NATIONAL ASSEMBLY FOR WALES

SUBSTANCE MISUSE COUNSELLING WORKFORCE SHORTAGES

February 2007

PCM SERVICES (WALES)

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………….. Substance Misuse Consultancy

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REPORT SUMMARY

Service Provision

The overall aim was to assess the currently available counselling workforce within the substance misuse field in Wales. The research sought to identify existing and potential counselling resources that might be useful. **It was not the aim of this research to determine the efficacy of counselling.**

The key objective was to identify workforce shortages and what might need to be done to alleviate these. There was a need to identify those services that currently provide counselling as there was no extant information readily available. This enabled the mapping of current services against the SMTF definition of counselling. The research sought to identify the methods of counselling currently provided. The availability of specialist training linked to appropriate, transferable qualifications was thoroughly investigated once the existing complex structures had been untangled. As part of the study, standardised questionnaires were sent to both providers and commissioners, tailored to commissioning or provider issues. In addition, a series of regional meetings with commissioners were held to provide an opportunity to discuss the issues.

Current commissioning processes and objectives are reviewed and some of the current problems are identified.

Service Conclusion and Implications

The principal identified key issue was that of funding rather than a shortage of available workers. Both providers and commissioners felt that they were not given adequate funding to develop counselling services as defined in the SMTF Module. Many commissioners felt that they were being given targets and goals that were unrealistic or unattainable without adequate resources or specific enough guidance.

Another key issue identified related to perceived problems with the SMTF module, “Psychological Therapy and Psychosocial Interventions in the Treatment of Substance Misuse”. Many commissioners felt that the module was unclear as to what was practically required from them in terms of delivering a counselling service, how it would fit in with other services and what the actual likely demand would be. Many commissioners felt that the module was “woolly” and that too much time had had to be invested in trying to understand the module. Additionally, many commissioners felt that the module was not a service specification, which they ideally would like, but rather a series of recommendations and discussions on counselling. In short there was felt to be no definitive outline of what counselling services the Welsh Assembly Government would like to see developed and no clear outcome goals.

There were also problems in gathering definitive data on counselling service delivery and waiting times. Some areas were able to provide data whilst others could not. There is a need for the collection of service data specifically against the SMTF modules to enable effective monitoring. This raises issues in the near future of data and record keeping to enable monitoring and evaluation leading to effective service development which is responsive to changing needs.

Workforce Development

There is fertile ground for a national approach to counselling training as part of a wider training strategy. Consideration should be given to forming an All-Wales Action Learning Group around service specifications to develop a template for substance misuse counselling. This process should also set minimum qualifications and an awards structure.

Although this development needs a bottom-up approach involving treatment providers, commissioners and service users, training links need to be considered regionally or even nationally and should not be devolved to the 22 SMATs / CSPs as this is a highly specialised field and needs a coherent, national focus. Career paths must be built into the process to support the recruitment and retention of staff. Existing good practice in internal training, courses and accreditation should be built upon and included in any process of development. There needs to be a national strategy on assessors and guidance on which organisations should become Assessor centres.

The Welsh Assembly Government must recognise the importance of funding workforce development. Any training developments must be linked to the Lifelong Learning infrastructure and the funding opportunities available therein so that employers can take advantage of public funding.

PART ONE: SERVICES, SMTF AND SHORTAGES

SECTION 1: COUNSELLING DEFINITIONS

1.1: TYPES OF COUNSELLING

In order to ensure that adult substance misusers in Wales had sufficient access to appropriate treatment services the Substance Misuse Treatment Framework (SMTF) was developed by the Welsh Assembly Government. The SMTF is designed as a series of modules to provide frameworks for service commissioners and providers to develop appropriate and effective services to a measurable quality. The module, "Psychological Therapy and Psychosocial Interventions in the Treatment of Substance Misuse" sets out a definition and framework for specialist counselling services.

*The Substance Misuse Treatment Framework Module **"Psychological Therapy and Psychosocial Interventions in the Treatment of Substance Misuse"** is referred to as SMTF.*

It is important to note that unless indicated otherwise, all references to 'counselling' in this report relate to the delivery of services as defined in this SMTF Module only.

Psycho-therapeutic and psychosocial counselling is not exclusive to substance misuse issues but can also be provided in the context of other health, social and life issues faced by people. Counselling services can play an important role in a service users treatment:

> "…the therapeutic relationship that develops between worker and client is one of the most important elements of substance misuse treatment" (SMTF).

There is a need for clarification on the exact role and definition of what counselling is. Counselling within the SMTF is split into two categories:

1. NON-SPECIALIST COUNSELLING:

This form of counselling does not provide the specialist intervention or structured counselling as the SMTF defines. Types of non-specialist counselling include:

- advice and information
- drop in support,
- informal key working
- reflective practice.

Alcoholics Anonymous can be seen as one example of a non-specialist counselling service that uses non-judgemental positive regard and empathy skills. Non-specialist (or generic) counsellors shouldn't be providing detailed interventions:

> "workers with generic counselling skills should not equate this with their ability to be qualified to provide structured counselling or other psychological therapies" (SMTF)

2. SPECIALIST COUNSELLING: This takes the form of specialist interventions and structured counselling. Unlike generic counselling, specific training needs to be undertaken (SMTF). It may be useful to refer to specialist counselling as *'structured counselling'* due to its more formal nature. Two forms of counselling interventions are:

   - cognitive-behavioural therapy
   - motivational approaches.

Unlike generic counselling, the aims and objectives of psychological and psychosocial interventions are defined in the SMTF Module as:

> "to make a measurable improvement to the clients welfare and ability to function.." (SMTF)

There is a clear division within the SMTF in the levels of skill required for generic and specialist counselling, with a clear emphasis on psychological therapy and psychological interventions as skilled activities requiring:

> "specific training and supervision to be carried out safely" (SMTF).

1.2: The Role And Use Of Counselling

Both forms of counselling are currently employed within both the substance misuse and mental health professions in Wales. It is on the more complex counselling interventions that the SMTF module focuses. Where complex interventions are required these often fall into the area of specialist counselling services. Specialist counselling within substance misuse is usually offered as part of a larger care package, involving a mixture of interventions. Counselling is usually offered after an assessment and often in situations such as relapse prevention and in dealing with destructive patterns of behaviour.

A number of different intervention models have been developed for both the substance misuse field and other non-specific counselling services. Some commonly used models are:

- **The Minnesota (12 Step) Model:** Often used by alcohol based counselling services, such as Alcoholics Anonymous, this views addiction as an 'untreatable illness' where an individual can be in recovery from via a strict program of actions and support, but not cured.

- **Motivational Interviewing (MI):** As outlined in the SMTF this form of intervention: "…encourages motivation to change, using directive and client centered methods. It helps clients to explore and resolve ambivalence."

- **Cognitive Behavioural Therapy (CBT):** This seeks to enable people to identify the occurrences that create particular physiological responses in them and to work with them to understand these better. In turn the person is helped to develop more effective ways of interpreting and dealing with these situations and thought processes.

Often services will develop or find a model that suits the area or type of clients that they work with. This can lead to geographical variations in services according to local priorities and in those counselling models used. Services may offer a mixture of structured interventions. These interventions will seek to tackle the underlying issues of an individual's addictive behaviour and to seek resolution, both emotional and practical, of these to enable the individual to develop more positive coping mechanisms.

In order to ensure high standards and staff competence many services seek external accreditation. Reference to external accreditation is made in the SMTF. Because of the complexity of specialist counselling interventions there is a clear need for competent and well trained staff to undertake these interventions.

This would primarily involve compliance by commissioners and service providers with the Drug and Alcohol National Occupation Standards (DANOS), in particular module SD10, "Counselling individuals about their substance use using recognised theoretical models". One of the key requirements of this module is the employment of accredited staff. Further standards and compliance relating to DANOS are defined in the SMTF module, as well as other ways of ensuring compliance with standards. Some of the recommended techniques of monitoring include:

- outcome and performance monitoring
- linking to other specialist counselling services
- written supervision protocols.

Specialist counselling can be expensive to operate. These costs are usually incurred in terms of training and workforce development costs and may also include higher staffing and organisational costs. This can limit the availability of counselling in the voluntary sector and see a predominance of statutory organisations delivering the service. This issue will be considered later in more detail when analysing the current service delivery pattern.

SECTION 2: SERVICE AVAILABILITY OVERVIEW

This section summarise the issues raised within the responses from commissioners and service providers. Due to the textual nature of the responses to most audit questions, it is not possible to always provide data tables.

COMMISSIONERS AUDIT

The audit was distributed in August 2006. The returns situation is summarised below:

Region	Sent	Returned	Partial Return	No Return
Dyfed Powys	8	6	1	1
Gwent	A very helpful combined response all commissioners was received.			
North Wales	7	2	4 commissioners responded via the service provider	
South Wales	9	3	-	6

COMMISSIONERS MEETINGS

Meetings took place in each of the four regions during October 2006 and were well attended and extremely helpful.

SERVICE PROVIDER CONSULTATION

The audit tool was distributed to 33 service providers on 11th October 2006. The final return rates were as follows:

Region	Sent	Returned	Return Rate
Dyfed Powys	6	3	50%
Gwent	7	2	29%
North Wales	6	1	17%
South Wales	14	7	50%

In all 13 returns were received out of the 33 sent giving a return rate of 40%. It should be noted that this does not necessarily reflect a low return rate. From the data received it seems that the response received from those agencies who actually deliver counselling services was approaching 100%. The non-returns represent those agencies who do not deliver counselling services and who could not, therefore, respond to the audit questions.

The importance of counselling and the key role that it can play within the treatment framework, primarily as part of an integrated treatment approach, is largely recognised by commissioners and providers:

> "Counselling is recognised nationally and locally as an effective tool to support individuals, and groups, when dealing with substance misuse issues."

It was difficult when analysing the audit responses on service availability to determine the extent to which the current provision meets the SMTF definition. Indeed, it was **not** a function of this research to review service delivery or to determine independently which services met the definition. This research was dependent on service providers self-selecting that they met the definition. This was also true in evaluating the reported levels of demand for counselling.

2.1: Service Models

Service providers were asked what models of counselling (e.g. motivational interviewing) that they currently employ. There were 12 responses. A number of different models are currently being employed with some organisations providing more than one model of counselling:

- Minnesota model (12 Steps) (2)
- Reality Therapy
- Person Centred Therapy (3)
- Cognitive Behavioural Therapy (5)
- Motivational Interviewing (6)
- Psychodynamic therapy (2)
- Psychosexual therapy
- Solution focussed therapy (3)
- Structured counselling (2)
- Social Learning Theory
- Brief interventions
- Transactional Analysis
- Bereavement counselling

(*N.B Number in brackets = number of providers currently using the model*)

The most widely employed models of **cognitive behavioural therapy** and **motivational interviewing** fit within the SMTF definition. On the basis of their responses many of those providers who returned an audit are providing counselling as defined within the SMTF. This does leave others potentially outside of the definition.

The BACP definition is the most common system of accreditation. In some areas this is being undertaken without clear guidance from the commissioners and the services are responding to expressed need and providing services they feel are required. There is some consensus on what approaches work or are at least perceived to work. This means that there is some sort of agreed approach on the mechanisms of counselling.

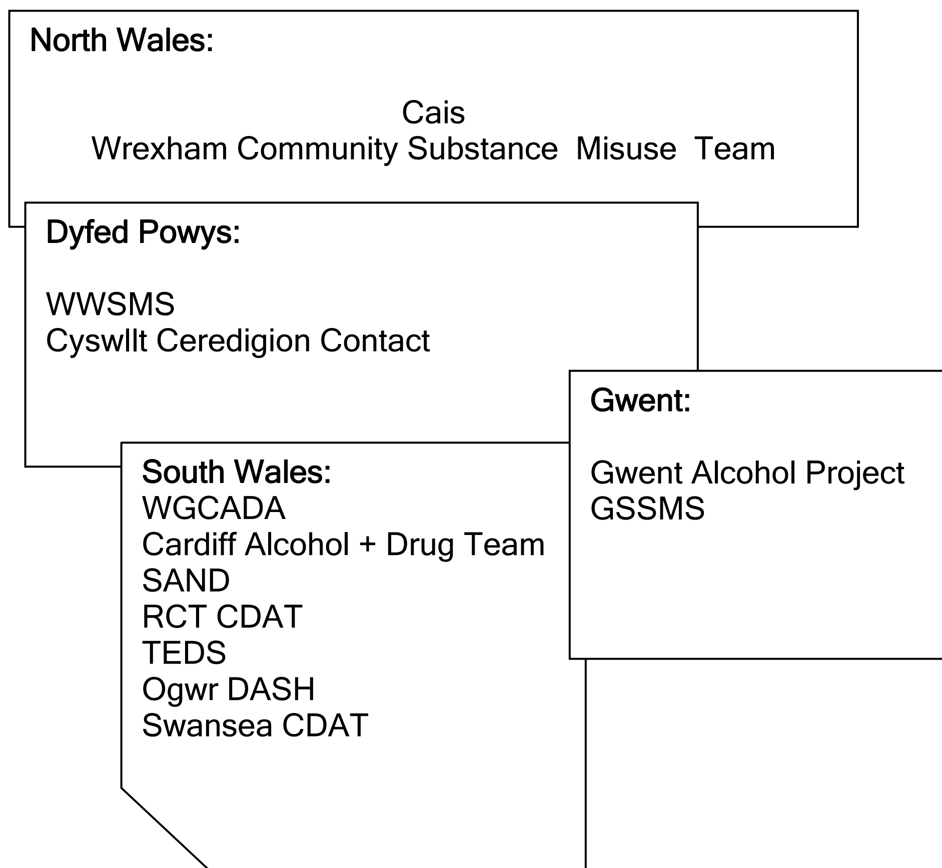
It became apparent that one of the current problems of the SMTF is that there is no actual way to ensure that the services that are being provided do match up to the treatment framework specifications. Indeed, one provider felt that the framework is too narrow and unclear and misses out on a range of opportunities. It is important that the service needs to be flexible. Services need to be able to meet and deal with changing needs, particularly with shifting patterns of drug use. There are also issues in commissioning ***research led*** services as opposed to ***client led services***. Research can be informative and helpful but the actual situation on the ground can often be radically different. Various factors, human differences for example, that cannot easily be accounted for in research conducted with a limited number of people, often come into play.

Another issue is that large areas of Wales are largely rural with the primary urban areas being found in south-east Wales and in some parts of North Wales. In the rural parts of Wales, the low population density, the spread of the population, differing mental and physical health problems and the consequent impact on service provision must be considered. The issue is whether counselling services will need to be structured and delivered differently in different geographical locations. This needs to be accounted for when commissioning services:

> "The service needs to be client lead and flexible within BACP guidelines. The reality of delivering a therapeutic service to substance misusers needs to be taken on board when comparing theory to practice."

2.2: Current Service Provision

The following agencies reported delivering counselling (as defined in the SMTF):



2.3: EXAMPLES OF CURRENT SERVICES [details taken from provider returns]

CAIS

Provides BACP accredited counselling across the six counties of North Wales (Conwy, Denbighshire, Flintshire, Wrexham, Ynys Mon & Gwynedd). The main elements of the counselling services are commissioned by Wrexham Health Board on behalf of partner agencies to deliver counselling across North Wales. Some Local Authorities purchase small additional amounts of counselling in response to identified needs and available resources. CAIS provides counselling to BACP accreditation standards for those clients that have appropriate need. In the last two years a step care model has been in existence in Mid and North East Wales which also offers a Motivational Enhancement session to those service users that could benefit from such treatment. This effectively means that counselling is increasingly being targeted at those with more complex and multiple needs which addresses not only substance misuse but also the underlying causes

West Wales Substance Misuse Service

Provides structured counselling as defined in the SMTF and delivers counselling to about 10% of its caseload. WWSMS provides usually 6 sessions over six weeks but can be more or less based on client review. The counselling service within WWSMS has its own operational policy and adheres to the BACP code of practice. At the time of writing WWSMS was in the process of seeking formal BACP accreditation. Counsellors in addition are substance misuse trained and also trained in MI, Relapse Prevention etc. meaning they are able to better interact with clients and this in turn enhances the treatment. This three dimensional integrated service can be an effective approach but needs adequate funding and staffing in order to work effectively.

Cardiff CDAT

The Cardiff CDAT clinical psychologist offers Cognitive Behavioural Therapy (CBT), systemic and motivational approaches on a sessional basis by appointment. CBT is also offered on a sessional basis by one senior member of the nursing team. As part of an initial interview clients are formally assessed by a member of the CDAT. Further assessment, using a variety of standardised psychometric measures in order to determine cognitive and psychological functioning, is then offered by the clinical psychologist in order to determine suitability prior to the delivery of an intervention.

Staff recruitment has been limited by funding issues. Because of the limited staffing currently, the team is unable to respond to the need for psychological therapy at the point at which these needs are identified. Availability currently stands at part-time (0.4 WTE) input from a clinical psychologist which includes additional specialist psychological assessments as well as therapy. An audit of client needs has been completed and consideration is being made to the evaluation of existing services. Awareness of clinical governance issues are provided at departmental meetings and service development team meetings.

2.4: OTHER COUNSELLING SERVICES

A number of other services provide counselling. Some of these deal with specific issues such as employment or bereavement. The services offered can be useful as clients needing non-specialist interventions can be referred onto these services. Some of the other services as reported by commissioners include:

NORTH WALES

- Alcohol Brief Intervention
- Touchstone 12 (Colwyn Bay)
- Community Drug And Alcohol Service
- G.P's practice counsellors (G.P's are also a source of referral onto substance misuse services)

DYFED POWYS

- PDAC
- Prism
- Walkways

SOUTH WALES

Although no examples were provided by commissioners there are some counselling services:

- South West Counselling Services, run by a BACP accredited counsellor
- Cardiff Counselling And Support
- Inroads Cardiff street drug project

GWENT

- Drugaid
- Kaleidoscope
- Fusion (under 18's)
- Include
- CAD
- Turning Point Crack
- Progress To Work

In addition to these a number of other services that provide elements of counselling, though not uniquely to the SMTF definition, exist. These include:

- **Alcoholics Anonymous:** Offers links to counsellors and employs the 12 Step model. Commonly AA offers group meetings where issues are discussed. Two types of meeting are offered, open where family and friends are allowed to attend or closed which is limited to alcoholics.
- **Barnardos:** Barnardos runs a number of counselling programmes, one example of which is the Skylight project. Skylight provides specialist services dealing with young people.
- **NHS:** Offers counselling on a broad range of issues ranging from mental health to bereavement counselling. Services may not be consistently available in all areas
- **Narcotics Anonymous**: Works very much in the same way as AA but has a primary focus on drug addiction.

2.5: Length of Interventions

The length of the counselling intervention is dependant on a number of factors ranging from the issues being dealt with to the model of treatment used. Some clients do not complete their treatment. One service reported a completion rate of around 15%. Rather than consider the length of treatment in terms of weeks the audit sought the length of intervention in terms of the number of appointments. Most providers offered six sessions initially and then an evaluation period after this. If the average appointment frequency is fortnightly then clients are on average in counselling services for twelve weeks. As some providers state, whilst six sessions may be initially offered this can be changed and renegotiated as work progresses. Some clients may also require long term therapy. Providers offering more complex interventions such as psychosexual therapy stated that 12 - 15 appointments were needed to complete treatment.

2.6: Client Assessments

Clients must be provided with the right sort of treatment or service. The SMTF states that the type and length of intervention and therapy employed will be based on an effective assessment process which will determine whether people are given access to the most appropriate and effective treatment services for their need. Within the audit providers were asked about the assessment process:

<table>
<tr><td>“The therapy will be based on the formulation developed of the persons difficulties and needs”</td><td>“ Age, levels of substance misuse, motivation, mental/physical health”</td><td>“Via in house referral and assessment by counsellor. Also discussed within counselling team reviews”</td></tr>
<tr><td rowspan="2">“Clients undertake full assessment (formal) prior to entry into the service”</td><td>“Assessment, clinical meeting, supervision”</td><td rowspan="2">“Clients and professionals refer to … for alcohol counselling. Initial appointment offered and client requests ongoing counselling”</td></tr>
<tr><td>“Through comprehensive specialist assessment”</td></tr>
</table>

These assessment processes fit within the framework offered by the SMTF. Effective assessment ensures that there is no resource wastage as a result of ineffective and/or inappropriate service use (SMTF). An adherence to these guidelines shows that services are using appropriate forms of assessment and in turn are providing services to the individuals needing them. With staff shortages though there are issues around who should provide the assessment with many counsellors doing the assessment which takes them away from other counselling issues.

2.7: LEVELS OF STAFFING

Numbers of dedicated counsellors (i.e. providing just counselling)

	Part Time and Session Staff	Full Time Staff
Dyfed Powys	-	4
North Wales	2.5	8
South Wales	5	8
Gwent	5	7
All Wales Total:	12.5	27

Numbers of staff providing counselling along with other substance misuse work

	Part Time Staff	Full Time Staff
Dyfed Powys	-	8
North Wales	-	-
South Wales	-	7
Gwent	-	-
All Wales Total:	0	15

Whilst there is a cohort of full time dedicated counsellors this is almost matched by counsellors that have other substance misuse intervention work to perform. Staff with other substance misuse tasks cannot dedicate as much time to counselling issues and this may impinge on the availability of counselling services. **There are 54.5 counsellors of varying status currently at work across Wales.** This would appear to be insufficient for a service where demand is reportedly growing.

In 2005/06, 19,937 people **(Stats Wales)** were seen in relation to having a substance misuse issue. Many of these clients will need access to some form of counselling during their treatment. It is interesting to note that almost 5% percent of these referrals were from mental health services.

	[1]Clients seen (2005-2006)	Counselling Staff (All Types)
N.Wales	3,573 (18%)	10.5 (19%)
D.Powys	3,229 (16%)	12 (22%)
S.Wales	10,379 (52%)	20 (37%)
Gwent	2,612 (13%)	12 (22%)
Outside Wales	144	N/A
***N.B** this does not take account of counselling delivery in mental health services but only within substance misuse services.*		

Low workforce numbers may be representative of funding issues leading to a lack of counselling services and uncertainty as to what role counselling should play in the substance misuse service delivery. In addition, the figures shown here do not take account of current counselling workforce numbers in mental health services and the level to which they are involved in substance misuse work. This overlap between mental health and substance misuse services should be given further consideration in future studies. Additionally, the staff numbers are those who are working within SMTF defined counselling services and as such does not take account of other workers who may be helping with the caseload.

[1] Substance Misuse Wales 2005 – 2006 (first release)

2.8: Waiting Times

Information was sought about waiting list times. At the time of the research most services that reported had long waiting times between initial assessment and first appointment. For example, in North Wales, 114 service users were waiting for an appointment with a further 66 waiting for a general assessment. There was an average of 25.41 days between initial assessment and first appointment.

However, this data was largely absent from the audit returns due to commissioners and providers not having the data. Therefore, it is hard to build an accurate picture of the levels of need across Wales. With the data available there is only a sporadic and ill defined picture of service need, both current and unmet. Where data was reported there was no distinction of whether the current level of need is for specialist counselling due to the self-categorising nature of the respondents.

To summarise by Region:

Dyfed Powys

Based on the responses, counselling in Dyfed Powys is being delivered to between 20 and 80 people depending on the delivering organisation. Dependent on completion rates this will vary. Appointments are weekly or fortnightly. As indicated, one agency reported a take-up rate of 10% of its overall number of clients for counselling.

Gwent

With only 2,612 people seen for substance misuse services, Gwent ranks below the three other regions in Wales. This does not necessarily mean that the need for counselling is any less as one organisation currently provides its counselling service to 115 people in fortnightly appointments.

North Wales

In North Wales the waiting times were comparable with those in South Wales. Appointments were again occurring on a weekly or fortnightly basis. Though as some counsellors are carrying a mixed caseload these times can vary. Waiting lists are substantial but the service was delivered to 1,630 people in 2005/06. This represents approximately 46% of all referrals. It was felt that there was a shortfall in the service with not enough capacity in the current service.

South Wales

The Cardiff and Swansea area during 2005-2006 saw the largest numbers of clients for substance misuse issues. In these areas they reported the weekly numbers of clients as ranging from 12 up to 130 according to the delivering organisation, with appointments ranging from weekly to fortnightly. There was an acknowledgement that there is a need for more staff to cope with growing demand or to free up counselling staff from their other duties.

Other appropriate comments regarding unmet need:

"We need a broader range of interventions and it needs to be commissioned as an intervention in its own right as part of a specialist treatment service"

"Yes. Research suggests that only 10% end up in criminal justice treatment services. This leaves 90% so 9 times current provision."

"I believe that currently, … experiences vast areas of unmet need with regard to providing psychologically based therapy. Recent figures obtained from waiting lists would suggest that clients are currently waiting in excess of 8 months for services."

"I feel that at present the input provided to … is extremely limited and very often is only able to identify a need, and offer techniques for crisis management, rather than provide a structured approach to dealing with psychological difficulties. Current time restraints preclude the provision of a service that is able to respond quickly to identified need and limits the opportunity to develop more appropriate services."

Many returnees cited the shortage of counsellors as one of the main reasons for long waiting lists. The main reason given for this shortage of counsellors was lack of service funding rather than a shortage of appropriate staff. If this specific service does not exist then there will, naturally, be unmet need which is difficult to quantify. Many commissioners and providers expressed the view that there were no counselling services as defined in their area. On the basis of the returns there appears to be no needs analysis undertaken in the majority of areas.

In conclusion, based on the available data, it would appear that there is:

- a high demand for counselling services;
- that services are currently struggling to meet the need;
- there are issues around counsellors carrying mixed caseloads and carrying out other work;
- demand is reported as increasing though the measurement of unmet need is largely non-numerical. In North Wales the annual growth in demand for counselling is put at 15%. If reflected across Wales this is a substantial service demand increase.

2.9: Staffing Issues

When asked regarding the development of staff the following responses were given:

"Efficiency of services much improved due to establishment of clinic type systems, service quality assured by counsellors working towards BACP."

"The therapies need to be provided by … staff supported by psychologists"

"If full time posts were funded it would enable the work to develop and relieve pressure on other drugs workers dealing with emotionally traumatised clients"

"It does seem that in the future it will be difficult to recruit staff with adequate group therapy training"

"By March 2007, approximately 50% of the counsellors will be fully BACP accredited with the remainder completing their studies by March 2008."

Issues raised regarding staff included the need for funding for training and appropriate remuneration levels. It was understood that the effectiveness of services depended on the competence of staff, the systems and processes and the support structures. This included the need for appropriate professional support and clinical governance mechanisms. This was one of the reasons expressed for the need for a clinical psychologist or psychiatrist needing to be involved in the service delivery. It was clear from meetings with commissioners that this input is extremely difficult to find in Wales. This is an area where the Welsh Assembly Government could provide strong, national support in developing an appropriate network of senior expertise.

Providers were also asked as to how they would justify the need for more funding and staff. The responses given to this were:

"Many clients presenting with drug/alcohol problems have suffered sexual/violent abuse in childhood. There seems to be too few therapists experienced to work with all the issues."

"Psychological services are currently required to provide quarterly activity reports which reflect the demand for services as well as the diversity of need. These reports also reflect the limitations of current service provision and would provide useful information with regard to the need for evidence-based interventions within this area."

The needs are evidenced by the number of service users waiting for counselling. They have complex needs including bereavement, rape and sexual abuse, dual diagnosis and self harm."

"By reinforcing the importance of psychosocial interventions within the treatment of substance misusers"

"Our current programme is always full. And at present we have a five month waiting list for our … treatment programme"

continued:

"Two workers who work within the agency setting would ensure a seamless route to a counselling service. Experience has shown that clients are more likely to attend if the service is delivered by staff who understand substance misuse"

"Need to develop more specialist treatment service, supported by services that are less structured, to meet the range of client needs. Currently there is a generic approach to treatment provision which is not cost effective use of specialist treatment services"

The arguments presented are cogent and appropriate. Even without equitable data it seems that this is an underdeveloped service in most parts of Wales. The lack of understanding regarding the current service availability and types is an inhibiting factor in being able to accurately quantify unmet demand for additional services and staff. There is a sense that this service, which can tackle and deal with the underlying psychological issues which may support addictive behaviour, is seen as a tag on or optional service. It is clear from the responses of all involved that there is a clear need for the service, a clear need for a consistent service of common standards, if substance misuse is going to be seriously tackled. This does not in any way diminish the need or impact of all the other services that people need in a successful, holistic and long term approach to dealing with the issue of substance misuse in communities across Wales.

2.10: Recruitment

Most service providers felt that recruiting appropriate staff was not an issue. Where a provider felt that it was an issue, they cited a lack of funding as the key reason that caused the problem rather than difficulties in finding appropriate staff. This view was shared by other service providers as they could not employ additional staff to meet growing need without increased funding. One provider reported that funding had not changed for 5 years.

Does your organisation have difficulties in recruiting staff for posts?	
Yes	2
No	8
No answer or another answer	2

A clear majority of respondents (67%) do not have a problem finding appropriate staff if suitable funding and service structures are available.

Most services (83%) felt that currently there was an unmet need for counselling interventions.

Do you feel there is an unmet need for counselling in your area?	
Yes	10
No	2

Those that said no felt that:

- Counselling did not fit within the current residential provision.
- There were other local treatment services/organisations who offer counselling.

This supports the commissioners view of there being unmet need, so there appears to be a consensus between providers and commissioners that the service needs expanding and developing.

2.11: Specialist Substance Misuse Counselling vs Mental Health Services

How much specialist counselling should be provided by substance misuse services? Clearer understanding of the relationship between mental health and substance misuse services is key to clarifying this. Within the audits, the general reported approach is the separation of mental health problems from substance misuse issues. It is reported that often the mental health services will not become involved in substance misuse cases. This means that counselling mechanisms need to be developed by services which are primarily substance misuse services. This appears to lead to a diversion of resources into a service that is, to a large extent, already available in the services commissioned by the Local Health Boards (LHBs). There may be a need to ensure that mental health services have the additional knowledge on substance misuse issues to provide counselling on those issues. This may be actioned by mutual working between substance misuse and mental health agencies through access to services, cross-boundary training and clear service protocols. There is a need for an integrated or co-operative approach, as one commissioner states:

> "At present more work needs to be done to ensure that counselling services complement other health and social care services for substance misusers"

The SMTF and related guidance is still new and within some areas there is already a changing approach to the delivery of counselling. There is a need for more acutely defined counselling services with clear outcomes that can be measured. The development of future monitoring and outcome measurement systems are vital for assessing need and developing appropriate services.

2.12: Commissioning – the Providers' Perspective

Across Wales providers say they are providing counselling whilst their commissioners are unaware of this or are not funding the service directly. There are a limited number of directly commissioned services, these being Cardiff CDAT and, hopefully, in Gwent due to the reprovisioning in services. In other areas commissioners are aware of these claims but either do not fund them explicitly or are unable to verify the statements. This in part is due to resource issues in the commissioning structure and weaknesses in understanding the exact role and application of counselling. A lack of clarity on what services are currently provided can lead to a duplication of services and the wasteful expenditure of resources (staff, time and financial):

> "For example, …… counselling service provides assessments to substance misusers which could be provided elsewhere, freeing up counsellors time to provide the core service"

This supports having a clearly defined commissioning structure in which both the providers and commissioners discuss what is needed. This integrated approach is also needed between the substance misuse planners and mental health commissioners. There are particular issues of cross working in co-morbidity cases. This can lead to a segregation of people with both mental health and substance misuse issues:

> "Dual Diagnosed service users can't access Mental Health provision because of their substance misuse"

2.13: Service Shortfalls

As already outlined, there is in some places:

- a shortage of appropriately qualified counsellors;
- in some areas they have a functioning workforce.

Many providers felt that there was a shortfall in the provision of psychological therapy and psychosocial interventions in their area.

> "We are currently not aware of any of these services being commissioned locally."
>
> "I believe that psychological needs are not always regarded as a priority unless they are specifically related to offending behaviour."
>
> "Clear commissioning specifications need to be drawn up to ensure that there is a skilled, appropriately trained and supported workforce employed to deliver this work."

Providers cited a lack of a strategic commissioning approach being largely due to a lack of specific funding. Providers felt that hiring appropriately qualified staff was not an issue. There were some issues of being able to afford and retain staff in what appears to be a competitive area of employment. Commissioners and providers felt that the funding was not available to enable proper workforce development.

> "Restrictions with regard to funding have limited the recruitment of staff."
>
> "Resources to employ staff are needed"

Providers also felt that there were issues with the way that the services were commissioned and that often the way that commissioning was undertaken could actually be obstructive or unhelpful in providing services.

> "I believe that the high degree of psychological distress experienced by service users within this specialty needs to be recognised and that funding specifically aimed at assessing and treating these issues is provided by health services."
>
> "Needs analysis/core funding/commissioning strategy locally implemented. Look at current waiting times for this type of therapy. Service user consultation."

Commissioners were asked their opinions on what they felt to be factors affecting the provision of counselling services:

As can be seen in the table below, there is a clear consensus from the available returns that funding is the key issue. Opinion was divided on whether staff shortages were an issue and this may stem from a lack of understanding. The main reason for the low number of returns was due to some commissioners stating that they did not commission counselling services. Commissioner's views were partly contradicted by the providers who felt they were delivering counselling services.

ARE THERE ANY MAJOR ISSUES AFFECTING THE DELIVERY OF COUNSELLING SERVICES IN YOUR AREA?			
	yes	no	don't know
staff shortages	1	1	1
staff skill gaps	1	1	1
lack of service providers		3	
funding availability	3		
training availability	1	2	
inconsistent service delivery	1	2	

Other responses included:

"As commissioners we receive a service from the provider, we have SLA's that provide the amount of service to be provided and the minimum standard to which it will be delivered. We will receive any perceived gaps in provision from providers."

A detailed analysis of current workforce provision is absent but with some of the returned audits we are able to build a rough picture of where the shortages occur. On average there are two councillors per service providing counselling. Some larger organisations have more counsellors, in some areas up to four. Rural areas seem to have a greater shortage than their urban counterparts (particularly the Cardiff area and the urban areas of North Wales).

There are reported shortages of specialist services mainly due to a lack of funding. This meant that it was difficult to gauge the level of staff shortfall as existing services reported little difficulty in attracting appropriate staff.

Commissioners felt that standards such as BACP should be increasingly used within the substance misuse field. There are clear issues relating to the design, commissioning and monitoring of services. There is little consistency of approach and varying degrees of understanding. The complexities of modelling this service can seem daunting when they require a specialised approach and knowledge set. Without a service model that can be easily adapted it is virtually impossible for commissioners to undertake an effective gap analysis before moving on to service design. Commissioners require a simpler modelling process with clearer recommendations if they are to take this issue forward successfully. They are often dependent on the specialist skills and knowledge of the providers and whilst this is vital to the commissioning process it cannot be fully independent.

Commissioners have to balance the differing funding priorities and to have an overview of the service structures and pathways in their own area. The Welsh Assembly Government can assist commissioners with this process by simplifying and clarifying the guidance issued. Existing shortfalls appear to be due to planning and funding issues with no clear unmet demand for counselling staff yet identified.

BACP Standards and Accreditation

Accreditation helps clients, colleagues and employers make informed decisions about the counsellor/psychotherapist they choose – reliable, safe and ultimately better decisions.

http://www.bacp.co.uk/accreditation/index.html

2.14: Standards and Support

Whilst services may be operating within the SMTF definition there is a need to understand what practical mechanisms are in place to ensure effective service delivery. Within the SMTF there are a number of methods suggested to ensure staff competence. These include:

- Adherence to relevant codes of practice (BACP,NHS etc.)
- Written supervision protocols
- Employment of accredited and qualified staff

Provider responses showed a varied picture, in general there appeared to be confusion and different levels of understanding. The role and content of the SMTF module is viewed as unclear and confused (and in places contradictory) and its use in service commissioning and monitoring is felt to be currently limited. In its place services are making use of external systems such as BACP or FDAP. Queries were received regarding the definition of counselling contained in the SMTF module and concerns regarding the need to value and validate other counselling type activities undertaken by the agencies. This was a very strong message from commissioners and providers who were very concerned that a focus on counselling services would undermine and devalue the many other very important services, particularly those that deal with the very practical issues faced by service users. It is felt that these are a vital aspect of dealing with substance misuse issues.

A number of organisations indicated that they currently employ the BACP system of accreditation which ensures that they are operating to a set criteria. Other organisations employ different forms of monitoring these include:

- Matching against the service operational policy
- British Psychological Society Code of Conduct
- Monthly audit of notes
- Professional supervision
- NAADAC membership
- FDAP (Federation Drug and Alcohol Practitioners) membership

Some services used NHS clinical standards as well. Some of these organisations were within the NHS and others were outside but applying the standards.

Another way of monitoring quality and staff is through the process of counsellor supervision, as detailed in the SMTF. Where these were in place they occurred at intervals from weekly to monthly. The majority of providers undertaking this support and supervision

mechanism for counsellors employ external supervisors with relevant qualifications. This is in accord with the SMTF.

2.15: Service Quality

To ensure that services deliver an effective service the outcomes of counselling interventions must be monitored. Providers named a variety of techniques that they currently employ to measure the outcome of interventions:

- quantative data from discharge forms
- client satisfaction questionnaire
- client completion rates
- Clinical Outcome in Routine Evaluation (CORE)
- client progress to change
- continued evaluation of clients aims and goals
- discuss clinical meetings
- improved health
- harm reduction
- interim review with client
- end of counselling review
- feedback from other departments and workers

CORE is a very interesting approach to delivering a quantative measure of service outcome for each individual client. It is a non-biased approach that produces data that can be used to measure counsellor and service performance. The development of a standardised measuring approach across Wales to enable accurate comparisons of outcomes would be very useful. CORE could be one approach to this.

2.16: The Approach Elsewhere

It is worth understanding how counselling services are provided and developed in other areas to ensure that Wales learns from good practice and avoids problematic approaches.

2.16.a: England: Models Of Care (MOC)

> The Models of Care provides the framework required to achieve "equity and parity and consistency in the commissioning and provision of substance misuse treatment and care" NTA).

Within the Models of Care report there is a section on the role of counselling within drug and alcohol treatment with particular reference to the difference between specialist (in this case referred to as care planned counselling) and generic counselling. There is a clear definition of these two types of counselling:

> "Formal structured counselling approaches with clearly defined treatment plans and treatment goals, and regular reviews, as opposed to advice and information, drop in support and informal key working" [2]

This clear-cut distinction is used to clarify the exact role of care-planned counsellors and define service specifications. Particular reference is made of qualifications and standards similar to the Welsh DANOS system. Within the research summary the report draws attention to the fact that:

[2] **Models of care for the treatment of drug misusers**, National Treatment Agency, *London* (2002)

> "styles of counselling vary, with less structured approaches generally used in the UK" (MOC Report 2002: 64)

This would seem to correlate with brief research undertaken into structured counselling programmes within England. The vast majority of the residential services that the NTA website provides links to, only offer generic counselling and usually these number about three generic counsellors per service.

Via the NTA, links to other services can be found, many of these services offer structured counselling programs. For example, London has a large number of structured counselling programmes. The exact nature of this structured counselling and its role and workforce is hard to determine based on available data.

2.16.b: Scotland: The Scottish Executive

Within Scotland there exists a wide range of substance misuse services but there are reported difficulties and shortfalls in the co-working of substance misuse and mental health services. Some mental health services are unwilling to deal with clients with a substance misuse problem and refer them onto substance misuse services who are then expected to deal with the mental health issue[3] (Co-Morbid Mental Health in Scotland 2006).

Agencies in some areas perceived themselves as being in competition for finite resources and were not referring clients onto to other services in order to retain funding[3]. At the time (May 2006) when the report on co-morbid mental health was published in Scotland, there was only one reported dedicated team that dealt with these issues. As in Wales there is some uncertainty as to what works and what is good practice and this has created problems for the commissioning of services[3]. Resources are limited which impacts on the ability to deliver specialist services. There is a growing awareness of the need to develop mental health facilities within substance misuse.

△ There was a clear theme of a shortfall in funding which is inhibiting both the development of existing services and the creation of new services. Service providers clearly understood the need for accreditation and quality standards. There is a real sense that the services that exist have not, in the main, developed through an overarching strategic approach. This means that:

- there is no overarching, independent understanding regarding the availability, type and quality of counselling services across Wales. This is an urgent piece of research which should have been completed prior to this exercise;
- the failure to do so means that the value of the data accrued in this research is diminished as there is no way of cross checking responses in order to validate them.

THE WELSH ASSEMBLY GOVERNMENT SHOULD SEEK TO REMEDY THIS INFORMATION GAP IMMEDIATELY

[3] **Co-morbid Mental Health and Substance Misuse in Scotland**, *Hodges; Patterson; McGarrol; Taikato; Crome and Baldacchino*, Scottish Executive Social Research, Edinburgh (May 2006)

SECTION 3: COMMISSIONING COUNSELLING SERVICES

There are a number of issues that were identified with seeking to employ the SMTF and its definitions.

3.1: COMMISSIONING AND SERVICE DELIVERY ISSUES

In addition to the audits that were sent to commissioners, a meeting was held with commissioners in each of the four regions (Dyfed Powys; Gwent; South Wales; North Wales) to discuss matters around counselling service delivery and the related workforce issues. A variety of issues that hinder workforce development and service implementation were highlighted through this process.

- **the majority of commissioners do not directly commission counselling services**

  Where counselling services exist they are commonly funded through a general financial agreement for a package of services often defined by the service provider. This means that:

  a. service design is responsive rather than proactive
  b. there are inconsistencies in service availability and design
  c. providers are not being presented with clear guidance, as illustrated by a comment from a provider:

     "There is a need to provide a more coherent counselling service which forms part of an overall package of care to substance misusers"

- **some commissioners do not fully understand the role or purpose of counselling**

  Some commissioners felt that this lack of clarity was partially as a result of the SMTF module. One group of commissioners indicated that the SMTF is a policy document and not an operational document. Commissioners stated that they would prefer to have service specifications rather than the SMTF's, which they felt were stand alone modules and not interconnected like their English counterparts in the Models of Care (MOC). As one commissioner stated:

  "We get the frameworks but because they're woolly we spend an inordinate amount of time, that we can't afford, discussing them and what they mean and not doing our other work".

- **the lack of clarity on what counselling is impacts on how commissioners commission counselling services**

  In some areas counselling is provided via the local mental health services or statutory substance misuse services. The implications of this are:

  - ⇨ the service model will probably be determined by the health service commissioners to their priorities;
  - ⇨ access for people with a substance misuse problem may not be a priority to already overstretched services;
  - ⇨ the additional expertise for treating the substance misuse issues may not be available
  - ⇨ there are often problems in co-ordinating a care package.

Commissioners who are unsure of what counselling services are, may commission a service that says they do counselling. In reality the service may not be providing counselling as defined in the SMTF but this is difficult for commissioners to identify. The implications of this are:

- ⇨ individuals may receive an inappropriate service;
- ⇨ commissioners may be over funding the service, or funding an inappropriate service;
- ⇨ the service is difficult to monitor and evaluate.

It must be noted that some commissioners do seek to commission counselling services. Gwent have recently undergone a full re-commissioning exercise and have sought to develop a regional counselling service based on DANOS and the SMTF.

Commissioners also recognised that a number of services provide poor counselling services in the sense that they are not providing structured counselling services as defined. In some areas an absence of specialist services can lead to providers delivering services they are not qualified to give in order to deal with a genuine demand.

Providers rightly highlighted the importance of generic 'counselling' and its application in the substance misuse field, as many service users will not require specialist counselling interventions. This is again an issue of definition as no generally accepted term exists apart from 'counselling' for these less formal interventions, and service user need, which would appear to be poorly understood.

> "It is important to recognise the value of good listening but to see that it is a separate activity from the therapeutic interventions"

- **Overall, commissioners know they need effective counselling services but are unsure as to what type and model as they feel this is not explicitly clear in the SMTF.**
- **Additionally, commissioners raised issues regarding funding and training for the development and training of a counselling workforce. For substance misuse commissioners and services this must be balanced against the cost of other services that they provide.**
- **This raises questions as to the role and importance of counselling in the overall delivery of substance misuse treatment. Many felt that counselling should not be provided at the expense of other equally important services.**
- **Providers raise the issue of the need for the delivery of counselling services to form a part of the commissioning process, giving providers clearer guidance on what they are expected to be providing, rather then being left relatively autonomous to resolve the issue:**

> "Clear commissioning specifications need to be drawn up to ensure that there is a skilled, appropriately trained and supported workforce employed to deliver this work"

Providers and commissioners need to undertake an integrated approach in the provision of counselling services with clearer guidance on possible service models. Clearer guidance of what services are expected to be available will help to resolve a number of issues.

EXAMPLES OF COMMISSIONER CONCERNS FROM MEETINGS:

"The Assembly does not fund a commissioner's post in each county but they ask us to develop and produce everything related to the SMTF's, KPIs, commissioning strategy…"

"WAG says there is money for training in Skills for Justice funding but how do commissioners get access to this? Counselling is only one part of the training need, there is a whole range of training needed."

"If they think the counties have the capacity to do this, they're wrong! We can fund training if one of our providers identifies a need but we can't do a structured approach. Everything is piled onto commissioners but often we don't even have time to read what comes out of the Assembly!"

3.2: DATA ISSUES

When researching service data it became clear that there were issues regarding data collection and recording within counselling services. A key issue in considering whether services were being provided against the SMTF definition was that data is not recorded against the SMTF definition. Additionally, there were difficulties in gaining accurate unmet need data. Often rough estimates were given in the audit responses, though on what information these had been based is not clear. **A lack of clearly defined service need data will have a detrimental effect on the planning, development and provision of services.**

At present services are provided when demand becomes apparent and funding is available. With some notable exceptions, there appears to be little long term forward planning of counselling services.

3.3: DETERMINING LEVELS OF NEED

It is worth considering how client need is monitored and determined. Commissioners were asked what processes they employed to determine the level of demand for counselling. The following responses were given:

"SMAT's across … … monitor current provision and any waiting lists."

"Through national and local assessments of counselling effectiveness and local needs assessment."

"New posts were response to the W.A.G. and Strategy on Co – Occurrence"

"Many of the existing services receive what is effectively grant funding and counselling is delivered as a part of their service. However this is being addressed in the specifications that are currently under development for new services and we intend to put in place SLAs (Service Level Agreement) for existing services in 2007-2008"

"The configuration of substance misuse services in … was reviewed during 2005/06 and a new model of service was developed. The review examined the demand and need for services in … by examining quarterly monitoring returns and by interviewing service managers and users."

It is clear based on these responses that in some areas a system of monitoring demand is in place though the approach and methodology is not consistent. Some commissioning bodies are in the process of developing monitoring systems. This development process gives a basis on which further studies of client need can be undertaken and in turn further service development with the accurate placement of resources.

3.3: Mechanisms Used to Determine the Type of Counselling Services to be Commissioned

These can be summarised as:

- SMAT's
- User feedback
- Review of current services
- Assessment of client needs
- BACP standards

From the responses there is no means of evaluating the efficacy of these approaches. However, there are a number of different approaches being used and some areas where this work is not being undertaken.

3.4: Contracting with Providers for Counselling Services

The following methods are reported as being used in order to establish contractual agreements with providers of counselling services:

- SMAT commissioning processes
- Tendering processes
- Regional inpatient detoxification contract
- Service Level Agreements (SLA) (3 commissioners used this mechanism)

SLA's are also used by some commissioners in determining the terms and conditions of employment of counselling staff. In some cases the terms and conditions are left to the service provider, whilst others use BACP standards. These also set out relevant qualifications and experience that should be held by counselling staff.

3.5: Monitoring Commissioned Services

Commissioners need to ensure that funds and resources are allocated sensibly through an active programme of monitoring. A number of mechanisms are currently employed by commissioners:

- SMAT's
- Internal service monitoring
- Annual self-assessment returns outlining their training needs and achievement of the DANOS standards
- Quarterly returns and/or reports from service providers
- Through Care Programme approach
- Qualitative and outcome based approach
- Outcome monitoring

This report is unable to comment on the effectiveness of these methods although indications from the regional meetings with commissioners would suggest that these are not always effective.

3.6: Use of the SMTF and DANOS

There are a number of issues in services utilising the SMTF and the general picture that emerges is of some confusion. Providers were asked on their awareness of the relevant DANOS module (SD10 "Counselling Individuals about their substance use using theoretical models"). Virtually all the returning providers were aware of the module but the current level to which they employ it is varied. Some providers appear to be following the module and acting in accordance:

> "I am fully aware and comply with this module"

Other providers either felt that the module was not relevant to them or were not currently employing the module. One person experienced access issues:

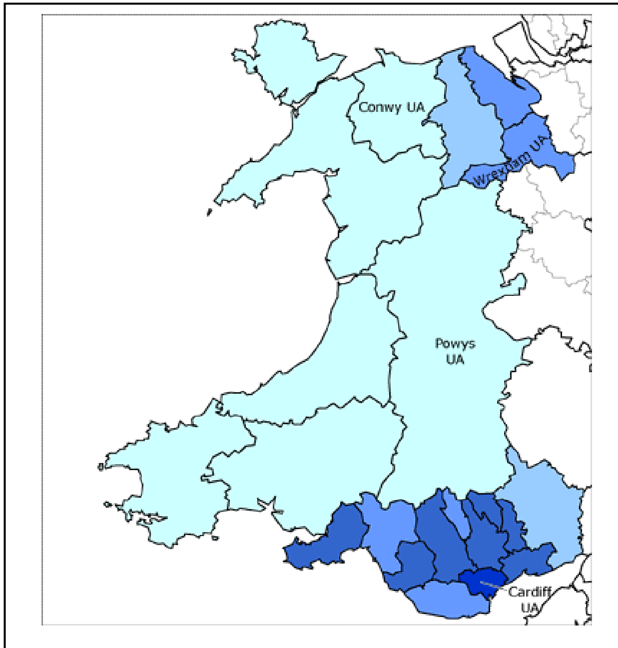
> "I am aware of DANOS but could not find this particular module on the website"

Similar issues around finding and accessing the SMTF module were also experienced by others indicating a need for such standards documents to be more widely available and easier to locate.

SECTION 4: CONTEXT

The areas are defined as Dyfed Powys, South Wales, Gwent, and North Wales. All statistics are based on figures from Stats Wales unless stated otherwise.

The population and spread between urban and rural Wales are well known. Of interest here is a possible link between population density and raised demand. This would have implications for service modelling.

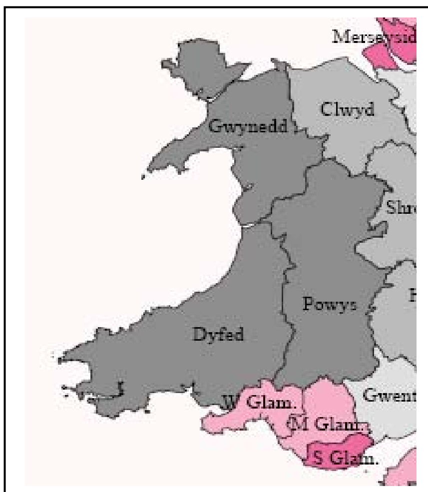


Comparative population density

(National Statistics Online : Population density by local or unitary authority 2001)

Dark blue areas reflect areas of high population density

These figures clearly show the population divide across Wales with the highest population densities being in south-east and north-east Wales. This will have implications for service delivery models and may require different approaches.



Percentage of resident population in rural areas

- Under 5.2
- 5.3 - 10.4
- 10.5 - 20.8
- 20.9 - 31.2
- 31.3 and over

National percentage = 10.4

Proportion of the resident population in rural areas, counties, 1991 Census (published 1998)

Taken from: http://www.statistics.gov.uk/articles/population_trends/urbrurdif_pt91.pdf

Deprivation occurs in both rural and urban areas and is often linked to economic difficulties, i.e. in rural areas the decline of agricultural based industries and in urban areas the decline of heavy industry. The shortest definition of deprivation is of it as 'unmet human need'. The five most deprived Lower Layer Super Output Areas (LLSOA's) were (Welsh Index Of Multiple Deprivation 2005 Local Authority Analysis)[4]:

[4] Welsh Index of Deprivation 2005 Local Authority Analysis

- Butetown, Cardiff
- Rhyl West 2, Denbigshire
- Penydarren 1, Merthyr Tydfil
- Penrhiwceiber 1, Rhondda
- Cynon Taf Castle 2, Swansea

In respect of local authorities, Cardiff had the biggest deprivation score of 78.9 whilst in comparison, Carmarthenshire and Pembrokeshire had scores of 58.6 and 58.4 respectively. Powys had a score of 41.3 and Wrexham a score of 72.5. The highest deprivation scores are in urban areas.

Higher rates of deprivation may not always mean there are higher rates of substance misuse and must be looked at in relation to other factors, such as population etc. However, there is a higher rate of referrals within these urban settings. It should be noted that the data only takes into account clients seen so there may be an unspecified number that are not contained in the data because they are not accessing services by choice, because of access problems or because of a lack of services.

As a percentage of population, the numbers accessing substance misuse services in each area represent:

Dyfed Powys:	0.64%
Gwent:	0.68%
North Wales:	1.48%
South Wales:	0.75%

The three regions of Dyfed Powys, Gwent and South Wales do not show any significant difference but the rate in North Wales is around twice as high. This may indicate that deprivation rates do not have a significant impact of referral rates or they may reflect a lack of services in the other three regions meaning a lower access rate compared to North Wales.

The top ten sources of referral for clients seen in the 2005-2006 period are:

Source of referral	Number of clients seen (2005-2006)
Self	5843
GP	3181
Other	1455
Probation Service	1420
Non-Statutory Drug Service	1083
Statutory Drug Service	1013
Youth Offending Team	822
Social Services	665
Family/friends	649
NHS A&E	586

This may have significance in determining assessment procedures and referral pathways into counselling services and have an impact on service design. Clearly the links with GPs and criminal justice services are crucial. These would be good sources in helping to identify demand for counselling services and to explore models of delivering these services.

As already indicated, the available statistics are not currently able to identify the service delivery and demand against the SMTF module definition. It would also be useful to be able to match the data against the deprivation data to identify if deprivation has any links to higher demand for counselling. This would, of course, require the analysis of current service provision and a match to the degree to which services are delivering counselling as defined in the SMTF.

SECTION 5: CONCLUSIONS

5.1: REPORTED ISSUES

There are a number of reported issues in relation to the current counselling service provision:

- DIFFERING PERCEPTIONS: There is a discrepancy between commissioner and provider views of the current service availability, workforce situation and apparent service/workforce shortages. This is creating an inconsistent approach in the implementation and provision of services across Wales.

- SERVICE AVAILABILITY: There is no comprehensive, independently verified directory of counselling services. This means that commissioners are dependent on provider's self-reporting. The development of an independent checklist to verify the degree to which services are meeting the SMTF would be of great value.

- SERVICE DEMAND: There is no detailed needs analysis to clarify what is the actual demand for this service.

- SERVICE MODELS: Providers and commissioners are unsure in some areas as to what sort of counselling they should be providing and are unclear on certain aspects of the SMTF definition. There is a need for clearer guidance on what type of service is needed. This should come from a client-centred approach developed from client consultation and service outcome monitoring.

- MONITORING OF STANDARDS: It was indicated that there were time and funding issues that could be prohibitive in implementing an effective monitoring system. Questions were raised as to the standards that should be followed and the validation process for these. This report has commented on the CORE system and that relatively straightforward outcome monitoring systems could and should be developed.

- WAITING LISTS: In some areas providers and commissioners are faced with expanding waiting lists that they cannot currently resolve due to staff shortages and funding issues. One area was experiencing a five month waiting list and is in need of additional staff to help deal with this issue. However, it would appear from the responses that the problem lies mainly with funding new posts rather than attracting suitable staff.

- UNMET NEED: In some areas this is an increasing issue and this is often due to the absence of appropriate services and funding. There is also an aspect where this service has not been a commissioning priority (nationally or locally) leading to either a lack of service or an unplanned response via other packages of funding which are usually provider led.

- YOUNG PEOPLE: Issues of the provision of mental health services to young people was also raised and it was felt that there currently exists a gap in the provision of such services. Most services focus on the above 20 year old range and in dealing with issues such as Hidden Harm there needs to be a greater provision of young people's counselling.

- WORKFORCE STRUCTURE: The need for a flexible workforce that can adjust to changes and developing trends in the substance misuse field was expressed. Services do not want to invest time and money into something that may be invalidated within a short period of time. This is particularly true of smaller services where funding is limited.

- COMMISSIONING: Commissioners need to be providing service providers with clearer guidance and specific, targeted funding to develop SMTF defined counselling services.

5.2: CONCLUSIONS

Levels of counselling services are varied and clearly linked to a number of factors. A consistent issue was around the SMTF and a perceived lack of clarity on what services are meant to be developed. The commissioners' view was that the SMTF does not provide a clear service model. A clear and well-defined service model is what the majority of commissioners would like to see, with a clear set of definitions and expectations. Alongside this they would want to see realistic outcome measures and funding to match.

Providers also expressed problems with the SMTF but the majority of providers have made use of other systems and standards, the most common being the BACP. There are variations across the regions in respect of the current availability of counselling services and staff. However, the shortage was mainly expressed as one of funding for services rather than a lack of suitable staff.

Another problem is that there exists no clear needs analysis or review of counselling services. It was not the goal of this report to do either but to determine the levels of workforce, shortages and standards. Future development needs to be done through a detailed analysis of need and greater awareness of the currently available counselling services. Adequate funding could then be applied where needed rather than, as the commissioning process seems to indicate, when a need becomes pressing or a provider asks to develop a service. Such an approach will not be able to cope with what appears to be increasing demand for counselling.

There are some areas where counselling services appear to be operating to the SMTF definition and employ accredited staff. In addition these services use external accreditation.

Overall, the delivery of counselling services is patchy and not well understood. Therefore, it is hard to produce a definitive view on the degree to which there is a shortfall in the workforce. Much more needs to be done to identify the current service pattern and to develop services before this can be fully known.

PART TWO: WORKFORCE DEVELOPMENT

1: THE STRATEGIC BACKGROUND TO WORKFORCE DEVELOPMENT AND LIFELONG LEARNING IN WALES

A number of key strategic documents have been examined to site the development of counselling training within the wider strategic context in Wales.

1.1 The strategic agenda for Wales[5]:

In Wales: A Better Country[6] the Welsh Assembly Government sets out its overall vision for change, with four key priority outcomes linked to the underpinning priorities of sustainable development, social justice and equality of opportunity. These priority outcomes are:

i. helping more people into jobs;
ii. improving health;
iii. developing strong and safe communities; and
iv. creating better jobs and skills.

The fourth aim identifies the need to improve the skills-base of the workforce in Wales and links to the workforce development issues explored within this piece of work.

1.2. Learning and the Economy[7]

According to ELWa, every business in Wales should value the benefits of learning by continually investing in workforce development and accessing the training needed to move forward. Between 2005 and 2008, there are a number of headline priorities that link to workforce development in the substance misuse field, including:

- An integrated, flexible business support service with the Welsh Development Agency and its successor to meet employers' specific needs;
- An enhanced programme of management and leadership training, prioritised to employer need;
- A new Workforce Development Account as the main way for providing direct support to employers;
- Investment in the Credit and Qualifications Framework for Wales extended to increase learner and employer participation and attainment in workforce development;

1.3. Sector Skills Councils (SSCs)

A new network of UK wide Sector Skills Councils (SSCs) has been set up to lead the skills and productivity drive in industry or business sectors recognised by employers. They bring together employers in their sectors, learning providers, trade unions and professional bodies to work with the Welsh Assembly Government to develop the skills that businesses in Wales need.

Each SSC agrees sector priorities and targets with its employers and partners to address five key goals to:

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[5] http://www.elwa.ac.uk/ElwaWeb/doc_bin/NPFSallocations/ELWa%20NPFS%20Sect_1.pdf
[6] http://www.elwa.ac.uk/doc_bin/SkillsObservatory/Learning%20Country.pdf
[7] http://www.elwa.ac.uk/ElwaWeb/elwa.aspx?pageid=3447#3

- Identify and articulate their sector's skills needs.
- Help develop more responsive provision to meet business needs
- Provide the business case for skills
- Engage employers in skills development
- Influence skills policy

There are two SSCs relevant to developing the workforce in substance misuse counselling, Skills for Health and the Care Council for Wales.

1.3.1 Skills for Health

The sector is very large and complex with a wide range of employers and occupations, employing 2.2 million people across the UK; over 150,000 in Wales. Around 70% are employed in the NHS Skills shortages are evident across the range of occupations and there are similar skills shortages across the UK as a whole. A key part of the role of Skills for Health in Wales will be the development of a business plan for Wales working with employers and key stakeholders.

1.3.2 The Care Council for Wales

The Care Council for Wales was established in October 2001 and is an Assembly Sponsored Public Body (ASPB), accountable to the Assembly for its functions. It aims to promote high standards of conduct, practice and training for social care, to ensure a properly trained, appropriately qualified and effectively regulated workforce for children and adults receiving social care services.

It is responsible for agreeing codes of practice which apply to social care workers and employers across the social care sector; setting up a register of social care workers to improve public protection, making sure that registrants found unfit to work in the sector are prevented from working in the sector; ascertaining training needs and promoting training across the social care sector; regulating social work qualifying and post qualifying training.

1.3.3 Sector Skills Agreement

The Sector Skills Agreement (SSA) is a five stage process to establish a common set of goals for employers, training providers, funding bodies and the government. Skills for Health is managing the SSA process for the health sector and it is a core part of their remit.

1.4. The Welsh Assembly Government and the Skills for Business network (SfB)

The Skills for Business (SfB) network, by bringing together all twenty four Sector Skills Councils in Wales, aims to help Wales to compete in a global economy through improving skills, encouraging the development of appropriate qualifications to meet employer's needs, and providing crucial labour market information to show where the needs are greatest. The Welsh SfB meets regularly as a team to reflect the needs and uniqueness of the Welsh situation.

1.5. Credit and Qualifications Framework for Wales (CQFW)[8]

The Credit and Qualifications Framework for Wales (CQFW), established jointly by the Welsh Assembly Government and the Higher Education Funding Council for Wales (HEFCW), covers all post-16 and higher education. From 2003 all learning, including mainstream qualifications, has been brought into this single framework that merges credits (learning achievements) and the levels (demands of learning) into a unified qualification system .

1.6. The National Planning Framework and Funding System[9]

The new National Planning and Funding System (NPFS) will help modernise the post 16 learning network, strengthening links between learning needs and delivery and ensuring equitable funding for schools, colleges and training providers. The new system will offer more choice for learners and more focus on quality learning, with less wasteful competition amongst providers and should increase the number of people in learning in Wales. Planning and funding will be based on demand intelligence from Sector Skills Councils, Community Consortia for Education and Training, and quantitative and qualitative market research, to make education and training supply more responsive to learner and employer demands.

1.6.1 Key Principles of the National Planning Framework[10]

The NPF is designed to be:

- learner-centred - ensuring learners have access to a wide range of available, high quality learning opportunities;
- reflective of the current and future needs of individuals, employers, communities and the wider social and economic needs of Wales;
- transparent and evidence based flexible enough to respond changes in the short to medium term, whilst focused upon long terms goals; able to allow providers to plan on the basis of security;
- responsive to the Welsh Assembly Government's priorities and related policy initiatives

1.6.2 Key Actions to be taken forward[11] include:

- A joined-up, comprehensive approach to supporting business including a new model for addressing human resource needs through Workforce Learning Accounts, combining a business assessment of training needs with flexible packages of support to meet them.
- A sector-based approach to address employer demand for skills through Sector Skills Agreements.

1.6.3 ELWAs interim report *"Developing the Workforce: Learning in and for the Workplace*" (August 2004) stated that learning must provide employer-responsive provision with greater bespoke provision for employers, a drive for quality and improved learning products along with improved processes to deliver such learning.

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[8] http://www.elwa.ac.uk/ElwaWeb/elwa.aspx?pageid=1612

[9] http://www.elwa.ac.uk/ElwaWeb/elwa.aspx?pageid=1404

[10] http://www.elwa.org.uk/elwaweb/doc_bin/national%20council%20circulars/ncc0601npfs_eng_final.pdf

[11] Taken from an internal Welsh Assembly Government document entitled *Skills Action Plan notes* provided by email by DELLS personnel in December 2006.

1.7. HEI Support for Business & Communities

Higher education institutions (HEIs) contribute more than £1 billion a year to the Welsh economy and have an important economic and social function. Businesses can tap into the technology and expertise of their local HEI and employers have a source of skilled workers. Higher education institutions support businesses by developing research programmes with businesses or independently; providing tailored courses for businesses to improve their workers' skills; promoting centres of excellence, often between HEIs, for high level, immediate opportunities for business advice (eg Centres of Excellence for Technology and Industrial Collaboration - CETICs). All HEIs have an Industrial Liaison Officer and a dedicated point of contact for businesses. One of their roles is to link with local decision makers such as local authorities, NHS trusts, and regional economic fora, leading to better informed decision making.

1.8. Third Mission Fund

HEFCW's Third Mission Fund supports higher education institutions (HEIs) in activities that bring economic and community benefits on a rolling three-year strategy (from 2004/05 to 2006/07) for activities which include services to business – eg training and consultancy; contract research; and skills & employability – eg developing graduate skills suitable for the workplace, working with employers to develop the curriculum. The Third Mission Fund acts as a catalyst to ensure that third mission activities are embedded in HEIs' overall strategic planning and managed at an appropriately senior level and maximises opportunities for HEFCW and institutions to work with partners. The Fund will increase from £4.1m in 2005/06 to £6.1m by 2007/08. All HEIs in Wales have a dedicated enquiry point for small and medium sized enterprises (SMEs) that assist SMEs in identifying business needs over half actively involve employers in curriculum development. 11 out of 12 offer distance learning for business while seven deliver work-based learning. 11 offer short bespoke courses for business on campus and seven offer short bespoke courses on company premises.

1.9. Community Consortia for Education and Training (CCET)

CCETs have been the Welsh Assembly Government's essential link with the local learning market, achieving more efficient delivery of education and training and promoting collaboration between schools, FE, training providers and others to meet the needs of individuals and employers. The Assembly has been working in partnership with the CCETs from each of the four regions identify opportunities for improved provision, including new patterns of collaboration and where necessary, rationalisation; ensure the work of education and training meets the needs of employers and others at every stage; and to ensure that collaboration with Higher Education institutions is sustained and enhanced.

1.10. Welsh Substance Misuse Workforce Development Strategy[12]

The Substance Misuse Policy Development Team established a workforce development group in August 2005 to prioritise and advise on the recommendations made in the All Wales Training Needs Analysis. This is the first step in ensuring the development of effective working relationships with key partners which will see the development of a longer term strategy at local, regional and national levels. The group will:

[12] Welsh Substance Misuse Workforce Development Strategy (2006) Cardiff: Welsh Assembly Government

- Define and describe the drugs and alcohol workforce in Wales including specialist and non specialist workers
- Provide a competency breakdown for each major occupational group mapped against the Drug and Alcohol National Occupational Standards (DANOS)
- Provide a Training Needs Analysis matched against DANOS
- Make recommendations for workforce development based on the study's findings

This work will operate through the Workforce Development Group with ministerial oversight; regional government structures i.e. the Substance Misuse Regional Advisory Teams; and local delivery structures, i.e. Community Safety Partnerships and their associated commissioning bodies.

1.11. Comment.

The Welsh Assembly Government[13] will determine learning provision and ensure that it meets local needs by using all available sources of information (including Community Consortia of Education and Sector Skills Councils) in order to underpin Regional Statements of Need. However, the Assembly itself acknowledges that there are problems ensuring that stakeholders are plugged in to these systems and that they know about them. The Assembly acknowledges that employers suffer more from gaps in the skills of their existing workforce than a shortage of skilled recruits and that they have to ensure that suitable qualifications and learning provision are available and well understood, particularly in the light of problems faced by small and micro organisations. However, smaller businesses lack the cash and time resources to devote to off-the job training and fear poaching and increased wage demands. The Assembly suggests supporting managers to become better trainers themselves; and looking at ways for professional trainers to provide more customised training support on site (including the use of e-learning technology).

Many employers are attracted to short, sharp, highly focused and non-accredited training programmes for their staff, missing out on qualifications and public sector financial support. The Assembly acknowledges the need to build a more flexible qualifications structure allowing for qualifications to be tackled in manageable chunks and built up over time along with straightforward assessment processes with the least possible bureaucracy. The unit and credit approach will increase the flexibility and relevance of qualifications in Wales which will gradually be brought into the Credit and Qualifications Framework for Wales (CQFW) to allow partial achievement to be recognised. It is important that the development of training, qualifications and workforce in the substance misuse field in Wales is fully integrated into the Assembly's proposals for Lifelong Learning. However, it is important to acknowledge that this is a highly specialised area of expertise and that it may be unrealistic to expect substance misuse commissioners and treatment providers to be fully cognizant with the issues and infrastructure attached to Lifelong Learning.

[13] Taken from an internal Welsh Assembly Government document entitled *Skills Action Plan notes* provided by email by DELLS personnel in December 2006.

2: RESPONSES FROM COMMISSIONERS

2. 1. Identified shortfalls in substance misuse counselling training

Some commissioners admitted that they do not know if they have a shortage as they do not know what they currently have in place. There is no clear understanding of what 'substance misuse counselling' is and what qualifications and training are needed for this. The availability of training and accreditation does not guarantee a pool of qualified people, for example, although there is a diploma course at University of Wales College Newport, commissioners report that there are not enough people trained to that level; most trainees attain certificate level at a local college of further education, while there is a severe local shortage of counsellors especially for mental health services with not enough staff suitable for delivering training or to be trained.

In the South Wales region there is no shortage of trained counsellors or training in Cardiff and the Vale, but there is perceived to be a shortage elsewhere in the region. Commissioners in North Wales were fairly confident that the local service provider, along with many local institutions, was able to provide a large pool of trained counsellors. In Dyfed Powys however, trained counsellors were more likely to be attracted from outside the area,

"*Counsellors just appear in our county ready trained. They move in from outside*."

Most of Wales seems to be well provided for in terms of accredited courses, except Dyfed Powys which has introductory and foundation level counselling courses in one county, but no advanced courses. In North Wales, commissioners stated that there is 'almost an over-provision of training' in the area, which also includes Lancashire. However, in South Wales a number of colleges locally (Swansea, Bridgend, Ammanford) have lost their franchises from UWC Newport to deliver counselling training. Furthermore, the system of training and qualifications delivery is based on a competitive commercial market that might undermine local training providers. An example was given of someone starting a BACP accredited counselling course, costing £400, in a local college of further education which was cancelled because of lack of numbers –it was the victim of competition with a local university course which was being provided for free, although it was not accredited. One regional commissioning group expressed concerns about training costs, claiming that they have been told that there is money for training in Skills for Justice funding but not how commissioners might access it.

In South Wales it was highlighted that workforce development regarding substance misuse counsellors followed a 'chicken and egg' scenario; the more students that are placed in substance misuse settings, the greater the numbers of competent counsellors entering the field. However, it was felt that many treatment agencies who take on counselling students are not geared up to supervising therapies so a lot of students have bad experiences and leave the field. A number of voluntary sector agencies recruit and run their own courses and training – but do not conform to any set standards or accreditation systems.

2.2. Monitoring qualifications

Commissioners were asked whether they check the qualifications and experience of those they commission to carry out counselling. Mostly they do not – one group of commissioners were unaware that they were commissioning any counselling at all. Some had included it in service level agreements, but did not specify monitoring criteria. In one region, there is a mix of staff who are qualified and unqualified in counselling, but no-one seemed to know whether they are qualified at Diploma or Certificate level. This raises the risk of providing an unequal service.

2.3. Commissioning training

Most commissioners do not commission substance misuse counselling training and would not know how as they are not plugged into local training networks. If they were to be expected to commission and pay for training as well, there would be funding and capacity issues as this would be way outside their remits and experience. Locally, commissioners felt that they could not cope with working with training providers, colleges, accreditation bodies, CCETs etc.

"*If they think the counties have the capacity to do this, they're wrong! We can fund training if one of our providers identifies a need but we can't do a structured approach."*

In one region there had been plans in the past for a regional training coordinator, but those were shelved when the DAATs went. There are a lot more constraints on commissioners now and less chance of getting a post like this through the system.

"*The Assembly does not fund a commissioner's post in each county but they ask us to develop and produce everything related to the SMTFs, KPIs, commissioning strategy…"*

Commissioners in another region stated that they did not feel that they could commission training although they acknowledged that service providers would probably want commissioners to pay for training. They did not know about CCETs, Elwa etc…

"how on earth can you do it locally?"

Mention was made of organisations with training functions such as Newlink Wales and CAIS that can make links with colleges on the behalf of commissioners. However, one commissioner pointed out that the Assembly was reluctant to approve spending on training and workforce capacity building in local plans. Another group of commissioners stated that although their local university,

"*turns out a lot of highly qualified counsellors, can we afford them?*"

Training could possibly be organised regionally but the overwhelming majority of commissioners felt that such specialised training as this should be dealt with nationally.

3: RESPONSES FROM SERVICE PROVIDERS

Our findings show that local commissioners do not commission training. It is often provided internally or purchased directly by service provider organisations, for example some service providers purchase BACP accreditation.

3.1. Access to counselling training and qualified staff

Access to counselling training was not a problem except in Dyfed Powys. There seemed to be little problem with recruitment of suitably experienced and qualified counsellors amongst the respondents, with all providing additional in-house training, and there was no perceived problem accessing suitable training, citing colleges and universities including UCNW Bangor, UCW Newport and UCW Swansea.

In South Wales, one service provider stated that they have a close working relationship with local colleges who provide counselling courses. The service offers placements together with recognised training within their model to these students who often go on to become supervised volunteers. The agency then often recruits from this pool of volunteers. Two other agencies in South Wales stated that they have no problems with recruitment.

3.2. Qualification and training status of counselling staff in a sample of responding agencies

Agency	Cardiff CADT	Ogwr DASH	TEDS	CAIS
No. of staff delivering psychological therapy and psychosocial interventions	3 Full Time 14 Part Time 2 sessional workers 12 qualified volunteers each seeing approx 2/3 clients per week.	Five	Two	
No. of staff holding recognised qualifications in psychological therapy and psychosocial interventions	All staff qualified to at least Diploma in Counselling, together with additional qualifications and specialisms within the counselling profession	1 full time, 2 part time and 2 additional full time staff for group work.	Two full time counsellors. Occasionally we also have trained volunteers	By March 2007, approximately 50% of the counsellors will be fully BACP accredited with the remainder completing their studies by March 2008. We believe that this should be the gold standards qualification for this therapeutic type of intervention which is subject to misinterpretation by others.
Qualifications	Diploma in Counselling; Masters in Counselling; Diploma in Counselling; Supervision Diploma in Cognitive Therapy; All trained in Motivational Interviewing and some are part of the M.I. worldwide network of trainers in this approach.	Post grad diploma in substance abuse; B.A.C.P. post. grad diploma in counselling; Certificate in counselling theory, skills and ethics; Certificate in bereavement counselling. Certificate in welfare studies; OCN in drugs/alcohol (in house training); Child protection (Gilbert/Marriot)	Diploma in Counselling; Diploma in CBT; Diploma in Consultative Supervision; BSCHons Behavioural Science; Masters in CBT	All CAIS counsellors are already qualified through the VACS system and also process *[sic]* an appropriate diploma in counselling.

Agency	Cardiff CADT	Ogwr DASH	TEDS	CAIS
Codes of Practice	Organisation member of the B.A.C.P. Individuals are members and accredited by B.A.C.P.	Regular supervision; Subscription to relevant publications; Adherence to ethical code.	Supervision with experienced qualified supervisor.	
Supervision procedures	As set down by B.A.C.P; opportunities for informal supervision; line management. External supervisor on a monthly basis for one and a half hours.	Access to supervision immediately when required. Group supervision weekly	Follow BACP guidelines. Monthly	
Qualifications of supervisors	Diploma in Counselling and appropriate training around clinical supervision	12 years experience of working in the drug/alcohol field; Post grad diploma substance misuse; Counselling skills, theory and ethics; Trained in child protection, self harm abuse and domestic violence.	Diploma in Counselling; Diploma in Consultative Supervision	
Other	People who work for Prism come from a range of professional and experience-based backgrounds. Many staff have counselling qualifications from Certificate to Masters level, but as Prism employees they are not regarded as counsellors, they are substance misuse workers.			

4: WORKFORCE STANDARDS, ACCREDITATION AND QUALIFICATIONS

Views were sought from commissioners, service providers, and representatives from skill sector councils, the Welsh Assembly Government (DELLS) and accreditation bodies. The All Wales Training Needs Analysis identified a very large number of job titles within the specialist substance misuse field and in its analysis of 556 job titles, 'Counsellor' was cited 61 times or over 11% of the total making it the largest cluster (the second, 'drugs project worker' featured 59 times, just under 11% of the total and Administration worker in third place with 56 or 10%). However, it is unclear what level of qualification and experience was required by these posts. One commissioner commented that,

"workers are often just recruited into a job titled 'counsellor', but only 16% of substance misuse counsellors' across the UK are qualified."

The All Wales Training Needs Analysis highlighted that although practitioners were enthusiastic about the notion of baseline framework of expertise (DANOS), there seems to be less enthusiasm for a wraparound comprehensive system, preferring central points for information on current training with a degree of quality assurance attached along with a well developed sense of pathways and cross-discipline.

5: DEVELOPMENT OF NATIONAL OCCUPATIONAL STANDARDS IN PSYCHOTHERAPEUTIC INTERVENTIONS AND COUNSELLING

The Skills Sector Councils (SSCs) have developed from the National Training Organisations that were responsible for setting National Occupational Standards (NOS). There are two Skills Sector Councils relevant to counselling and psychosocial therapies: the Health SCC and the Care Council for Wales. The Health SSC has produced a Project Initiation Document outlining its future plans, including the development of NOS for psychosocial therapies. At the moment the responsibility for NOS in counselling lies with ENTO, but this may be transferred to the Health SSC. The Health SSC is currently scoping projects including developing NOS in psychosocial therapies and the functions of psychotherapists (but not all therapies). It is still in its early stages with a strategy group, plus functions undertaken by counsellors. This is being tied in with developments within the Welsh Assembly Government.

The scoping exercise is identifying what the different therapies are; what is the need for them; how broad is the scope of the work. In the past a lot of the competencies in the health sector have dealt with clinical functions based on firm evidence but there is not so much evidence for psychosocial therapies. Criteria will be sought across the UK for:

- Effectiveness
- Extent and degree of use and
- Extent and degree of formalised training

An initial consultation will take place through November and December 2006 with a broader consultation from January 2007. There should be generic National Occupational Standards by March 2007and the process for more specialised therapies should be completed by the end of the year e.g. Cognitive Behavioural Therapy (CBT), humanistic, interpersonal, family, systemic, hypnotherapy etc. This development will also look at the application of different therapies with different conditions, which could be a key issue for substance misuse, to identify what really works.

6: DEVELOPING NATIONAL OCCUPATIONAL STANDARDS AND QUALIFICATIONS FOR SUBSTANCE MISUSE COUNSELLING IN WALES

The Health SCC suggest that tying everything together may be difficult and suggests two stages, the first is to tie in with British Association of Counselling Practitioners (BACP) criteria; the second to tie into the NOS developed by the Health SSC. The Health SCC could develop a framework of qualifications for the substance misuse field but would have to work with the Welsh Assembly Government on this. Some awarding bodies have devised qualifications based on DANOS in consultation with SSCs and government departments.

The main focus for the Care Council for Wales is to maintain high standards of social care for adults, children and young people through the development of National Occupational Standards.

Psychotherapy is only a small part its profile, although other talking therapies are covered. Its principal focus is around the application of DANOS though working with the Health and Justice SCCs to develop clusters of DANOS into awards, based on recommendations in the all-Wales Training Needs Analysis which found that employers prefer bite-sized chunks of training to large scale courses. The Health and Social Care NOS already include many DANOS . The health, social care and justice SSCs will work with the Awards Bodies to accredit them, while the Welsh Assembly Government will work with training providers.

Potential routes for development of qualifications

- Health

In terms of qualifications and accreditation, there is a national quality framework for health:

1st stage is gatekeeping (e.g. SSC)

2nd stage is adoption by the QCA or its Welsh equivalent

3rd stage would be to approach the awarding bodies

4th stage is to have the standards used in Further and Higher Education

In Wales, the development of the Credit and Qualifications Framework allows single units to be accredited through the Quality Assurance system; the SSCs can suggest units to be linked together, rather than develop a proliferation of small awards. The Care Councils in the UK have developed skill sets for a number of service user groups including drugs and alcohol which will be transferred onto an interactive CD Rom and sent out to all services.

- Vocational qualifications

It is possible to develop vocational qualifications (NVQs) from NOS. However, although competencies will be developed, they will not be assigned levels until they are incorporated into a qualifications framework. NOS will be the basis of the workforce design but may not be developed as NVQs; such development depends on how many practitioners will want to do a qualification and at what level (i.e. 2, 3, 4, 5). Substance Misuse NOS would have to be combined with other suites of competencies to form an NVQ qualification.

If it is intended to develop a vocation-related qualification, it would have to be adopted by Awarding Bodies such as City & Guilds, Edexcel etc. They will want to know how commercially viable it is, how worthwhile it will be for them to develop and implement an Award as they are operating in a commercial market.

There are difficulties in the Health field in getting qualifications developed because of very small numbers so the Awarding Bodies will not foot the cost of development. Most qualifications for health and social care are quite generic with few specialist qualifications because of the low numbers requiring them. Historically the Awarding Bodies work through employers and have been let down in the past by developing awards on the basis of over-estimates from employers. Most Awarding Bodies will require at least 1000 people a year to make an award viable.

- Academic qualifications

The other option would be to develop a qualification through a university, such as a Higher Education Diploma. Universities will develop qualifications for smaller numbers but will charge a lot more to the individual – typically around £2,000 for a HE Diploma.

The Credit Qualification Framework For Wales (CQFW) means that individuals can gain qualifications through the accumulation of credit-rated units. Some Welsh universities are recognised bodies that can place qualifications into the CQFW as they meet the Credit Accord for Wales. In theory a generic diploma with additional learning could be credit-rated in the CQFW towards another qualification OR simply as additional credits.

Qualifications can be delivered by the universities who are awarding bodies – a separate training provider would have to be recognised by the university – there are around fourteen recognised bodies in Wales including the Universities of Wales and Glamorgan, City & Guilds and Edexcel. Many Welsh universities have already put their existing qualifications into CQFW modules and units. Continuing Professional Development (CPD) could be utilised for a specialist module on top of a generic counselling diploma, with the specialist input credited at the same level or higher.

Currently, CAIS and Newlink Wales both accredit courses through universities (although Newlink Wales does not feature counselling qualifications in its course programme) through University of Wales Bangor and University of Wales College Newport respectively. This means that a credit can be gained, linking to the Credit and Qualifications Framework in Wales and allows issues surrounding drug and alcohol abuse to fuse with expertise in higher education quality assurance and accreditation. The collaboration allows modules of higher education to be offered to the wider workforce, not just within one agency.. For example, CAIS's collaboration with the Department of Lifelong Learning within the University of Wales Bangor Credits offers a formally accredited programme in Drug and Alcohol Counselling with 30 credits at Higher Education Level 1.

- Accreditation via a specialist central awards body[14]

The Counselling & Psychotherapy Central Awarding Body (CPCAB) is a UK awarding body managed by professional counselling practitioners, trainers and supervisors in its 13th year of operation, it is the only awarding body in Europe to specialise in the field of counselling. One of the largest awarding bodies in this field, it has around 130 Recognised Training Centres across the UK, but none in Wales and around 10,000 candidates registered annually.

CPCAB has accredited three centres/organisations to deliver substance misuse counselling qualifications, Clouds in Wiltshire, plus RAPT and ADAPT in prisons. All their criteria are linked to DANAS and they work closely with the various centres and ensure they are providing excellent training and a good qualification. There are currently no centres providing this training in Wales, but CPCAB has expressed an interest in assisting new centres to start and they have a policy of providing considerable support for tutors/centres preparing for approval. They also visit regularly to ensure that work continues to meet their standards after approval.

The Open College Network.

A number of short courses on offer in substance misuse counselling, for example Motivational Interviewing via organisations such as Drugaid and the Training Exchange, have been accredited through the Open College Network. These include courses accredited at levels 2 and 3, which correspond to NVQs 2 and 3 within the Credit and Qualifications Framework. However, these do not meet the higher level of accreditation necessary to conform to the Welsh Assembly Government's Treatment Framework for counselling and psycho-social therapies.

[14] Information via email from http://www.cpcab.co.uk/; Sue Chance, Deputy Head of Qualifications, schance@cpcab.co.uk

Other examples of workforce development

- **Scottish Training on Drugs and Alcohol (STRADA)** [15]

STRADA is linked with the Department of Adult Continuing Education at the University of Glasgow and offers a very large range of DANOS linked accredited courses encompassing the broad spectrum of substance misuse training and professional education. It provides a centralised service but currently offers only two counselling-related courses, on Motivational Interviewing – Introduction and Practice-based.

- **Cardiff workplace development and training**

CADT in Cardiff has been recruiting and training specialist substance misuse counsellors for some years. They are trained to BACP criteria and the service focuses on development and practice needs in generic counselling along with best practice in substance misuse on top, delivered through in-house modular training. The service receives 1500 new referrals a year and are meeting the demand but with some shortfalls. They have expanded their team with volunteers trained to Diploma standard who are supervised within the team. This also helps with recruitment. They have close links with Newport University and Barry College counselling courses who provide them with students. Their counsellors are registered with BACP and operate within a defined structure. Each full-time counsellor delivers 15-20 hourly sessions face-to-face.

CADT operates on the principle that substance misuse counselling needs to be within a therapeutic holistic approach to meet other issues, but specialist counselling in substance misuse has better outcomes than generic counselling. However, counsellors need a qualified generic response to all people's problems. Some agencies will compartmentalise clients who need to address other issues such as bereavement and abuse etc. Substance misuse counsellors need core skills to diploma level then specialist Substance Misuse skills added on. It is not just about training people to be counsellors but also specialist training in what works for a specific client group. Therapists must believe that it's their role to deal with substance misuse; they need up to date knowledge; they need appropriate support.

- **Gwent Training strategy**

The Gwent commissioners are jointly putting in a training strategy across Gwent, firstly mapping existing staff and then mapping against the training needed. The mapping is not yet ready for consultation as providers not coming forward with all the information needed on their staff training and qualifications.

At the moment the commissioners are using DIP funding to buy in non-accredited training mapped to DANOS. Some colleges are providing volunteers to BACP standard and in future it is hoped that these could feed into a pool of qualified staff. The commissioners are happy to take on the training role as a region but need funding as they cannot pay out of current budgets.

[15] http://www.projectstrada.org/index.asp?id=192

7: CURRENT TRAINING AVAILABILITY

UNIVERSITY OF WALES NEWPORT

Substance Abuse Issues for Non-Specialist Counsellors (ref. 078)
Qualification: Certificate of attendance
Accreditation: None
Requirements: For non-specialist Counsellors
Time: 2 day Summer School
Location: University of Wales Newport, School of Health and Social Studies
uic@newport.ac.uk

CAIS

Introduction to Drug & Alcohol Counselling
Qualification: 30 credits at Higher Education Level 1
Accreditation: Bangor University
Requirements: For those who are working with or intend to work with individuals who have problems with drugs and/or alcohol
Time: 1 day a week for 8 weeks
http://www.cais.co.uk/pages/training/CaisTraining.pdf

HIT

HIT provides a Certificate in Counselling People with Drug and Alcohol Problems course in Liverpool, which is accredited by the Award Body Consortium (ABC), incorporating CENTRA. This course enables specialist young people's and adult drug workers to develop the skills necessary to provide care-planned counselling as defined in the Models Of Care. The course runs over two terms. Students are expected to attend 14 evening sessions and a short non-residential event per term.
http://www.hit.org.uk/displaypage.asp?id=17

LEEDS ADDICTIONS UNIT

Cognitive Behaviour Coping Skills
Qualification: Certificate of attendance
Accreditation: None
Requirements: For people who require specialist training in the alcohol and drugs field. Current experience of working with people with drug and alcohol problems is an advantage.
Time: 4 days

Graduate Diploma In Addiction Studies:
The focus of the programme is the development and enhancement of clinical skills for those working in the addiction field and an examination of the evidence base which supports them.
Modules Include:
Alcohol, Drugs and Harm Reduction, Motivational Interviewing, Cognitive Behavioural Coping Skills, Family and Substance Misuse, Social Behaviour and Network Therapy, Substance Misuse and Criminal Justice.

BSc (Hons) Addiction Studies:
This course is designed for those who are currently practising in the field of health, social welfare and addiction and would like specialist knowledge and practitioner skills in the treatment of addiction field.
Modules include:
Prevention, Alcohol, Drugs and Harm Reduction, Intervention, Motivational Interviewing, The Family and Substance Misuse, Psychopharmacology and Physiology of Addiction,

Advanced Motivational Interviewing, Social Behaviour and Network Therapy, Substance Misuse and Criminal Justice.

http://www.lau.org.uk/training/courses.htm

THE TRAINING EXCHANGE
Evidence Based Approaches to Counselling Substance Users
Drawing upon the most up-to-date research on treatment outcomes, EBA is a training programme that aims to develop the knowledge, understanding and skills that enable students to demonstrate competence in supporting drug users through change.
Students are assessed and can submit evidence to accredit their learning with the National Open College Network (OCN). The course encourages participants to put theory into practice by combining input with activities to rehearse and develop skills. The course is divided into 4 units; students need to attend 13 days of formal training (78 hours) that take place over 8 months.
Accredited through the Open College Network Levels 2/3

http://www.trainingexchange.org.uk/courseinfo.asp?courseid=42

CLOUDS
Addictions Counselling (ref. 232)
Qualification: Foundations Degree
Accreditation: Mapped to DANOS, Accredited by Bath University
Requirements: full-time basis for novice practitioners, or a part-time approach for those already working in the field.
Method of Learning: Evidence-based, with work placements and residential
Time: Full-time - 18 months with 12 months in work-placement, part-time – 2 – 4 years with work place assignments
Location: Salisbury
Details of the DANOS linked counselling component on their foundation degree at http://www.clouds.org.uk/default.asp?PageID=38

Clouds also offers a number of stand-alone, five-day residential courses such as Cognitive Behavioural Approaches; Alcohol & Drug Use: Counselling Models that are accredited through CPCAB
Requirements: For professionals working in the field of addictions treatment

The Federation of Drug and Alcohol Practitioners (FDAP)

FDAP's National Counsellor Accreditation Certificate (NCAC) scheme is a professional certification for drug and alcohol counsellors. FDAP is recognised by the United Kingdom Register of Counsellors (UKRC) as an accrediting body. This makes NCAC a nationally recognised award and means that NCAC counsellors can join the UKRC register on the same terms as accredited practitioners of the British Association for Counselling and Psychotherapy (BACP) and the Confederation of Scottish Counselling Agencies (COSCA). NCAC accreditation also provides complementary evidence of competence in a number of the DANOS units, specifically units AA2, AA6, AC1, AC2, AF2, AI1, AI3 & BI5. NCAC accreditation is valid for three years, after which members must apply for re-accreditation. It is open only to current members of FDAP.

Applicants must have:

- Competence in the full range of 'core functions' of drug & alcohol counselling.
- A clear personal philosophy and approach to counselling.
- An on-going commitment to professional development.
- Four years of work experience as a counsellor - at least 2.5 yrs in substance use field.
- 600 hours of supervised face-to-face individual, couples or group counselling - at least 400 hours in substance use field.
- A further 300 hours of supervised experience related to other 'core functions' - at least 200 hours in substance use field.
- 450 hours of training relevant to the counsellor's role in the drug & alcohol field.

Alternatively, experienced counsellors can be eligible for NCAC accreditation if they have four years' supervised experience as a drug/alcohol counsellor and are already accredited as a counsellor by one of the following organisations: BACP, UKCP, NAADAC (US), IC&RC or BPS (as a counselling psychologist), or by any organisation recognised as an accrediting body by the United Kingdom Register of Counsellors (UKRC).

http://www.fdap.org.uk/certification/certification.html

8: Conclusion

There is fertile ground for a national approach to counselling training but as part of a wider training strategy and a long-term approach. It is important that the Assembly involves service providers as well as training providers, skills sector councils, and awards bodies in future development, possibly via Action Learning Groups. Consideration should be given to forming an All-Wales Action Learning Group around service specifications to develop a template for substance misuse counselling. This process should also set minimum qualifications and an awards structure and should define what exactly is substance misuse counselling and how does it differ from normal counselling and should link to mental health training, services and deficiencies.

Although this development needs a bottom-up approach involving treatment providers, commissioners and service users, training links need to be considered regionally or even nationally and should not be devolved to the 22 SMATs / CSPs as this is a highly specialised field and needs a coherent, national focus. Career paths must be built into the process to support the recruitment and retention of staff. Practice teachers need to be attached to the services that offer counselling, to facilitate student placements and agencies that supervise trainee counsellors should be required to have standards, approval and accreditation. Existing good practice in internal training, courses and accreditation should be built upon and included in any process of development. There needs to be a national strategy on assessors and guidance on which organisations should become Assessor centres, this could be determined by the central Workforce Development Group acknowledging that there are inherent difficulties in workers being assessed by a potential competitor.

Once standards, accreditation and awards have been developed, the field, including training and treatment providers and commissioners, must be made fully aware of them; this includes dissemination by conference, training and Action Learning Sets – many in the field, especially commissioners, do not currently have the time to even read many of the key strategic documents coming from the Welsh Assembly Government, such as the Treatment Frameworks and more effective methods of communication must be built into the developmental process.

The Welsh Assembly Government must recognise the importance of funding workforce development; some commissioners felt that there is a discrepancy within the Assembly, with increased prescribing capacity being 'pushed' at the expense of developing the workforce. Any training developments must be linked to the Lifelong Learning infrastructure and the funding opportunities available therein so that employers can take advantage of public funding. This needs to be communicated centrally and clearly as employers and commissioners are unable to become involved in structures that might give them this information such as CCETs and are therefore at a disadvantage.

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