Counsellors in the National Health Service: A mixedmethod study of efficacy and satisfaction from the counsellor perspective

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Counsellors in the National Health Service: A mixed-method study of efficacy and satisfaction from the counsellor perspective

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Abstract

Background: It is difficult to know how many counsellors work in the UK's National Health Service (NHS). At a time when the British Government is pledging an expansion of the mental health workforce, it is important to understand both the opportunities and barriers for counsellors to work in the NHS.

Aim: To understand counsellors' job roles, pay, perceptions of services, workplace stress and reasons for leaving the NHS.

Method: An online survey was advertised to members of the British Association for Counselling and Psychotherapy (BACP); just under 2,000 counsellors responded. The sample was majority female, white and had completed training. Mixed methods were utilised to analyse the data which incorporated use of thematic analysis.

Findings: The data suggest that, as a workforce, counsellors are prone to being "squeezed" out of the NHS workforce; that they are comparatively "underpaid," are "pressurised" by high level of work demand and are consequently experiencing concerning levels of workplace stress; and that they perceive themselves to be, in multiple ways, "undervalued." Despite this, members reported high adequacy of therapist qualifications and supervision quality within NHS services.

Conclusions: Counsellors have expressed a desire to undertake more work in the NHS and are a potentially cost-effective mental health workforce in comparison with other types of professionals. However, this study has evidenced significant structural, cultural and pay and promotion-related barriers that are pushing counsellors out of the NHS. Of particular concern is what appears to be a broad undervaluing of counsellors as a professional group.

KEYWORDS

burnout, counselling, job role, NHS, pay, stress

1 | INTRODUCTION

1.1 | Counselling workforce

In the United Kingdom (UK), counsellors and psychotherapists are employed to work in the National Health Service (NHS)—a term which incorporates all statutory funded healthcare services across the UK—to treat mental health conditions, including mild to moderate depression as recommended by the National Institute for Care Excellence (NICE, 2009).

Employment of therapy practitioners who offer "counselling" in the NHS has been shaped by both NICE recommendations and the way that these have been interpreted in primary care services. For example, within the Improving Access to Psychological Therapies (IAPT) service, which provides the framework for much of the NHS mental health treatment in primary care in England and Wales, counselling is offered to clients as a high-intensity (step 3) intervention if initial low-intensity (step 2) treatments (such as self-help based on CBT or computerised CBT) do not improve symptoms. However, in IAPT, other high-intensity treatments, particularly cognitive behavioural therapy (CBT), are recommended as the frontline therapeutic treatment for both depression and anxiety over counselling, as per NICE recommendations (The National Collaborating Centre for Mental Health, 2018; see also Pybis, Saxon, Hill, & Barkham, 2017).

In some countries, for example the United States of America, counselling is a regulated profession whereby in certain states, a license is required to legally offer services (American Counseling Association, 2019). Conversely, in countries, such as Australia and the UK, no such regulation exists (Pelling & Sullivan, 2006). In the UK, the titles "counsellor" and "psychotherapist" are not registered nor statutorily regulated, which has resulted in a lack of clarity (including between different professional bodies) about what the terms mean for training and professional competencies. The British Association for Counselling and Psychotherapy (BACP) is one of the largest therapy professional bodies in the UK with over 47,000 members, which incorporates both counsellors and psychotherapists, and is currently working with other professional bodies to agree on scope of practice (see: BACP, 2018). For the purposes of this study, the term "therapist" will now be used to refer to both counsellors and psychotherapists unless otherwise specified.

It is not easy to determine the number of therapists working in the NHS. According to the most recent NHS workforce statistics (NHS Digital, 2018), in March 2018, there were 4,697 NHS employees in the category known as "psychotherapy." This category includes psychotherapists but also anyone else who falls under the category "psychological therapist," such as BACP counsellors. A separate source of data is the 2015 Adult IAPT Workforce Census Report (NHS England & Health Education England, 2016), which showed that almost two-thirds of the stepped-care IAPT workforce comprised of high intensity (step 3) therapists, with the remainder being employed as low-intensity (step 2) therapists. In 2015, counsellors made up 17% (including both Counselling for Depression (6%) and "non-IAPT-qualified" counsellors, 11%) of the high and 6% of the low-intensity IAPT workforce (total "whole time equivalent" workforce 6,987). However, these figures are now out of date, so it is unclear how many therapists are currently employed in IAPT.

The data suggest that the total number of "psychological therapists" in the NHS has more than quadrupled since 2009 (NHS Digital, 2018). However, whilst the statistics show a positive increase in the number of appointed therapeutic posts, it is unclear whether there has been an increase or decrease in the number of counselling posts during the same period. Given the lack of data, it is important to seek information on the employment profile of therapists who work, or recently worked, in the NHS.

1.2 | Workforce stress and burnout

Mental healthcare staff have been shown to experience poorer wellbeing and increased burnout compared with other healthcare staff (Johnson et al., 2017). The New Savoy Partnership's annual UK mental health staff wellbeing survey (Rao et al., 2016) found an 8% increase in workforce depression since 2014, with nearly half of all surveyed mental health workers reporting experiences of depression within the last week. The survey also showed that psychological therapists appeared in the bottom 61%–80% of the population for wellbeing, attributed to service cuts, increased stress and burnout, issues with staff feeling undervalued and compromised staff support in an overstretched service.

"Burnout," a term associated with mental and physical exhaustion because of one's work (Freudenberger, 1974), appears to be a serious and growing risk within NHS mental health services, with Westwood, Morison, Allt, and Holmes (2017) estimating that half of high intensity therapists working in IAPT settings experience burnout. A systematic review of 62 burnout studies (O'Connor, Neff, & Pitman, 2018) indicated that the average mental health worker experienced high levels of emotional exhaustion and moderate levels of depersonalisation, which were attributed to work-related factors including heavy workloads and negative work relationships. Conversely, fair treatment from colleagues and a sense of professional autonomy have been identified as protective factors against burnout for IAPT psychological therapists (Westwood et al., 2017).

1.3 | Widespread impact of workplace stress

The impact of stress in mental health staff, such as therapists, affects more than just the individuals (and their families). Therapist stress and burnout is found to be significantly associated with poorer client outcomes (Delgadillo, Saxon, & Barkham, 2018; Eliacin et al., 2018). Furthermore, it is estimated that stress-related sickness absence costs the NHS £2.4 billion a year alongside increased staff turnover (Quality Watch, 2017). Of all the NHS workforces, "mental health and learning disability" staff display the second highest levels of NHS workforce sickness only behind ambulance staff, further indicating poorer wellbeing of mental health professionals (NHS Digital, 2017).

1.4 | This study

In February 2016, the UK government announced "The Five Year Forward View for Mental Health" (Mental Health Taskforce Strategy, 2016), which plans to increase access to mental health services, in part by expansion of the mental health workforce with 3,000 additional practitioner posts by 2020/2021. The counselling workforce is potentially well placed to contribute to this expansion of mental health provision and fulfil IAPT's recent commitment to client choice in therapy (NCCMH, 2018). BACP has an existing counselling workforce of approximately 47,000 members where paid employment remains a challenge (survey), yet calculations from Barkham, Moller, and Pybis (2017) suggest that counselling is a potentially more cost-effective and time-effective therapeutic solution compared to CBT, which could provide the government with considerable savings.

However, more needs to be understood about the employment profiles and experiences of the *current* (and recent) counselling workforce. To our knowledge, no research to date has specifically explored the experiences of therapists working in the NHS. This study aimed to understand the types of roles that therapists occupy, to identify where/how the therapist workforce in the NHS could potentially be expanded. Equally, the study aimed to understand the experiences and perceptions of therapists to establish whether there are barriers which make it harder for therapists to work in the NHS.

2 | METHOD

2.1 | Design

Data were analysed from a pre-existing joint online survey of members from four UK counselling/psychotherapy professional associations; the Association of Child Psychotherapists, BACP, the British Psychoanalytic Council and the United Kingdom Council for Psychotherapy, between 1 and 31 March 2017. This was a broad exploratory survey which sought information from members regarding their NHS job roles, work experiences and perceptions. Due to the authors' affiliations with BACP and limited permissions to analyse data from the other organisations, only data from BACP members (who made up 64% of the total sample) are presented here.

The survey aimed to capture professional demographics of members working in the NHS, types of job roles and settings where members worked, members' experiences and perceptions of working in NHS services as well as levels of workplace stress. The survey comprised 50 questions, most of which were closed questions with predefined response options. Some questions also included an "other" option to allow for a unique response and one open-ended (free-text) question. Examples of closed questions include "Which NHS region do/did you work in?" and "How long have you been a psychotherapist/psychoanalyst/counsellor?". Qualitative data for this study were generated from the free-text responses to the following two questions (for question one the responses were those in the "other" free-text box):

1. What are your reasons for no longer working in/for the NHS?
2. In terms of providing an effective and efficient service to clients seen in your service what ONE thing do you feel would MOST improve your service?

Participants' perceptions of their NHS services were examined by asking them to rate the adequacy of their NHS services along various dimensions using a 4-point Likert scale which ranged from "completely inadequate" to "completely adequate." Changes to their NHS service over the past 5 years were rated using a 6-point scale ranging from "large negative change" to "large positive change" and included an option for "do not know" and "no change."

Additionally, the Health and Safety Executive (HSE) Management Standards Indicator Tool (HSE, 2017) was used to assess members' work-related stress. Edwards and colleagues (Edwards, Webster, Van Laar, & Easton, 2008) found the tool to be a reliable and representative measure of work-related stress across organisations. The tool consists of 35 questions, such as "I have a choice in deciding how I do my work" and "My working time can be flexible," which participants respond to using a 5-point Likert scale ranging from "strongly disagree" to "strongly agree." Questions assess potential stressors in seven areas, as defined on the HSE (2018) website.

Responses to questions were then analysed using the HSE Management Standards Indicator Tool User Manual (HSE, 2004). A mean response was calculated for all participants to provide percentiles of performance for each stressor. Results below the 20th percentile benchmark score indicate urgent action is required, results between the 20th and 50th percentiles indicate good performance but potential improvement, and results above the 80th percentile indicate very good performance that needs to be maintained (HSE, 2004).

2.2 | Participants

A purposive sample of 2,010 BACP members (approximately 4.5% of the total BACP membership) participated in the survey. Data were excluded from respondents who never worked in the NHS, had left the NHS more than 5 years previously or did not complete any of the questions (see Figure 1). The final sample thus consisted of 1,918 participants of which 63% (n = 1,210) currently worked in an NHS service and 37% (n = 708) had left an NHS service within the past 5 years. The sample size for individual questions varied, as those who had left the NHS in the last 5 years were not asked about their perceptions of their services or their current work-related stress. In addition, not all eligible participants answered all questions—for example, demographic data were completed by about 80% of the whole (eligible) sample.

Of those who provided demographic data, 82.5% (n = 1,277) were female, 16.4% (n = 253) were male, 0.1% (n = 1) selected "other," and 1.0% (n = 16) preferred not to say. Ethnically, 84.6% of respondents were White British/Irish/Welsh, 7.1% White Other,

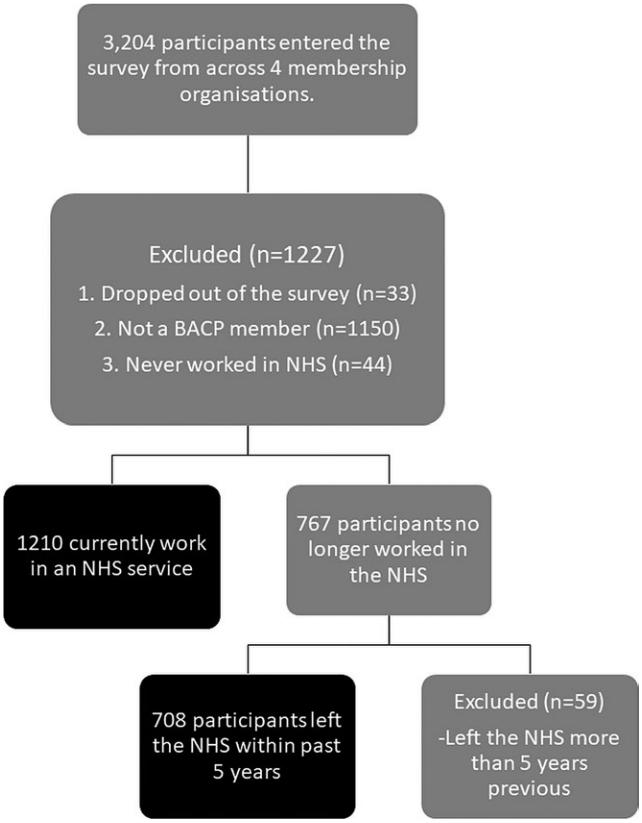

FIGURE 1 Exclusion criteria for study data (note: darker squares signify included data)

2.1% Asian/Asian British, 1.3% Black/Black British, 1.8% Mixed Ethnicity, 0.2% Arab, 0.8% Other and 2.1% preferred not to say.

Of the 1,545 participants who provided information about their professional status, 92.2% (*n* = 1,425) were practising therapists, 4.5% (*n* = 69) were trainees, and 3.3% (*n* = 51) were not currently practising due to either retirement or extended leave (for example, maternity leave). Over half of participants (57.2%, *n* = 1,078) had started working in the NHS more than 5 years ago, 26.2% (*n* = 494) started 2–5 years ago, 10.8% (*n* = 203) started 1–2 years ago, and 5.8% (*n* = 110) started less than a year ago. The sample was thus predominantly female, white and had completed training, with a significant number having substantial NHS experience.

Most respondents worked in England (*n* = 1,694, 90.1% of those who provided an answer to this question), with smaller proportions working in Wales (*n* = 91, 4.8%), Scotland (*n* = 56, 3%) and Northern Ireland (*n* = 40, 2.1%).

Most members' main workplace settings were within secondary care services (*n* = 741, 42.7%), followed by those working in IAPT (*n* = 469, 27.0%), non-IAPT primary care services (*n* = 402, 23.2%) and children's services (*n* = 122, 7.0%).

2.3 | Analysis

A mixed-methods approach was utilised to address the different aims of this study. Quantitative methods were used to assess the perceptions and employment profile of therapists working in the NHS whilst qualitative analysis was used to understand their experiences of working in this environment. Statistical analysis software, "IBM SPSS Statistics 25" (IBM Corp, 2016), was used to conduct quantitative analysis on members' responses to questions rating aspects of both their current NHS service and their service over the past 5 years. Frequency counts, descriptive statistics (for instance, means, percentages) and cross tabulation analyses of results with members' main workplace settings were undertaken. Workplace settings were categorised into four main areas within the NHS as follows: IAPT; children's services; and non-IAPT primary care services and secondary care services.

Qualitative analysis adopted a critical realist epistemology, acknowledging that participant views of reality are accessible yet affected by social context (Lund, 2005). A reflexive approach was taken to recognise the impact of personal experiences and attitudes upon the analytical process. The first and second authors of this paper are researchers with a psychology background; they are not therapists, nor have they worked for the NHS. The third author is a counsellor and researcher and has worked briefly for the NHS in an unpaid capacity; however, she has also supervised numerous students who have worked in NHS settings. All researchers have paid roles for BACP, a professional body for counsellors and psychotherapists.

Free-text analysis was performed on answers from two open-ended questions. The first of these questions (which asked why respondents left the NHS) consisted of both predefined answers that included reasons non-indicative of work-related concerns and an "other" option that allowed for free-text responses. "Other" responses from this question were initially filtered and retroactively coded to record additional commonplace reasons for leaving the NHS (see Table 1). Remaining free-text responses to this question (and all free-text responses to the second aforementioned open-ended question) were then analysed using thematic analysis (TA), a qualitative methodology which enables the search of data for themes and patterns (Braun & Clarke, 2006). This process involved an initial period of data familiarisation whilst noting salient ideas, followed by an iterative process of coding the text and collating supporting data extracts. All codes were then organised into a table of subthemes and accompanying extracts, which was subsequently refined to capture the core themes presented here.

3 | RESULTS

3.1 | Therapist role and pay

Few members reported working full time in the NHS, with only a fifth of those who answered (*n* = 364, 20.1%) working 35 or more hours per week. Almost half of members who worked < 35 hr per week (49.0%, *n* = 791) responded "yes" when asked whether they would want to do more therapeutic work in their service. Participants reported working a sum total of 35,557 hr each week in their NHS role(s); 3,869 (10.9%) of these hours were reported as unpaid work hours with a mean of 5.4 unpaid hours being worked *by each participant* on a weekly basis. Almost 40% of trained therapists (39.5%,

TABLE 1 Reasons for leaving the National Health Service (NHS)

Reason for leaving the NHS	Frequency	Percentage (%)
I found alternative employment	197	33.1
My contract was not renewed	109	18.3
I retired	103	17.3
Placement ended[a]	73	12.3
I was made redundant	46	7.7
My role/salary was downgraded	21	3.5
Moved house[a]	21	3.5
Resigned[a]	13	2.2
Family reasons[a]	8	1.3
Illness[a]	5	0.8
Total	596	100

[a]Indicates responses in the free-text "other" box that were coded after survey finished. The remaining 176 free-text responses did not fit clearly into any of the categories in the table and were thus qualitatively analysed.

n = 561) and 79.7% (*n* = 55) of trainee therapists reported working unpaid hours, with 10.8% (*n* = 3,031 hr) and 34.5% (*n* = 309 hr) of their total weekly hours being unpaid, respectively.

Of the participants who reported their salary banding (*n* = 1,187; of which *n* = 397 were currently working in NHS and *n* = 790 used to work in NHS), most reported being employed at band 6 (*n* = 536, 45.2%), 26.5% (*n* = 314) worked at band 7, 14.5% (*n* = 172) at band 5, 7.5% (*n* = 89) at bands 8a-8d, 6.2% (*n* = 74) at band 4 or less and 0.2% (*n* = 2) at band 9. Patterns of pay banding were also examined for different employment settings, and it was found that those who were paid on the lowest pay bands (band 5 or less) mainly worked in secondary care (22.4% of the total number working in these services, *n* = 114) and IAPT services (20.5% of those working in IAPT, *n* = 73). Members working in children's services were paid on the highest bands with 43.1% being on bands 7 and above, compared to only 21.5% of the therapists working in primary care. Therapists currently working in the NHS reported being paid on lower bands than those who used to work in the NHS; whilst 72% (*n* = 286) of therapists currently working the NHS were paid on band 6 or higher, from the group that had left the NHS in the last 5 years 82.9% (*n* = 655) reported being paid on band 6 or higher.

"Down-banding" (being dropped down a salary/band level by the employer) was reported by 25.8% (*n* = 419) of therapists, who indicated this was either planned for their services or had happened in the past 5 years. Of these, 37.5% (*n* = 178) reported service-level down-banding from band 7 to band 6 and 26.9% (*n* = 128) reported down-banding from band 6 to band 5. Furthermore, over a quarter of those currently working in the NHS stated their service was facing either downsizing or closure within the next year (27.2%, *n* = 218).

3.2 | Therapists who left their NHS role

Out of 708 therapists whose status was "no longer working in the NHS," 641 people (90.5%) provided information on their prior main workplace setting. Results showed that across all main workplace settings, comparatively more therapists from children's services had left their NHS role (57.1%, *n* = 45) compared to other services. Relatively, those working in IAPT were more likely to stay in services with 67.8% (*n* = 318) from this setting still currently working in the NHS. To understand why some respondents no longer worked in the NHS, both quantitative and qualitative responses were analysed (see Table 1).

Reasons for leaving the NHS were provided by 772 respondents; 22.8% (*n* = 176) of these were free-text responses and the other 596 (77.2%) responses were either pre-defined or categorised through the process described above. Quantitative results established that "I found alternative employment" was the most common reason for therapists leaving their NHS role (*n* = 197, 33.1), followed by "contract was not renewed" (*n* = 109, 18.3%), "made redundant" (*n* = 46, 7.7%) and "role/salary was downgraded" (*n* = 21, 3.5%). To understand further reasons for stopping work in the NHS, a thematic analysis was conducted on the remaining free-text responses.

Analysis of these responses yielded multiple subthemes which were categorised into three overarching themes: "undervalued profession," "detrimental to client and practitioner wellbeing" and "failing service structure" (see Figure 2).

3.2.1 | "Undervalued profession"

Responses highlighted a common participant perception that the profession and its practitioners are deeply undervalued, both within NHS service management and by government. Members described a lack of paid therapeutic roles, stating that services are either "too reliant on volunteers" or recruit only for "advanced roles." Additionally, some respondents described leaving their roles due to limited opportunities for promotion or career development, as many services offer "no consistency in terms of progression."

Some therapists stated quitting their role owing to experiences of bullying management, described as being disrespectful of both the therapists and their profession.

> … I felt bullied

> Bullying from the clinical lead…who had little regard for the fields of Counselling and Psychotherapy

An equal number of respondents described leaving either willingly or involuntarily because of limited or cut funding. Some therapists reported feeling undervalued following expectations to work increasing numbers of unpaid hours which made "working more onerous, and less client centred," whilst others reported having their roles cut or outsourced to another organisation:

> …funding was not available to retain me permanently,

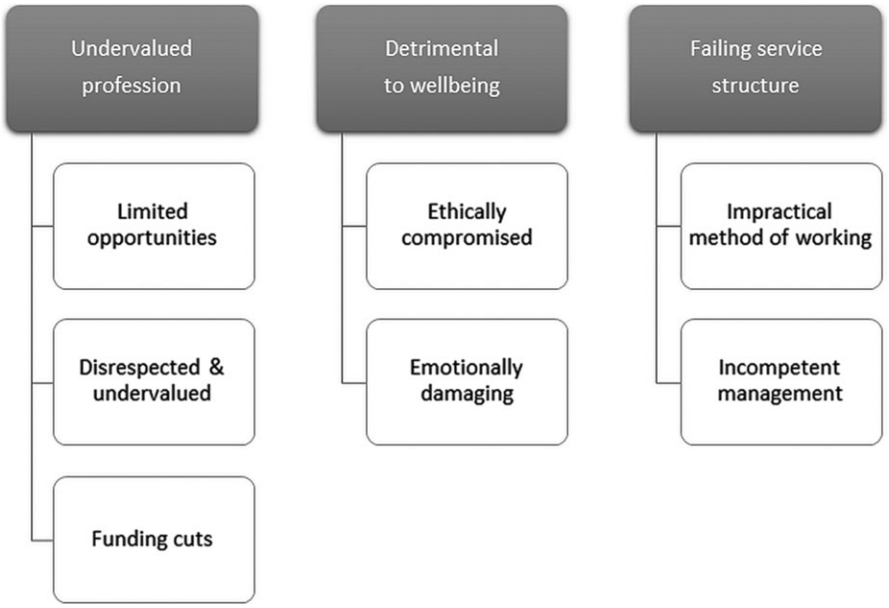

FIGURE 2 "Why I quit" thematic map

3.2.2 | "Detrimental to client and practitioner wellbeing"

Another reason that therapists stated for leaving the NHS was feeling ethically and morally compromised in their role: "lowering standards challenged my ethical stance." Therapists felt there was an "expectation…to produce endless stats at the cost of counselling," which compromised the safety of their service and ultimately led to their decision to leave the NHS: "I felt my work in IAPT as a counsellor was becoming unsafe and unethical… I couldn't offer what clients wanted under the pressure imposed by IAPT."

Alongside fear of detriment to client wellbeing, the data suggested that some therapists also left due to a fear for their own mental health. Some responses indicated that therapists left after experiencing stress and burn out, whilst others described increasing feelings of unhappiness within their role or experiences of a toxic work environment: "I found the environment and context very stressful and not conducive to therapeutic work."

3.2.3 | "Failing service structure"

Mounting problems within the management and organisation of services was another factor reported by therapists. Respondents described an impractical method of working, consisting of restrictions on their practice alongside "unmanageable" demands.

> …didn't allow me to work with my clients in the way that I wanted to.

On top of this, a handful of respondents described having unsupportive management which prompted their resignations:

> A new practice manager came and made the job unsafe and stressful.

3.3 | Therapists currently working in the NHS

3.3.1 | Workplace stress

For participants currently working in the NHS, a government health and safety tool which identifies stress in the workplace was utilised to assess the degree of therapists' workplace stress against government benchmark figures (Edwards et al., 2008).

Results indicate that no factors scored above the 50th percentile and only "demands" and "change" scored equal to this, signalling "good performance but potential improvement" required. The remaining five factors (see Table 2) scored below the 50th and 20th percentiles to signal "improvement needed" in these aspects of the members' NHS roles. Overall, the response from almost a thousand NHS therapists suggests that they were experiencing unacceptable levels of workplace stress by government standards.

3.3.2 | Therapist perceptions of their NHS service

Therapists currently working in the NHS were asked to rate the adequacy of NHS services and their perceptions of change to services over the past 5 years. Most respondents perceived current services as "mostly" or "completely" adequate in terms of therapy session length (n = 920, 93.4%), therapist qualifications (n = 898, 92%) and quality of supervision (n = 772, 79.4%). However, over half of respondents found the number of practitioner posts (n = 587, 59.0%) and waiting times (n = 600, 61.1%) to be "completely" or "mostly" inadequate, with over a quarter of respondents (n = 274, 27.9%) specifying waiting times as "completely inadequate." Furthermore, nearly half of all respondents rated staff morale (n = 478, 48.8%) and the number of sessions offered per client (n = 456, 46.2%) as "completely" or "mostly" inadequate.

TABLE 2 Mean scores for factors on the Health and Safety Executive (HSE) Management Standards Indicator Tool

Factor	Mean	Percentile	Action required
Demands (*n* = 945)	3.3	=50th	Good performance but potential for? improvement
Control (*n* = 946)	3.6	≥20th; <50th	Improvement needed
Manager's support (*n* = 946)	3.5	≥20th; <50th	Improvement needed
Peer support (*n* = 943)	3.8	≥20th; <50th	Improvement needed
Relationships (*n* = 945)	4.1	≥20th; <50th	Improvement needed
Role (*n* = 947)	4.1	≥20th; <50th	Improvement needed
Change (*n* = 939)	3.0	=50th	Good performance but potential for? improvement

Considering the change to services over the past 5 years, fewer respondents recorded positive changes compared with negative changes. Just under half indicated positive change for the number of clients being referred for treatment (*n* = 379, 46.2%) and the range of treatments available to clients (*n* = 353, 41.9%). However, negative change was perceived by almost two-thirds of respondents for staff morale (*n* = 536, 65.4%) and over half of respondents for the number of therapeutic posts (*n* = 439, 53.9%). Moreover, waiting times were mostly perceived to have worsened (*n* = 489, 57.5%) with 28.8% (*n* = 245) of respondents rating this change as "largely negative."

Respondents were asked to comment on their perceptions of change to thresholds for client symptomology severity for entry to services over the past 5 years. Opinion was divided over this, with 44.7% (*n* = 433) of respondents perceiving that thresholds had not changed, and 43.6% (*n* = 422) believing that a greater severity was now needed to access services.

Analysis was performed on 833 free-text responses to the question which asked participants currently in the NHS the one thing they would change in their service. Analysis resulted in five subthemes, grouped into two overarching themes: "change in attitude" and "change in service structures" (see Figure 3).

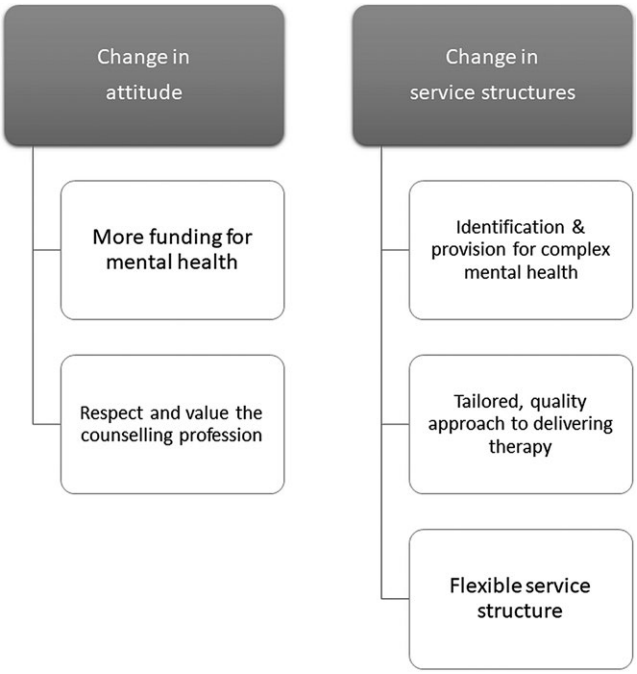

FIGURE 3 "One thing I would change" thematic map

3.3.3 | "Change in attitude"

Across the data, respondents suggested a variety of changes which indicated a desire for the NHS and stakeholders to re-evaluate their attitude towards the counselling profession by valuing and investing in it. Multiple requests for additional funding were grouped under this theme as therapists repeatedly described losing out to other services when attempting to secure basic provisions for the continuation of their service, and this was seen as a consequence of negative stakeholder attitude. Members also described a constant struggle of trying to make ends meet with limited staff, equipment and rooms to practise:

> More funding to hire more staff

> More resources—staff, accommodation, training and funding

Respondents felt their services deserved more funding which could then be used for the "expansion of service into primary care," thus solving service issues by yielding "shorter waiting times" and "improving patient access to services."

Furthermore, therapists indicated they wanted respect from their peers and recognition as trained, qualified professionals. Members frequently described having their clinical judgement overlooked:

> Listening to the clinical judgement of the counsellor rather than being governed by 'numbers'. (PHQ-9, GAD-7)

Overall, responses in this theme reflected how members felt their service was neither valued nor understood by other professionals within their field. This caused one respondent to recommend "an understanding of the Counselling role by the NHS" as the one thing to change within their service.

3.3.4 | "Change in service structures"

A second theme in the data was the perception that changes to the NHS service structure are required, including change to therapeutic delivery pathways and how services respond to the gap(s) in complex mental health care.

In terms of service structure, respondents identified a gap within the referral system whereby patients with complex psychological problems are passed to services ill-equipped to treat them, leaving services and practitioners overwhelmed and patients often left to "fall through the crack(s) between services." As one respondent put it:

> …there is little understanding of complex mental health issues and therefore some referrals are inappropriate as 6 or 12 weeks is insufficient.

This perception prompted requests for a more rigorous and better-informed assessment and referral process in addition to an expanded secondary care service: "If secondary services [were] increased so they take people with chronic, severe and complex needs which the IAPT service is not equipped to treat." Respondents also requested flexibility in the number of sessions allocated to each patient, recognising that some people require more or less therapy depending on the complexity of the issue:

> You can't work with PTSD or layers of abuse in 6 sessions! It's unethical and potentially harmful.

Additionally, some members perceived that therapy in the NHS had become a target-driven, "dustbin for all" service. One respondent depicted their service as a "conveyor belt" which wrongly focused on quantity over quality of therapy delivered to patients:

> We are delivering 'subtherapeutic' or 'diluted' levels of therapy to clients.

Respondents argued that NHS services need to recognise the individualistic nature of therapy and provide a quality service which promotes patient choice and appropriately caters to individuals' specific needs: "Informed choice of therapy, clients are not given info on the range of therapies available." Additional survey responses identified areas of desired improvement within the organisation and management of their services, with some respondents criticising poor management and appealing for managers who supported their profession and who generally "know what they are doing."

Other therapists felt they had unjustly lost time for reflection and supervision following budget cuts to services, thus prompting requests that an effort was made to protect this in services: "Protected space for reflective practice. This has been squeezed out to see more clients." Finally, some respondents perceived a lack of communication across mental healthcare professionals, and they felt this should be addressed as a matter of priority, to provide "more joined up" services across the NHS.

4 | DISCUSSION

This study has provided important information on the experience of almost 2,000 therapists who currently, or have recently, worked in the NHS. The data point to a perception of multiple problems with NHS psychological therapies services, in particular a lack of funding, issues with problematic service structures and inadequate management. A key finding is that therapists perceive not only lowered staff wellbeing but also significant negative impacts on clients as a result of the issues with services.

National Health Service services are locally commissioned and can vary. Recent research suggests that NHS site factors do have a significant impact on client outcomes, with some services markedly less effective than others, even after controlling for patient variables, therapy type and sessions attended (Pybis et al., 2017). The results of this study potentially suggest some of the factors that may explain the variable effectiveness of NHS psychological therapy services. The results also suggest some of the factors that are responsible for practitioner burnout, which has also been found to have a measurable negative impact on NHS client outcomes in therapy (Delgadillo et al., 2018). This study thus contributes to a growing literature on the concerning impacts on clients of the current NHS context.

The rest of the discussion focuses on what the results say about the experience of therapists—as a group of professionals—working in the NHS. This experience is summarised under four headings: "squeezed," "underpaid," "pressurised," and "undervalued."

4.1 | Squeezed

The quantitative data on why respondents left the NHS suggest that 30% of therapists were squeezed out of the NHS due to their contract not being renewed, being made redundant, or their role or salary being downgraded. Twenty-six percentage of participants reported that their service either had engaged in down-banding of posts or planned to and 23% of those currently working in the NHS reported that their service itself was facing downsizing or closure *within the next year*. The data did not suggest much difference in job roles in IAPT, perhaps because the big losses of job roles in primary care occurred over 5 years ago, as the IAPT system rolled out from 2009. Overall participant reports suggest a clear squeeze on therapists in the NHS that works to push them out of the workforce.

4.2 | Underpaid

For this section of the discussion, the terms "counsellor" and "psychotherapist" will be differentiated to highlight disparities in pay between professional groups. Since a large majority of BACP members identify as "counsellors" (BACP, 2017b), the data suggest

that those with the professional title of "counsellors" are, in comparison with other psychological therapies practitioners (including psychotherapists), less well paid. The information on salary bands suggests that two-thirds of the respondents of this survey (all members of BACP) are paid at band 6 or *less* (over 20% at band 5 and below), with counsellors in secondary care and IAPT less well paid than counsellors in other parts of the NHS. In comparison, according to the NHS careers website, "psychotherapists" and clinical and counselling psychologists are paid at band 6 whilst training and band 7 (minimum) when qualified, whilst IAPT high-intensity therapist trainees may be appointed at either band 6 *or* 7 (Health Careers, 2015a,c; NHS Health Education England, 2017). The same website says that counsellors "might be paid at any bands in the NHS"—in other words there is no minimum banding suggested (Health Careers, 2015b). Arguably, the statement reflects a lack of clarity in the NHS about counsellors' professional roles/competencies. Unlike other practitioners, counsellors enter the profession at a range of educational training levels from vocational diploma level 4 to postgraduate level 7 so the pay differential may reflect differences in training and corresponding assumed differences in therapeutic competencies (BACP, 2017a).

The data in this study shed no light on comparative pay for different types of practitioner doing the same role or on job application or promotion success rates across the professions. It is thus not possible to assess whether counsellors are systematically exploited as an NHS workforce. However, it is clear that they are relatively less well paid than other practitioners doing psychological therapies roles. Moreover, data showing that the proportion of counsellors in higher paid roles was greater for those who had *left* the NHS compared to those who remain certainly support a negative interpretation as do the qualitative data that suggest counsellors experience problems with career progression in the NHS. Another (not contradictory) conclusion is that counsellors are, for the NHS, a cost-effective mental health work force. Further, whilst almost 50% of respondents currently working in the NHS said that they wanted more work, only 20% actually had a full-time role. This suggests that there is a significant un-tapped workforce that could fill current NHS needs.

It is also important to note the significant amount of unpaid work revealed by participants' responses—*over ten percentage of all the hours worked* were worked unpaid. Moreover, it was not just trainees who worked unpaid; a significant number of fully trained therapists also reported working some (21%) or all (19%) of their NHS hours unpaid. BACP members who are qualified/registered—but not accredited—may seek unpaid work to accrue the number of clinical hours required to apply for accreditation, which is often required for paid employment. However, the scale of unpaid work by therapists in the NHS is nonetheless hugely significant particularly given that IAPT psychological wellbeing practitioners, high-intensity therapists, and clinical psychologists are conventionally *paid to work whilst they train*. The information on the scale of unpaid work also provides further evidence for the idea that the counselling workforce is potentially exploited in the NHS.

4.3 | Pressurised

The quantitative data suggest a perception of increasing waiting lists and severity of client presentations whilst the qualitative data point to the experience of "unmanageable" levels of demand by some respondents which they experience as ethically compromising to their practice. The majority of participants also perceived both the number of practitioner posts to be inadequate to meet demand and that the situation had worsened in the last 5 years. Correspondingly, there was a broad perception that levels of staff morale were inadequate and worsening. This accords with the data on workplace stress which suggest that therapists working in the NHS are experiencing stress at a level that should raise organisational concern. Also concerning was the number who reported leaving the NHS due to workplace bullying. Overall, the picture gained was of a workforce that feels pressurised and stressed.

4.4 | Undervalued

The data on pay and the commonplace nature of unpaid work, as well as the reports of insecure contract work and "outsourcing," suggest an organisational and literal undervaluing of the therapist workforce. This is echoed by the qualitative data in multiple ways. There is a sense that therapists are undervalued both *personally*, in that their well-being is not protected organisationally or by management from burnout/workplace stress/bullying, and that they are undervalued *professionally*, by colleagues and managers and by the "system." In addition, the impression is that therapists feel that their work with *clients* is undervalued, with services being underfunded and their working practice being constrained by a rigid and unwieldy service structure which (in their view) makes it harder for them to work safely or effectively with clients. Whilst there is evidence that mental health workers as a group may often feel undervalued (Eliacin et al., 2018; Rao et al., 2016, n.d.), it is possible that this may be particularly so for counsellors, who are very often hierarchically (in terms of job role and salary) lower than other workers. Certainly, overall the impression gained is that there is an organisational culture of dismissiveness towards therapists in the NHS that is harmful not only to this group of practitioners but also—and crucially—to the aims of the NHS to promote care which "supports recovery" for clients (Mental Health Taskforce, 2016).

4.5 | Limitations and future research

Those who responded to this survey constitute an opportunity sample who may not be representative of all BACP therapists who work in the NHS; theoretically those who were less satisfied with their NHS roles (historically or currently) may have been more likely to respond. As a single data point, it is also not possible to draw strong conclusions from this survey about change over time in the role of therapists in the NHS. In addition, the data reported on changes in service provision are based on respondents' perceptions, rather than a potentially more objective service audit or equivalent. However,

these limitations notwithstanding, the findings are significant, particularly in view of the difficulty of establishing accurate workforce figures for therapists from NHS workforce data. This suggests the value of repeating this type of workforce survey to capture changes across time in the experience of therapists working in the NHS. Additionally, it would be valuable to explore the influence of professional regulation on therapist experiences by replicating the present study with therapists from a country which regulates the counselling professions.

5 | CONCLUSION

This study has found that members of the biggest UK counselling and psychotherapy professional organisation (BACP) want to work more hours in the NHS than they currently do and that they are potentially a cost-effective mental health workforce, in comparison with other types of psychological therapies practitioners. However, the study has also evidenced significant barriers that function to push therapists out of the NHS, not least what appears to be a broad undervaluing of this group of therapists as a professional group.

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