanding of fundamental psychological processes that can inform assessment, diagnosis and formulation and underpins the selection of intervention, which may include transdiagnostic approaches. They gain experience with clients across the age range (from infants and children to adults of working age and older adults), working in primary, secondary and tertiary settings, with presentations encompassing the complete spectrum of mental health difficulties as well as helping individuals with learning disabilities, neurodevelopmental disorders and psychological difficulties arising in the context of physical health and trauma. They commonly work with co-morbidity and multiple morbidity, applying psychological knowledge to assess, formulate and intervene in contexts where innovative practice is required.

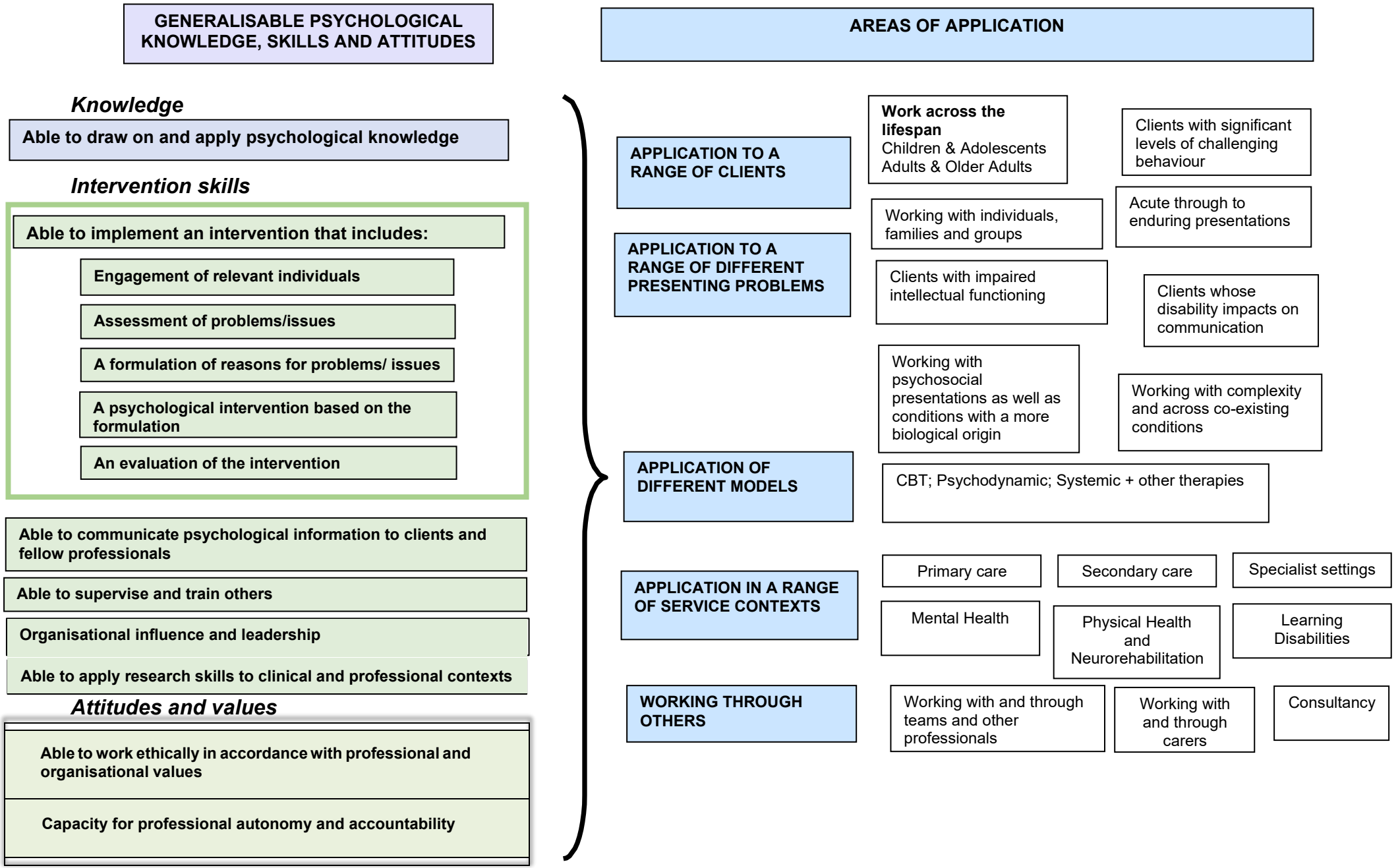
iii) Clinical Psychologists have extensive training in research skills, making a significant contribution to treatment development, and indeed to the evidence-based approaches which underpin the IAPT curricula.

iv) The training of Clinical Psychologists makes it possible for them to deliver interventions based on organisational and system change, drawing on their psychological expertise to analyse existing provision and to formulate and implement changes to the ways in which services are delivered.

v) Supervision, consultation and leadership are increasingly emphasised within clinical psychology training, such that these are roles that can be undertaken soon after qualification.

To summarise, HI and Clinical Psychology programmes overlap in that CBT is taught and practised to a good standard in both, but there is a critical difference in 'bandwidth'; clinical psychology training has a much broader remit, and (in a sense) equips practitioners to be
'psychological problem solvers' with a wider reach and clinical application.

Figure 1 Outline of Clinical Psychology training



Part 3: Interviews with Course Directors and Service Managers[1] Summary of method and findings

Background

The comparison of curricula described in Part 2 of this report describes the skills and knowledge with which High Intensity CBT therapists and clinical psychologists should be equipped, but this may or may not reflect the ways in which these competences are deployed on the ground. For this reason, interviews were conducted with course directors of High Intensity CBT programmes and clinical psychology doctorate, and also with service managers who employ these groups of workers.

Method

Nine Course Directors and eight service leads were interviewed using a semi-structured interview.

Findings

Viewed through the narrow lens of CBT therapy, HI therapists and clinical psychologists could be seen as carrying-out similar roles, but it is clear that this would be misleading; our informants were clear that their approach and their range of application differs in significant ways. They were also clear that this difference does not lead to one group being privileged or preferred over the other; their training prepares them to take on different roles within NHS services. Drawing on their differences allows services to provide comprehensive care and ensure that clients receive appropriate services matched to their needs.

Part 2 of this report focused on training curricula in order to scope the competences of work of HI therapists and Clinical Psychologists, but this has its limitations, in that this may or may not reflect their deployment in clinical services once qualified. To gain a more concrete sense of commonalities and differences in their capacities it

[1] We would like to thank all the course directors and service leads who participated in this project and provided their valued views

makes sense to ask how their roles are executed in practice and how services deploy them. This information was gleaned through interviews with Course Directors who are involved in the training of both HI therapists and Clinical Psychologists, and with service leads who employ and manage both clinical psychologists and HI therapists.

It is worth signalling the risk of interviewing individuals who would see this discussion as an opportunity to advocate for one or the other role. For this reason, we attempted to identify course directors and managers who were likely to be in a position of equipoise, on the basis that they are responsible for managing a 'mixed economy' which includes experience of both sets of practitioners. Given issues of timescale and resources we were unable to carry out a systematic search for such individuals. Rather, we undertook what might be denoted as purposive sampling, identifying a small number of senior managers in services across a range of geographical patches in England, enabling us to explore a range of settings and differing service models.

Method

A semi-structured interview was developed to guide discussion. There were two interview formats, one for trainers (Table 1) and one for service managers (Table 2).

Table 1 – Interview structure for trainers

I would like you to think about the curricula for clinical psychology training and for HI therapy training. With these in mind, please consider the competences and roles for which clinical psychologists are trained and for which HI Therapists are trained. ***With this in mind, in your view:*** ● What is each profession trained to do? ● What is the scope of their work? ● What are the most important skills and competences that they possess? ● What do they have in common? ● What are the differences between them? ● If you were to imagine a clinical psychologist and an HI therapist five years after their training is completed, how do you think each of them would be

Table 2 – Interview structure for service heads

I would like you to think about the competences of clinical psychologists and HI therapists in your service, and the ways in which they are deployed – their roles and contribution to your service.

With this in mind, in your view:

- What is each profession trained to do? (What is your perception of the competences and roles of CPs and His)
- What is the scope of their work?
- What are the most important skills and competences that they possess?
- What do they have in common?
- What are the differences between them?
- How are they deployed in the service?
- Do they carry the same case mix? Any differences?
- Are there any differences in the complexity of cases they see?
- Are there cases that you would think it inappropriate for them to take on?
- Are there any differences in:
    - case mix
    - balance of face to face working and indirect
- Do they have different roles in the team, especially in relation to training and supervision?
- Do they have different contributions to service development or leadership within the service?

Participants

Constraints of time and resource mean that only a fairly small sample of participants could be interviewed, and we were aware that small samples may not represent the views of the wider population of course leaders and services managers. We attempted to address this by sampling from as many geographical locations as possible (so as to consider different service configurations and variations in local practice). However, sampling was not in any sense random; our aim was to identify a diverse group of senior practitioners with direct experience of the issues under discussion. As such selection of participants was guided by our knowledge of national provision.

Nine Course Directors and eight service leads were interviewed, either face-to-face (for those based in London) and by phone or Skype for those based elsewhere. Interviews took place between June and August 2017 (Table 3). Most interviews were with one individual, but in some locations joint interviews were conducted with a lead for clinical psychology and a lead for HI therapy.

Table 3 – interview participants

Interview format	Informant	Role
Individual - phone	Richard Bennett	Course Lead for Postgraduate Diploma in Hi- intensity Psychological Therapies and Deputy Course Director for Centre for Rational Emotive Behaviour Therapy - University of Birmingham
Individual - face to face	Sheena Liness	Course director CBT Adult IAPT Programmes Institute of Psychiatry, Psychology and Neuroscience/King's College London
Individual - phone	Theresa Powell	Programme Director, Doctorate in Clinical Psychology, University of Birmingham
Joint - phone	Richard Brown	Programme Director, Doctorate in Clinical Psychology, University of Manchester
	Mary Shinner	Programme Lead for Postgraduate Diploma in CBT - University of Manchester
Joint - phone	Margie Callanan	Programme Director, Doctorate in Clinical Psychology, Salomons Canterbury Christ Church University
	Daniel Salter	Director of CBT Programmes - Canterbury Christ Church University
Joint - Skype	Lusia Stopa	Programme Director, Doctorate in Clinical Psychology, University of Southampton
	Sharon Pettit	Programme Director, PG Diploma in CBT for Anxiety and Depression (IAPT) - University of Southampton

Interview format	Informant	Role
Individual - phone	Tim Cate	Associate Director of Psychology and AHPs - Tees, Esk and Wear Valleys NHS Foundation Trust
Individual - phone	Meherzin Das	Trust Professional Lead for Psychology and Psychological Therapies - Dorset Healthcare University NHS Foundation Trust
Individual - email	Ann Gledhill	Professional Lead for Psychology - Somerset Partnership NHS Foundation Trust
Individual - phone	Annette Haddrell	Professional Lead for Psychology - Somerset Partnership NHS Foundation Trust
Individual - phone	Jeff Halperin	Head of Psychology and Psychotherapy Services - Camden and Islington NHS Foundation Trust
Individual - face to face	Judy Leibowitz	Clinical Lead IAPT - Camden and Islington NHS Foundation Trust
Individual - phone	Andrew Nicholls	Interim HPFT Head of Recovery and Psychological Services - Hertfordshire Partnership University Foundation Trust
Individual - phone	John Pimm	Clinical Lead for Psychological Therapies Pathway - Buckinghamshire, Oxford Health NHS Foundation Trust

Discussions were recorded and transcribed for the purposes of analysis, which took the form of a thematic analysis of the recordings – essentially:

a) an initial examination of the transcripts to identify major themes within each interview

b) having extracted these themes, a further analysis to identify those that were common across interviewees (and therefore reflect a consensus view).

Results[2]

Primary competences

Participants were clear that there was an important distinction between the roles of HI therapists and Clinical Psychologists, with the former being seen as well-trained specialist workers with specific expertise in delivering CBT, primarily (but increasingly not exclusively) to adults presenting with anxiety disorders or depression.

> I am expecting my CBT therapists to […] reliably be able to assess, to formulate, to deliver evidenced based protocols that are adapted to the individual formulation; so, they are formulation driven interventions but in line with evidence. […] And I'm also expecting them to also be able to collect data, to be able to look at their own data
> […] and to be able to use supervision effectively

> …if someone is coming with a relatively circumscribed - for want of a better word, simple - problem, then I would have thought they are much more appropriately seen by a HI therapist [who] will probably deliver strongly adherent highly competent CBT for that person

> [...] what they are required to do, and their main focus is on providing high quality psychological therapy mainly on an individual basis [...] so their role is very much as therapists

> [...] The high intensity CBT therapists [...] have a bespoke set of skills; they are trained to handle people who have mild to moderate amounts of anxiety and depression and [...] so they have received] specific training for [...this] specific purpose

Clinical Psychologists were identified as having a much broader range of skills that usually encompassed CBT but included a broader range of therapeutic models applied to a broader set of clients and presentations, and including areas of knowledge and skill that were not represented in HI therapists, such as a capacity to undertake research, to operate 'indirectly' through other professionals or carers, and to input at a more organisational level.

> … clinical psychologists are not just therapists, they have other skills, training, attributes, in terms of things like understanding research, service evaluation, audit, leadership and they are trained across the lifespan and they are trained in different models, and so they've got a lot of transferrable skills [and are able] to work in a lot of different ways in a lot of different settings.

[2] The quotes in this section have been edited to make them more legible (removing redundant speech and correcting the usual grammatical errors found in spoken language)

> [...clinical] psychologists have a more generic skill base, with generic skills in assessment, formulation and providing different kinds of therapeutic interventions, using psychometric measures, using research, doing audits, working with service providers, service delivery, [...] work[ing] with commissioners, work[ing] with whole services and systems

Level of knowledge of CBT

All participants noted that they had greater certainty about the level of CBT knowledge among HI therapists than is the case for clinical psychologists. This reflects the fact that the former train in line with a national curriculum which explicitly sets out the CBT-related knowledge and competences they should have acquired; in contrast clinical psychology programmes vary in their focus on CBT and the amount of time devoted to this approach. As such there was a sense that while many clinical psychologists had a sophisticated knowledge of (and competence in) CBT, for some – perhaps older members of the profession – there was evidence of some variability.

> [Clinical psychologists] are trained in CBT, but [...] we have a proviso that [they learn about] at least one other model, as well as multiple theoretical approaches, trans- diagnostic formulation as well - so not just delivering stand-alone therapies but also being able to integrate ideas and produce coherent therapies for people for whom evidenced-based unimodal models aren't working. But I think probably it's fair to say, that the level and depth of knowledge in CBT is probably greater in the high intensity therapists - there is probably more time spent teaching CBT skills for particular disorders on that programme. So that is a real strength for that training.

Several informants noted that the BPS changed its Accreditation Criteria in 2010, mandating that all clinical psychology training programmes offer CBT training at an appropriate standard of proficiency by benchmarking training to a recognised CBT competence framework (usually that developed by Roth and Pilling (2008) which itself is the benchmark for the national HI CBT curriculum). They also noted that two clinical psychology training programmes (at Bath and at UCL) are now accredited by the British Association of Behavioural and Cognitive Therapists (BABCP), that other programmes are likely to follow, and that this development 'kitemarks' the standard of CBT training at a level equivalent to HI therapists. Participants expected that these developments would (and already are) leading to more consistency in the competences demonstrated by clinical psychologists.

> [There is a deficit] in clinical psychology that we need to address, which is being caught up on clinical courses at the moment, but people trained prior to that have got a deficit around CBT skills.

> […] clinical psychology courses need to take seriously the value of having their clinical psychology trainee very thoroughly CBT trained and own the fact that they are, because there is a little bit of kind of, "we are too good for that",

> you know that that goes on, that sort of like, “we don't really need to learn how to do that therapy properly because we are kind of more individualistic and we can design our own things”.

Contrasting the ways in which HI therapists and clinical psychologists applied CBT, some service managers observed that while the former were narrower in their approach, they also tended to be very adherent – or faithful - to particular CBT models for specific presentations. In contrast there was a sense that, at least some clinical psychologists, had a weaker grasp of CBT models and a tendency to over-value taking an idiosyncratic approach – an unhelpful combination.

> …you are getting a very, very highly articulate, intelligent, interpersonally strong person who is then employed in a role where they can use a range of different ideas, model and approaches. However, the weakness with that is that if [they] haven’t got the basics, they are then very vulnerable to straying from the evidence base, in my experience, and also, they assume that they have a level of competence, which they don’t have in specific [therapies].

Dealing with complexity

Notwithstanding some of the concerns regarding clinical psychologists moving away from delivery of ‘standardised’ CBT models, there was also a clear sense that when appropriately deployed, the broader experience and training of clinical psychologists equipped them to recognise as well as to manage clinical complexities.

> […] I’m [thinking about] things like interpersonal dynamics and situations that might arise when delivering something like CBT in a high intensity setting and recognis[ing] when it doesn’t quite fit the model and what we are doing isn’t quite right. I mean, many of the time I’ve seen [an] HI therapist work and be completely oblivious to unhelpful patterns of relating that the clinical psychologist would be able to spot because of their awareness.

> […] It’s in the cases where the person has had [protocolised CBT] and not responded or where their problems are much complex and trans-diagnostic, that’s where the clinical psychologist are strongest because they can pull together ideas that fit outside that model.

Identifying appropriate treatment pathways

Although both HI therapists and clinical psychologists have a clear role in identifying appropriate treatment pathways for clients, there was a consensus that clinical psychologists were more suited to undertaking assessments, formulating the client’s difficulties and making judgments about appropriate pathways of care. This became more pertinent where complexity was evident, and where work involved client groups beyond the usual remit of an IAPT service.

> [...] clinical psychologists have a much broader role [...] in my service we have [...band] 8b psychologists coordinating all of the clinical work coming into the service from other teams, so they are responsible for making [clinical] judgements around appropriateness, [...] and providing clinical leadership within that, […] juggling where [...] a referral might best go. So again, that breadth of knowledge of psychological models and psychological interventions is a real strength there.

> [...] clinical psychologists [...] will have had experience of working with people with more severe problems, with some specialist services, [...] older adults, learning disabilities, children. [...] and that is [...] quite a useful added thing because one of the issues in all of the IAPT services in my view, is [...] the clinical decision making around the edges - who is suitable for IAPT, [...and] who is not, who needs to go somewhere else and [...] that's I think a big thing, a big difference [...between clinical psychologists and HI therapists].

> [...] clinical psychologists also provide assessments in a way that CBT therapists don't. So, if it is unclear what might be the best direction [for a client] or even if someone might [...] or might not be a candidate for therapy at a particular time, [those clients are...] likely to go in the clinical psychology direction at any banding rather than the particular therapist.

Case-mix

While there was a clear consensus that HI therapists were skilled at delivering CBT, there was also a sense that their area of competence focused on working with a fairly specific range of clients and presentations, following a protocolised intervention. Although there was also a recognition that subsequent training could expand their repertoire of skills, service managers indicated that clinical psychologists had a training that allowed them to work with a much broader range of clients and presentations, with a capacity to consider complexity of presentation and needs.

> […] it's important to identify what [HI therapists] can and can't do and[...] are not skilled and experienced in doing […] essentially it is more symptom focused work, it's more circumscribed […] There are times where they [… are] being asking to deal with more complex cases, [… but] that is a bit misleading that because sometimes they do very, very well with specific complexities […], but where the presenting problem has multiple causes which need to be taken into account, such as systemic difficulties, working with more personality issues, the HI staff are much less well-resourced to do that than clinical psychologists.

Face-to-face vs 'indirect' working

Participants consistently noted clear differences between clinical psychologists

and HI therapists in the proportion of their time spent in face-to-face and 'indirect' work (usually supporting others to deliver care). Specifically, HI therapists were seen as being trained and employed to deliver face-to-face therapy work with clients, with little time dedicated to indirect working. In contrast clinical psychologists were expected to spend less time doing face-to-face work, instead providing 'indirect' interventions or support through supervision, training and consultation:

> [...] I would be expecting [an] HI worker to be doing mostly face-to-face work, and I would expect clinical psychologists [...] have a bit more by way of indirect supervision, consultation work [...], working with other professional groups, [...] definitely doing more teaching and training [compared to HI Therapists].

> High intensity workers will certainly have a high level of face-to-face contact [...] so indirect work for an IAPT high intensity worker is virtually non-existent. [...It is different for clinical psychologists], so they will be leading on formulation and meetings on complex cases, they will be leading pathways, [and so] they might not be doing as much face to face works an IAPT high intensity worker would be.

Entry level to the training and its implications

Several respondents noted that the entry levels for training as an HI therapist and clinical psychologist were very different. The distinction they drew attention to was only partly the difference between a Diploma and a Doctoral level; entry to clinical psychology training is extremely competitive and sets a high academic bar. The consequence of this 'sifting' is a sense that clinical psychologists are high achievers, with a direct (albeit generic) consequence for their capacities in the workplace.

> […] you need to remember that there is a base difference in the people: it is not just the training that is the quality issue. One person has done a doctoral level training and to get to a doctoral level training would have done a lot of things before that and will also be probably on average, your doctoral trainees will have been higher performers generally. Now they have to be to get through the doctoral process, it is much more competitive.

> [discussing the candidates that enter HI training programmes] We don't get the quality that I would like to see, [...] I know it is different in different parts of the country [...but] we don't get huge numbers of applicants that we can pick and choose who we can take; [...] The funding comes with the employer, [they] have a say in selection and we don't get to select who we want., [...and as such] we get much more variability in quality [of candidates] than in clinical [psychology training, where] we get some people who absolutely fly, who are

naturally therapeutic, who are good therapists, as a result of their personality but also their previous experience in mental health, and they take to this like a duck to water.

Audit/research

There was a clear and consistent view that the research skills of psychologists made them highly suited to developing, carrying out and interpreting service audits, and so directly contributing to service development. Although HI therapists were seen as having a role in audits, this was more by way of contributing or participating rather than design and implementation:

> If you don't have clinical psychologist in a service, that is a significant element that gets lost. If you think in particular in the importance of quality improvement
> initiatives […] in which there are very much sort of bottom-up changing practice in teams which are favoured by Trusts and there is quite a big role for clinical psychologist to play in terms of helping enable teams to develop quality improvement programmes which have a strong audit and research component and that is an important role for clinical psychology to play. […HI therapists] have not had training to do that and would not feel comfortable doing that.

> …psychologists are trained in audit and research and HI therapists are most definitely not.

Service development/quality improvement

Respondents noted that training in clinical psychology conferred a broad understanding of service issues across a wide range of clinical contexts, and that (in combination with research and analytic skills) this had clear application in relation to service development and quality improvement.

> […] doctoral level training does give [trainee clinical psychologists] an ability in relation to audit and research and a relevance across the whole range of clusters, which specific training in delivering a therapy does not. […] This generic analytical skill of analysis - this was put to me actually by one of our execs, saying to me
> 'psychologists are really good at analytical thinking, at writing well, at distilling arguments and [...] we should be doing more of that', and that is part of the role [improving] the delivery of health care rather than just being a therapist.

> […] they've been trained how to analyse a service problem and then take a systematic way to actually resolve that problem. So, service development, service innovation, they have had training in, so they very quickly become people in a service who you can use to lead and facilitate and to sort of

develop new areas. And IAPT is full of new areas to develop all the times.

[...] we need to have systems that work better, that are more therapeutic in themselves, and the way that we deliver care needs to be more therapeutic and clinical psychologist can increasingly do that stuff [because of their] training in systemic approaches, it's an approach which is much more appreciative of if you like system dynamics and behaviour change and much less focused on a delivering the specifics of a therapy.

Certainly, things like service design, audit, management and service evaluation are the kinds of things clinical psychologists are being increasingly trained to do and expected to do in their first post after graduating. So, it wouldn't be unusual for someone to be asked to gather together a business case for a new service in their first post.

Enabling healthcare staff to support and work with complex cases

Supporting the work of healthcare staff in a range of clinical contexts was identified as an important 'indirect' mode of working for clinical psychologists, enabling staff to develop their skills in psychological thinking and applying these ideas in clinical practice.

Clinical psychologist's skills in team working and MDT working is really helpful: skills in terms of supervision of non-psychological professionals, working with both trained and untrained people, carers, with nurses and [having] the skills needed to help the of team formulate, how to get psychological thinking interfaced with say physical thinking, or social thinking, so creating a biopsychosocial model which you need in an MDT. Clinical psychologists are far more skilled at doing that, well they have had the practice of doing it.

So, you can see in particular, [...] in terms of the new psychology roles in primary care which are often around [...] practice-based mental health, which is providing a lot of support to primary care and GPs in managing quite complex cases. And what is really needed is a [...] pretty sophisticated assessment and understanding of the possibilit[ies] for a patient, and helping the GP manage what is often a difficult presentation and being aware of the many maintaining factors. And [...] I would be thinking that clinical psychologists are [...] able to decide that much, much better than an [HI] psychological therapist would, you would bring in more of the HI therapists to do specific bits of work with those patients, rather than supporting staff in managing them.

In relation to deploying limited psychological therapy resources, some participants reflected on the critical importance of embedding psychological thinking within clinical services as a whole. The aim is to build services that hold in mind

psychological issues across all their patients, not just those directly accessing psychological input, with a broader intent to manage their conditions more effectively. The breadth of training received by clinical psychologists was seen as equipping them to take on this level of system change.

> [...] we need to have systems that work better, that are more therapeutic in themselves; the way that we deliver care needs to be more therapeutic and clinical psychologists can increasingly do that [with their] training in [...] systemic approaches. It's an approach which is much more appreciative of, if you like, system dynamics and behaviour change, and much less focused on a delivering the specifics of a therapy.

Supervision

There was some agreement that there were differences in the expectations of when HI therapists and Clinical Psychologists would begin supervising, to whom they would offer supervision, and the type of supervision they offered. In terms of timing, HI therapists would not usually be expected to begin supervising until they had gained experience in role, whereas this was seen as something that could be expected immediately of clinical psychologists. Given the nature of their posts and training, HI therapists would be expected only to offer CBT supervision, whereas clinical psychologists could address both CBT and other approaches. Respondents also noted that HI therapists would usually supervise other HI therapists, whereas clinical psychologists could be expected to work with a broad range of healthcare professionals.

> CBT therapists do provide CBT supervision within the service, but the clinical psychologists offer supervision beyond that, beyond our service and into other teams, and can provide supervision to staff using a broader range of models.

Training

Training was mentioned by several respondents, and while this was a role that some HI therapists could undertake, it was seen as something for which clinical psychologists were equipped by virtue of the background knowledge acquired through training.

> [Thinking about] training other people, [clinical psychologists] can deliver training really well but also have the ability to [draw on] research design and put in new training so they [have the] academic ability to extract ideas and [the] ability to present them, they have had far more training in how to do that during the doctoral programmes. So, they can [deliver] training as [well as be] developers of training.

> I have had newly qualified clinical psychologist coming in, they can do some really exciting things, so I get them to lead more projects, they were doing

> things like working more with GPs, they were doing training events, I mean one of my new [band] 7 [clinical psychologist was] running training events for health professionals within a few months of her coming out [of clinical psychology training], but I would have never done that with a new CBT therapist, it wouldn't have felt safe for them as well.

Consultation, leadership and management

There was a clear sense that clinical psychologists could take a role in consultation, leadership and management at a fairly early stage in their careers, and that training increasingly set this expectation and gave trainees experience of this.

> […] our expectation and requirements of psychologists at a very early stage of their career is that they will help clinically lead the teams, and through the breadth of training they are capable of applying a sort of a range of models.

> […] it is all about daily management, so we have what we call 'huddles' and team psychologists will lead those alongside medical and nursing colleagues […] so a very different model of working compared to probably elsewhere - sophisticated formulation, complex case management are all part of the role. [Thinking about specialist services] we have people who are leads in PD services, leads for DBT, CAT training – [...] people can lead a very specialist [service] or remain broad generic working psychologists [but] be heavily involved in all aspects of organisational delivery from service design, to patient flow and management.

Service design and organisation

Participants noted that there were very few if any instances of HI Therapists being involved in service design or organisation given the specific remit of their roles as therapists delivering (mostly) face-to-face therapy within IAPT services. In contrast clinical psychologists were seen as more likely to take on these activities within their current roles, given their training and skill set:

> Certainly, things like service design, audit, management, you know, service evaluation, are the kinds of things increasingly clinical psychologists are being trained to do, and expected to do in their first post after graduating. So, it wouldn't be unusual for [a clinical psychologist] to be used to gather together a business case for a new service in their first post [post qualification].

> [...clinical psychologists are] heavily involved in all aspects of organisational delivery from service design, to patient flow and management [whereas HI therapists would often not be].

Career pathways and post-qualification development

Participants were asked how they saw HI therapists and clinical psychologists

developing in their role post-qualification, and specifically about where they saw these workers five years after they had completed training.

There was a clear sense that HI therapists would – and should- avail themselves of the various CPD trainings increasingly embedded into IAPT, and so extending their experience with clients other than adults (for example, to include working with older adults, or with people with co-existing physical health conditions). Further, there are also options for them to extend their range of therapeutic modality beyond CBT (for example, to include couples work for depression, or to undertake a brief training in Interpersonal Psychotherapy (IPT)). In terms of their workload and work-pattern, participants thought that some HI therapists would be supervising other HI therapists, and that a small proportion would have management responsibilities within IAPT. Overall, however, the sense was that – for the most part - their working pattern would remain characterised by direct working, offering face-to-face therapy, and so with rather limited diversification of role.

The evolution of work-patterns for clinical psychologists reflected the fact that they have a specific and different starting point from HI therapists, in that from the outset direct face-to- face work with clients is only part of their remit, so that while areas such as supervision, consultation, service development, audit and research form a small part of their remit on qualification, these are areas that would be expected to become increasingly prominent as they gain experience in post.

> Clinical psychologists five years on should be in a role where they are doing a lot of, crucially, consultation, training, supervision, support[ing] service design, service development, audit, research, looking at change management in systems. [...] HI therapists would mostly remain within their specific therapeutic domain; that might broaden a bit and they may have some more senior roles (for example in an IAPT service) but it is unlikely that they are going to progress easily outside of that [...] There may be rare exceptions to that [...but on the whole] they are much less likely to have a system-wide role or senior managerial role.
>
> [...an] HI [therapist] may have become (though it's not a formal position in IAPT services), [...] a sort of senior HI worker, a kind of informal title. [...] They [may] be looking after another group of other high intensity workers, maybe some PWPs, maybe do[ing] a bit more supervision, less face-to-face work but [face to face therapy work] would still be the main part of the job. If you looked at them day to day, you wouldn't see much change in five years [to their day to day working pattern]. Whereas the clinical psychologist after five years,[...] would be leading a team, [...] be seen as the leader, be a very experienced clinician. [...They may be] applying for consultant grades after five years [...] and so become very much a senior clinician at that point moving forward, with the opportunity to go onto senior

> professional roles. There is a career framework [for clinical psychologists], there is no career framework for high intensity workers.

Value and importance of both roles

All participants agreed that both Hi therapist and clinical psychologists were highly valued and needed within the NHS. Many reported that services would struggle to deliver comprehensive care to the public if either group were lacking from psychological therapy services. Nonetheless they were clear that each offered something different to services, with their trainings reflecting this; as such both roles were required.

> [in discussing the different skill sets and competencies that HI therapist and clinical psychologists have] ... so in a service you definitely, you need both, yeah you need both.

> [...] I would say I respect and value both roles very highly, in terms of the Trust we have fantastic IAPT therapists and fantastic psychologists [...] the roles are different but what people are doing within their roles is of a very high standard.

> Interviewer: [*clarifying and summarising the respondent's comments*] So it's important for services to have a good mix of both [clinical psychologists and CBT therapists], [...] - they [both] bring things to the service, that there are some similarities but there are differences between them and we need both of them?
> Respondent: Yes absolutely, we definitely need both roles.

Discussion

Our interviews included both trainers and employers of clinical psychologists and HI therapists and yielded a clear and consensual view: although there are some similarities between the two groups, there are also distinctive differences.

Beyond the obvious fact that their training is of different duration, the training for these workers have different aims and this is reflected in the roles taken up within NHS services. In outline, HI therapists are trained as specialists, expert in delivering face-to-face CBT to an adult population presenting with depression and anxiety in (broadly speaking) primary care settings. In contrast clinical psychologists have a training that encompasses CBT with adults but extends beyond this to include a much broader grounding in psychological approaches and interventions.

HI therapist were seen as working almost solely face-to-face, delivering psychological therapy through direct client contact. For clinical psychologists, therapy was seen as only part of their work, especially as they became more senior, with the proportion of

direct work decreasing as they took on more 'indirect' roles, supporting other staff (through training, supervision and consultation) and contributing to service delivery and design. This shift of role with greater experience was not seen as characteristic of HI therapists; for the most part the main focus of their role continued to be face to face therapy.

A further point of difference is that clinical psychologists were seen as working not only within primary care, but also across a range of other services and settings (including secondary care mental health services and physical health settings). In relation to client groups their range extends beyond adults to include older adults and children and adolescents, as well as people who present with acquired or developmental cognitive difficulties.

Considering the overlap in clinical skills and clinical activities, both groups were seen as having:

- Knowledge and skills in CBT assessment and formulation (with working age adults)
- Knowledge and skills in delivery of CBT informed psychological interventions (for working age adults)
- Knowledge and skills in delivery of CBT supervision (of CBT therapists)

Participants were clear that the core characteristic of HI therapists is their specialist knowledge and skill in delivering model-adherent CBT interventions, giving them a critical role in IAPT and contributing to the treatment of large numbers of clients. On the other hand, clinical psychologists were seen as adept at incorporating a number of psychological models and theories into their work, having a repertoire that included, but also extended beyond, CBT. As such they were seen as working with more complex cases than HI therapists, especially where standard CBT protocols may not be suitable or appropriate for the client.
For example, although HI therapists may deliver complex CBT interventions (e.g. for OCD), there would be cases for which the broader training and skills of a clinical psychologists would be more appropriate (e.g. clients with multiple co-morbidities and co-presenting problems). Linked to this point, it was noted that clinical psychologists often work in settings where HI therapists would not; indeed some participants commented that their IAPT services only rarely employ clinical psychologists at all, as their skills were more suited to other settings such as secondary care adult mental health or physical health settings.

The curriculum for clinical psychology training goes beyond teaching of therapy skills, and this was reflected in comments about some significant differences in the two groups, which included:

- Designing and leading on research, audit and service evaluation
- Integrating psychological knowledge and skills across all services and so

influencing wider service delivery and organisation
- Service design and organisation
- Clinical and / or service leadership
- Consultation
- Innovating new approaches to treatment
- Designing and delivering training to a wide range of professionals and audiences
- Clinical supervision of a wide range of health professionals and teams, including psychological therapists working in therapeutic modalities other than CBT

Participants noted that these skills meant that clinical psychologists were well placed to contribute to operational and corporate aspects of health services, and able to lead and advise on service provision and delivery. They also noted that clinical psychologists were well placed to develop the psychological skills of the wider healthcare workforce, helping to create more responsive systems and services in the context of limited direct psychological therapy resources within the NHS.

Conclusions

Viewed through the narrow lens of CBT therapy, HI therapists and clinical psychologists could be seen as carrying-out very similar roles, but it is clear that this would be misleading; our informants were clear that their approach and their range of application differs in significant ways. They were also clear that this difference does not lead to one group being privileged or preferred over the other; their training prepares them to take on different roles within NHS services. Drawing on their differences allows services to provide comprehensive care and ensure that clients receive appropriate services matched to their needs.

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