Cats, elephants, alligators and the fantasy of *The Sopranos*:

A qualitative study of the experiences of commissioners and managers delivering IAPT services using the Any Qualified Provider policy

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This is to certify that this research report is my own unaided work:

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ABSTRACT

Background: Primary Care Psychological Therapy services (PCPT) face pressure to deliver effective services due to the increasing prevalence, complexity and societal costs of Common Mental Health Disorders (CMHDs). Furthermore, commissioners and managers deliver services within a complex system of evolving policy and healthcare practice where successive policy changes, such as Improving Access to Psychological Therapies (IAPT), have significantly shaped PCPT design. Any Qualified Provider (AQP) represents one policy aimed at addressing financial pressures, extending patient choice and stimulating quality-assured competition. AQP shares features with several NHS developments which will arguably impact Counselling Psychology going forward, such as partnership working in 'Sustainability and Transformation Partnerships', and the increased use of 'Payment by Results'. However, to date, there has been little significant discourse within Counselling Psychology around AQP, service design and the practical implications of policy changes.

***Aims**:* This research investigated the impacts of AQP on existing IAPT services and considered implications for Counselling Psychology in the context of policy change and new models of care for effective PCPT. It aims to inform and support clinical leaders with an awareness of the wider impacts of policy to improve the real-world effectiveness of services to address the rising problems with mental health.

***Method and analysis**:* Semi-structured interviews with a cross section of commissioners and managers in different regions and organisations generated leadership perspectives on AQP. Thematic Analysis offered a broad overview of the impacts of AQP in IAPT.

***Results**:* Four superordinate themes were identified: *Resources and AQP delivery*; *Partnership working in AQP*; *Bureaucracy in AQP*; and *Patient experience in AQP*.

***Conclusions**:* AQP offers insights into the partnership working of clinical leaders in a local IAPT service, and their adaptations to financial and bureaucratic pressures. To address increasing CMHDs, PCPT needs adequate funding to provide quality patient-centred care. Clinical leaders are willing and able to work within new quasi-market structures, but they prioritise clinical and relational values. Policy makers should embed these values in policies impacting PCPT to ensure the quality of services. This is an area where Counselling Psychology could – and should – engage more effectively with service design and policy.

Keywords: Any Qualified Provider (AQP); Improving Access to Psychological Therapies (IAPT); commissioning; mental health policy; Counselling Psychology.

1.0. INTRODUCTION

I would not give a fig for the simplicity this side of complexity,
But I would give my life for the simplicity on the other side of complexity

(Wendell Holmes, cited by Lederach, 2010, p.31)

1.1. Background and introduction

The study reported herein explores the use of the government policy directive ‘Any Qualified Provider’ for the commissioning, organisation and delivery of Improving Access to Psychological Therapies services (IAPT). The following introductory sections will set out a context for this research, and explain its scope and purpose.

Mindful of new models of care that need to effectively address the increasing prevalence of common mental health disorders, this study explores how ‘Any Qualified Provider’ (AQP) – as an example of flexibility in policy directives – affects the dissemination and implementation of Primary Care Psychological Therapy services (PCPT), which is currently delivered by IAPT in England. Whilst AQP as a policy directive is not widely used in PCPT, it shares features with major shifts in the ways that NHS services are being designed and delivered, such as partnership working within ‘Sustainability and Transformation Partnerships’ and the increased use of ‘Payment by Results’. The current research into AQP – set against the existing policy context of IAPT itself – might therefore offer insight into how clinical leaders (commissioners and managers) balance clinical, practical and political imperatives in the implementation of effective services in a changing policy context.

By critically analysing the range of responses to the policy layers of AQP, this study aims to inform and support clinical leaders with an awareness of the wider impacts of policy on the delivery of services. It is hoped that this awareness can improve the effectiveness, efficiency, sustainability and ethical quality of real-world therapy services, in order to address the rising problems with mental health. Research into the policy impacts on services is currently lacking in Counselling Psychology, and therefore Counselling Psychology is poorly placed to ensure that it contributes positively to the design and delivery of quality therapy services. The study’s ultimate aim therefore, is to provide new knowledge that will help inform the development of future services, against the backdrop of a changing policy landscape and new models of care – particularly with reference to the discourses within Counselling Psychology (CoP) and the implications for its practitioners. It is hoped that learning from this study will also be applicable to wider policy initiatives and care professions beyond Counselling Psychology, AQP and IAPT, where policy may affect the quality of clinical provision.

After a reflexive statement to position myself in relation to the research, I will explore the concept of policy and how it shapes the services that provide therapy. I will then establish what I mean by an ‘effective’ therapy service before reflecting on related Counselling Psychology discourses and debates. A historical review will outline how government policy enabled the IAPT programme to become the dominant Primary Care Psychological Therapy service to treat the increasing prevalence of common mental health disorders (CMHDs) in England. It considers how the policy backdrop of IAPT affects the delivery of therapy in PCPT, and to what extent the current principles of IAPT can effectively meet the future challenges of service delivery. It reflects on services prior to IAPT, and to what degree potential flexibility in current and future policy directives – such as the current example of AQP – might limit or open opportunities for more effective PCPT beyond the current design of IAPT.

With this background in mind, the methodology section offers a rationale for the collection and analysis of data that explores any evidence for flexibility in policy directives, using the experiences of clinical leaders who are delivering IAPT using AQP. The results section then presents a thematic analysis of these experiences and responses. In the discussion section, I reflect on these findings to offer a Counselling Psychology informed discourse on leadership and politics in mental health, and more general care services. A final conclusion summarises the learning from the experiences of the clinical leaders interviewed in this study in relation to the policy layers evident in AQP and ends by reflecting on Counselling Psychology’s role in the future models of care.

1.2. Reflexive statement

This study represents an evolving perspective from at least three personal lenses spanning over six years: firstly, as a Counselling Psychology trainee; secondly, as a person with a longstanding interest in politics and social change; and finally, as a clinical lead experiencing the real-world effects of policy on myself, colleagues and clients. A fourth personal lens, as a person who has experienced similar psychological distress to recipients of IAPT services, informs the importance of this topic for the delivery of good quality and meaningful therapy to people in psychological and emotional distress. This fourth lens anchors the research in the person-centred values of Counselling Psychology, but it will not focus as a significant perspective in the research methodology due to the nature of the aims of the research (to inform the practices of clinical leaders). This is not to undermine the value of research from the service-user perspective, but this perspective lies beyond the scope of the current study.

As a novice therapist with the quality of the therapeutic relationship as my primary concern, I became interested in operational impacts upon therapy. I undertook my initial placements with two different organisations delivering IAPT under AQP in one locality. Curious about the contrasting adaptations and changes made by managers and therapists to preserve their therapeutic identity, I consequently conducted a small research project to examine manager's perspectives on the opportunities and threats from AQP (Baker, 2014, see appendix 17).

My interest in politics and social change expanded my field of vision beyond the local setting and managerial perspective to the wider implications and generalisability of any learning from AQP. My developing CoP lens (still somewhat as a novice), with its maverick identity (Moore & Rae, 2009) and commitment to ethical and relational practice (Hemsley, 2013), built on perspectives gained from my previous photography and teaching careers to consider the complexity of organisational change associated with AQP and its impact on clinical practice.

Whilst my theoretical interest in politics and social change is very much to the fore, my experiences as an employee in different settings shifted my focus towards the practical effects of politics on clinical relationships. For instance, as Psychosocial Lead in a service undergoing retendering and a coincidental CQC (Care Quality Commission) inspection, I managed staff who were experiencing insecurity and anxieties during the subsequent loss of the tender, and a less than cooperative handover to the incoming provider. I reflected on the diversion of resources from front line services in response to these top-down challenges.

Most relevant to this study, is my experience as therapist and supervisor in IAPT. I am active in attending conferences and training, and during the course of the current research I have gathered informal data from colleagues in other parts of the country who have experienced AQP. For instance, I observed first hand the hostility between teams in two rival AQP services competing for a new block contract. I saw a picture of service instability when another therapist described their experience of AQP in a different location as *'the wild west'*. These experiences have shaped my research. My research has in turn shaped my experience, and has at times made me acutely aware of the adverse effects of policy on staff and clients, in addition to my original curiosity about effects on therapeutic identity in AQP in IAPT (referred to here onwards as AQP/IAPT). Just as personal development from reflection on client work can be seen as a form of research (Worsley, 2017), I consider this study as reflective professional development – where I bring my use of self to the research process and do not view operational and political forces as separate from myself, or indeed from each other.

The space in the middle: the splitting of ethical actions?

The three lenses outlined above weave throughout this study: the overarching impacts of policy that shape the services that offer provision; the central importance of the therapeutic relationship in a clinically effective therapy service; and a meeting in the middle, where practical and operational decisions are made about how to deliver an effective therapy service in the context of top-down policy directives. This space in the middle therefore represents an interplay between operational imperatives (which include policy effects) and clinical values. James describes the difficulties of balancing ethics at personal and operational levels for Counselling Psychologists working as managers as a potential subconscious '"splitting" of ethical actions' (2017, p. 311).

Splitting in this sense involves the need to cut off from the reality of the tensions between meeting the top-down demands in a managerial role and fulfilling personal and ethical commitments as a clinical practitioner. 'Splitting' is a term used in object relations theory, first coined by Fairbairn (1952) to describe a defence that is learned by a child in response to the perceived irreconcilable conflicts between the hoped for 'good object' of the nurturing parent and the lived reality of the ‘unsatisfying object’ when a parent is unable to soothe the child’s distress. Splitting occurs when the good and the bad cannot be integrated into one acceptable whole, which otherwise might result in overwhelm and distress. Ethical splitting in the managerial role might result from the challenges of honouring the ethical commitments to self, staff and clients embedded in the profession (the ‘good object’ of clinical values) and being unable to integrate the top-down pressures for money-savings and targets (the ‘unsatisfying object’ that places limitations on desired-for clinical values) into an acceptable whole. The resulting ethical conflict appears unresolvable and splitting then occurs to manage the ethical dilemmas. Rizq, for example, has interpreted IAPT in terms of these psychodynamic interpretations and describes this splitting in the ‘disavowal’ of the conflicts evident in IAPT (2012b, p.319).

Ethics are important at all levels and the delivery of public services involves multiple considerations, beyond what happens in the therapy room. For this reason, my position is not negative towards policy, because I understand that compromises need to be made in a context of dwindling resources and the inevitable interdependence of clinical work and policy. However, my position *is* one that takes an ethical stance where I endeavour to understand the assumptions made by the range of stakeholders and, where necessary, challenge those stakeholders – whether it is myself, commissioners or policy makers – to use resources efficiently with client-centred ethics in mind. I realise that this position may be somewhat idealistic, but in my view it is better to start from a rigorous ethical position and to make concessions from that place, rather than to start from an already compromised position due to unchallenged assumptions and expectations. The ethical dilemmas are very real problems however, and deserve careful examination in order to avoid the need to split off from the tensions that they present to clinical leaders.

In this text therefore, I may refer to the ethical conflicts that arise for clinicians and clinical leaders in real-world services as ‘the splitting of ethical actions’. The conflicts addressed in this thesis exist in a complex web of practices and lie predominantly between political, operational, and clinical imperatives.

The space in the middle: practical responses and new knowledge.

With its interest in pragmatic real-world responses, I also realise that this thesis is ambitious in its scope and reaches across several disciplines, such as: social policy; organisational psychology; management studies; primary care medicine; and of course, Counselling Psychology and therapy. However, I believe that this interdisciplinary approach is necessary in order to augment Counselling Psychology's research base in applied settings, as Plsek and Greenhalgh suggest: 'New conceptual frameworks that incorporate a dynamic, emergent, creative, and intuitive view of the world must replace traditional "reduce and resolve" approaches to clinical care and service organisation' (2001, p.625).

Applied Psychology is the collection of 'branches of psychology in which research findings are applied to practical problems, considered collectively' (OED Online, 2019). It is therefore perhaps striking that Counselling Psychology (CoP) has little research on practical real-world questions in service design. I wish to extend the identity of CoP by using its reflexive philosophical stance to contribute better to the practical challenges of delivering therapy in challenging and complex health systems. I believe that a transdisciplinary view of the Counselling Psychologist's role in public health systems can offer useful insights and solutions to real-world problems, such as mental health (Holbrook, 2013; Repko & Szostak, 2017). However, for Counselling Psychologists (CoPs) – or indeed other health professionals – to enact these insights, requires that they continue to evolve their own understanding of how extended parts of health systems interpret and act upon the world. This requires *inter*disciplinary understanding (Callard & Fitzgerald, 2015; Fitzgerald & Callard, 2015). The difference between transdisciplinary and interdisciplinary approaches will be discussed in further detail in the methods section, together with the challenges involved in using such approaches in academic research.

My philosophical perspective on knowledge development draws on Deleuze and Guattari's notion of the 'rhizome', in contrast to the more traditional 'arborescent' (tree-like) structure of knowledge building (Deleuze et al., 2013). In a tree-like structure, knowledge building is seen as hierarchical, which can make it hard for one branch of knowledge to deeply interact with another without one or both branches having to learn the new knowledge branch from its basic starting point. The rhizomatic model allows different paths of knowledge and ways of thinking to collide and then create (sometimes randomly) 'nodes' of meaning. These can then form the basis for new knowledge, novel ideas and solutions, which might not arise from traditional knowledge formation based on the arborescent model. As an academic in both the fields of psychology and visual culture, I have experienced the benefits of approaching the same topic from different theoretical angles.

In this study, I hope to better understand the space in the middle where practical compromises can be made by clinical leaders in response to the ethical splitting. By looking at the nodes of opportunity – where new knowledge can be built – I hope to contribute to a real-world leadership discourse for CoP and other care professions, and perhaps to add to a clinical discourse for policy makers with the goal of protecting the role of clinical values in service provision. As part of this aspiration, the following section offers an overview of the impact of policy on healthcare services.

1.3. Policy, Politics and their Impact on Healthcare Delivery

> *Health policy refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society. An explicit health policy can achieve several things: it defines a vision for the future which in turn helps to establish targets and points of reference for the short and medium term. It outlines priorities and the expected roles of different groups; and it builds consensus and informs people*

(World Health Organisation, 2019)

Changes of governments often introduce corresponding changes in social structures and services. Hunter (2015) says that politics is central to public health policy and the care systems that emerge are ‘messy’ – complex adaptive systems, where new organisational forms arise within the care system from the negotiation of policy directives.

Power dynamics and healthcare systems.

Due to funding arrangements and statutory responsibilities, these policy directives inevitably impose a power dynamic. Smail broadly defines power as: ‘the means of obtaining security or advantage’ which is embedded at every level in societal relations (2005, p.28). Power relations are often subconscious or taken-for-granted, and they frequently determine the behaviour of individuals or groups of people and their perception of autonomy. Smail describes those forces of power that are beyond our awareness or perceived as not within our control as ‘distal powers’ that lie beyond the ‘power horizon’ (2005, pp.32-33). Political forces beyond the power horizon might therefore be seen as part of the ethical splitting discussed earlier – the bad object that makes “good” clinical values hard to integrate into an ethical practice. Power gradients between top-down policy and health care services interact with other institutional codes and power dynamics (see for example, Gadamer, 1996 and Foucault, 1973). The power horizon means that it remains difficult to determine how much influence clinical leaders hold over policy directives in the development of services. Any new knowledge that makes these forces more conscious may help to resolve the conflicts and may (or may not) offer up practical responses.

Policy in health services is thus often seen as a powerful top-down force that drives the implementation of new services in direct accordance with its aims. Some psychology/therapy commentators see policy as an opportunity for public benefit (see for example, Layard & Clark, 2014, in relation to IAPT), in alignment with Smail's notion of 'benign power' (2005, p.29). However, there is very substantial critique of the negative effects of IAPT's policy context (amongst others, see: Binnie, 2015; Dalal, 2018a; House, 2016; Marziller & Hall, 2009; Rizq, 2012a). The policy context of healthcare systems – which includes the policy context of IAPT – is 'messy', as Hunter states (2015). Therefore, to identify opportunities to resolve ethical splitting when navigating these power dynamics, clinical leaders also need to better understand the complexity of these systems.

Complex responsive systems and 'policy experiments'.

Whilst politics is undoubtedly a powerful driver, the direction of influence is not always unidirectional or predictable. Firstly, policy is often uneven and contradictory, and it intersects with other policies and political drivers with unintended consequences for systems (Kingdon, 2014). Without being drawn into detailed analysis of complexity theory, it is useful to view policy implementation as a complex responsive process (Stacey, 2010). This affords the recipients of policy directives more influence than the complex adaptive process suggested by Hunter (2015), whereby participants are seen to simply adapt to new requirements (McDaniel et al., 2009). This understanding is important because the healthcare systems impacted by the dissemination and implementation of policy are themselves becoming increasingly complex (Holmes et al., 2012; Plsek & Greenhalgh, 2001) and improving these systems is becoming correspondingly more challenging.

Yet another source of complexity is the process of mapping policy onto service implementation. Ettelt et al. (2015, p.292) suggest that these 'policy experiments' and 'trialling of policy ideas' are challenging due to mixed agendas that may not always correspond to the espoused aims of policy, and may not correspond to good care practices.

For example, Common (2004, p.47) cites Marmor in describing the competitiveness of ‘policy warfare’ as different governments seek to appear at the leading edge of innovation and progress. This policy warfare can be seen in Lansley’s sweeping reform of the NHS in the Health and Social Care Act 2012, intended to ‘entrench a consistent and coherent structure of reforms [that] would not change just at the behest of a change of secretary of state, or even more a change of government’ (Lansley, cited by Timmins, 2012). The debates surrounding the negative impact of these legislative changes on the NHS have been ongoing and, at times, intense. As well as hidden agendas, policy changes act upon already existing layers of ‘multiple shocks, setbacks, and unanticipated events’ when translating research theory into practice (Greenhalgh et al. cited by Proctor et al., 2009, p.25). No policy can therefore be viewed as a simple translation of ideas into organisational forms that will neatly resolve the problems that the policy seeks or claims to address. The implementation of policies and research is an uneven process and therefore requires careful consideration (Steen, 2015).

This section has explored the impact of power dynamics and complexity in the relationship of policy with healthcare systems, and how this contributes to ethical splitting. As part of the current evaluation of the impacts of AQP policy on IAPT, it is also necessary to explore the nature of the clinical values that might be threatened by policy in the ethical splitting. Therefore, the next section examines more closely the relationship between policy and definitions of service effectiveness.

1.4. Delivering effective therapy services

The uneven process of translating research theory into practice – and the ways in which policy can hijack narratives about successful treatment to win political points – not only neglects to acknowledge the complexity of healthcare systems, but also the complexity of clients and the therapeutic change process. This section therefore expands on the challenges of improving therapy services within a complex responsive system. It will explore what it means to deliver an effective PCPT service, and identify tensions and compromises for the clinicians and leaders delivering this service.

Definition of service delivery.

Service, in this context is taken as the outcome of a variety of processes within the system which impacts different stakeholders. The research is primarily concerned with service's clinical effectiveness in treating Common Mental Health Disorders. Delivery of services takes into account the commissioning, organisation and delivery of the service, and may also be described here as the dissemination and implementation of services (May & Finch, 2009). When I refer to those responsible for delivering services, I may refer to managers and commissioners as 'leaders', or 'clinical leaders'. I assume that the core desired outcome of the service is to deliver clinical effectiveness for the patient via operational decisions, and to represent the concerns of clinicians (Checkland et al., 2012). I also assume that clinical leadership is not restricted to a job role, and that clinical leadership may be enacted by practitioners other than managers or commissioners (Gale, 2016, p.568). I may refer to clinicians delivering one to one therapy as therapists, counsellors or practitioners.

The primary recipients of a mental health service are considered to be the clients who receive therapy. For clarity and to be able to best engage with the varied literature, from here onwards, the terms 'patient', 'person', 'client' or 'service-user' may be used interchangeably. The British Psychological Society (BPS) states that the term 'patient' should be avoided in non-medical contexts (BPS, 2018c, p.47). However, to make this study accessible to relevant audiences, I will use the term 'patient' where appropriate and necessary.

Effects on service delivery in a complex system: micro; meso and macro effects.

With the above awareness of the complexity of health systems, we might consider different impacts upon the outcomes of the service occurring at the micro, meso and macro levels (van Dijk, 2007). For instance, Fotaki (2014) categorises the activities at each level in public health as: interpersonal (micro), organisational (meso) and institutional (macro) levels. In IAPT, we might see this manifesting at the micro level as clinicians using their own theory-in-use (Schön, 2013) that guides clinical decision-making about the therapeutic relationship and the client's needs. However, therapists are also required to meet meso level service expectations, such as meeting performance targets, attending supervision or continued professional development as required by the employing organisation, which are incorporated into the therapist's theory-in-use whilst delivery therapy. Macro effects from institutions (including the power dynamics described earlier), such as professional bodies or political agendas, perhaps hidden from view, may also filter down to the therapeutic relationship. Clearly, there is crossover of the categorisation of effects at each level. For instance, a professional body might be considered as a meso or macro effect by different therapists.

Evaluating service effectiveness.

The ways that outcomes are measured in a complex system are not straight forward: therefore, the word 'effectiveness' needs some clarification in relation to PCPT services. However, researchers have not settled on a standard term for effective services. Most studies of effectiveness relate to specific treatments – or 'clinical effectiveness' – usually evaluated using Routine Outcome Monitoring (ROM, also sometimes referred to as: 'Routine Outcome Measures') from client self report measures to measure recovery. However, as discussed later, there is much debate about the reliability of ROM to assess effectiveness and/or recovery.

Various theoretical approaches attribute the source of any assumed effectiveness to different aspects of therapy. For example, many humanistic approaches identify different aspects of the therapeutic relationship as central to effective therapy, such as relational depth (Cooper, 2013), empathy (Bohart et al., 2002), 'common factors' in therapy techniques (Lambert, 1992; Wampold, 2015) or individual therapist characteristics (Wampold, 2001). Other approaches to therapy specify adherence to theoretical models or protocols as the key marker of effectiveness (Cukrowicz et al., 2011; Waller & Turner, 2016; Webb et al., 2010). Client factors are also one of the strongest determinants of effective outcomes (Bachelor et al., 2007). However, evaluating the effectiveness of real-world treatments is different to a treatment's assumed clinical efficacy, which is often demonstrated in lab-condition Randomised Controlled Trials (RCTs). Clinical efficacy studies are sometimes subject to researcher allegiance and can show different results, depending on the measures used (Patterson, 2017; van Ingen et al., 2009). With multiple effects on the therapist, multiple therapeutic change factors and doubts over how to evaluate clinical effectiveness, a more meaningful evaluation of the effectiveness of clinical treatments requires a wider set of parameters.

The overall effectiveness of real-world treatments (that help clients get better) are therefore subject to real-world micro, meso and macro factors, that may not be generalisable from claims of clinical efficacy. Aside from measures of recovery and ROM, other measures can be used to evaluate real-world effectiveness, such as acceptability of treatment, both for the client and therapist (Bower & Gilbody, 2005) and choice of treatment (Goldman et al., 2016). Investigating appropriateness for treatment and drop out rates can also identify to what degree the treatment package 'fits' individual client need, and can be considered as additional measures of effectiveness (Merrifield & Mahase, 2018).

Beyond the one-to-one treatment context, real-world factors such as the design and implementation of the service – both within the organisation and between other services and stakeholders – have multiple and sometimes subtle effects on the way treatment is delivered and on professional identities (Murphy, 2011; Speed & Gabe, 2013). For example, burnout in therapists has been demonstrated due to organisational pressures in IAPT (Steel et al., 2015; Westwood et al., 2017). Delgadillo et al. (2018) suggest that therapists can experience depersonalisation symptoms from burnout due to stressful working conditions and show that client outcomes are adversely affected. Research cited by Cooper reports improved client outcomes with a therapist's 'ability to create a welcoming and safe atmosphere' and being 'genuine, themselves and not faking things' (2013, p.73). Therefore, if a therapist experiences depersonalisation or disengagement as a consequence of service factors and are unable to offer relational depth, these service issues will affect real-world clinical effectiveness. Often, the evidence for the real-world factors impacting effectiveness does not exist in the existing audit process, but instead can be found in alternative forms (see for example, the *Surviving Work in Health* blog: https://survivingworkinhealth.org). Whilst it is important that studies evaluating the effectiveness of real-world clinical practice acknowledge the difference from lab settings (van Ingen et al., 2009), in reality there are many wide ranging service variables that impact not only client outcomes directly or indirectly, but also staff wellbeing.

Beyond clinical effectiveness, the general effectiveness of a service – taking into account real-world service contexts – includes cost-effectiveness, affordability and efficiency (Kendall & Frank, 2018). With most services, it usually falls to managers and commissioners to ensure that cost-effectiveness balances other factors such as access numbers, accessibility to different groups, training, staffing levels, estates, budgets, and so on. This process involves balancing out the needs of different stakeholders, alongside practical and operational demands (Vos et al., 2005). Widening this out further to the local and national health care system, factors such as coordination between services, referral pathways, consultation exercises, and long-term sustainability, also contribute to overall service effectiveness (McDonald et al., 2007).

In general, there is little consensus of what service effectiveness means (Bond, 2018). If effectiveness is expanded to read as service quality, degrees of effectiveness will vary according to the perspectives of stakeholders and their expected outcomes of the service. Evaluations that include this range of perspectives are limited and do not easily offer clarity for service design or improvement (Shield et al., 2003). Furthermore, any consensual agreement of what comprises an effective service involves compromise across a wide range of stakeholders across micro, meso and macro levels (Barkham et al., 2017; Lovell et al., 2017). There is a general paucity of research into measuring effectiveness at the service level that reflects this range of stakeholder views and expectations (Petrosyan et al., 2017). Stakeholders include: clients and their families; advocacy groups; therapists (and their families, which also applies to all other stakeholders); managers; GPs; commissioners; finance departments; and government officials. Each part of this system will have effects and interactions with all other parts, to a greater or lesser extent (Kringos et al., 2010) and each interaction in turn shapes the organisation or institution to a greater or lesser extent (van Dijk, 2007). As Marzillier (2017) suggests, authentic ‘success’, or the effectiveness of real-world services, is measured by outcomes and effects far beyond the measures that most statutory services take into account when evaluating effectiveness. To illustrate this, Martin et al. describe how institutional bias means that: ‘official records may provide a distorted picture or diminish important particularities of context’ (2015, p.20). Furthermore, efforts to reveal a more nuanced data set around patient experience and consultation for example, may meet considerable resistance when it threatens established power structures (Walker et al., 2018).

Future service design is often based upon previous evaluations of service effectiveness. Therefore, it is important that these evaluations reflect as accurately as possible the range of effects within a complex system; the appropriateness of the outcome measures used to evaluate the effects (Delgadillo et al., 2018); and the power structures that interpret them.

Effective service implementation within a ‘nexus of practice’.

To understand more about how various service effects impact overall effectiveness, it may help to examine the decision-making processes of those implementing services in more detail. May and Finch describe the complexity of the interactions within the system as ‘interaction chains’ and propose that the implementation of services involves ‘material practices that are produced, reproduced, and transformed, in relatively formal settings – within an institutional or organizational framework – which are consciously composed and purposively directed’ (2009, pp.539-540). This implies that those who have the jobs of commissioning, organising and delivering services, are processing and negotiating multiple demands (and power relationships) in order to decide upon their actions. Hui et al. (2017) situate these negotiations within a ‘nexus of practice’ and assert that social phenomena can usefully be studied with practice-based methods in real-world contexts. Therefore, who does what – and why – has a great impact on the actual outcomes of the system.

With regards to health care systems then, the nexus of practice – which includes the one-to-one therapeutic encounter – involves the ‘purposive social action’ of those implementing services, and this contributes to the overall effectiveness of the implementation in complex systems (May et al., 2007, p.539). As Delgadillo et al. (2018) demonstrated, service pressures directly impact the practices of clinicians and then, indirectly, client outcomes. Rogers and Murphy suggest that the socio-political environment also negatively impacts clinician’s practices through regulation (2017). Similar to Delgadillo et al. (2018), Steen concludes that effective implementation of IAPT, across a range of contexts and processes (and therefore its associated practices), is required for effective treatments and outcomes (2015) – which includes any effects upon the practices of staff, for example. Leaders disseminating and implementing clinical services must therefore negotiate different sets of practices concerning government policy, operational decision-making and clinical effectiveness.

Policy effects on the splitting of ethical actions.

The implementation of services can be viewed within a nexus of practice, where leaders negotiate political, operational and clinical imperatives to formulate purposive social action. What might then contribute to a splitting of ethical actions in PCPT, is the complexity of therapists delivering treatments within a messy health care system which is impacted by multiple and varied factors.

We have seen that effective therapy needs effective implementation, which can be evaluated in many ways. This involves balancing ethical commitments to the client in the room, and also a wider understanding that publicly accountable services need to be cost-effective, accessible and equitable. Compromises have to be made so that the service as a whole can be effective and there may be other tensions around the political or philosophical position of the therapist, manager or commissioner: Cotton suggests that the ‘current marketised and legalised model of care’ creates splitting between staff and patient, and between colleagues (2017, p.67). Furthermore, the omnipresent nature of the policy backdrop may naturalise certain forms of decision making, for instance, decisions involving the importance of data gathering. Decision-making and action in this context will be challenging, even though the imperatives of delivering the best therapy to the highest number of people is usually the primary ethical commitment of therapists, service managers and clinical leaders.

Given that Pybis, et al. (2017) identify differences in patient outcomes that are significantly attributable to service differences more than modality, it is important to better understand the conflicts and challenges during the implementation process. They call for research that captures ‘the naturally nested nature of the implementation and delivery of psychological therapies’ (2017, p.1). Therefore, understanding and making conscious the splitting of ethical actions that arise during service implementation, must consider the wide range of factors causing tension in the nexus of practice, including any hidden policy agendas (macro effects) that influence meso level effects, such as the ‘political logics of marginalisation’ highlighted by Glynos et al. (2015, p.50). This may then inform the practical real-world decision-making processes beyond the micro or meso contexts to offer more effective services.

The previous two sections have explored two sides of the ethical splitting – the desire for patient-centred service effectiveness and the imperatives of policy-driven practices – and have highlighted the nature of the complex range of decision-making required in the current policy context of healthcare systems. The following section explores the relevance of these processes to Counselling Psychology.

1.5. The space in the middle: Counselling Psychology, leadership and politics

How can clinical leaders find a middle ground to manage the splitting of ethical actions between clinical values in service effectiveness and policy/operational imperatives to find practical solutions?

We have seen that translating policy to service implementation significantly impacts the therapy treatments. Because of the hidden nature of policy and the subconscious nature of the splitting of ethical actions, it is important that clinical leaders have skills on an operational and policy level – as well as on a clinical and personal level – to navigate the challenges and promote opportunities for effective services. For reasons given above, operational and policy awareness are seen as interchangeable and inherently connected. This section will highlight relevant debates in Counselling Psychology and aspects of Counselling Psychology identity that relate to the challenges and opportunities identified thus far.

Leadership discourse within the applied psychologies.

The British Psychological Society (BPS) as a whole responded on behalf of applied psychologies (BPS et al., 2007; Lavender & Hope, 2007; Onyett, 2007) to government recognition over a decade ago that psychological services needed to operate differently (DoH, 2007a; DoH, 2007b). More recently, the BPS has highlighted the lack of consultation with applied psychologists in developing policy, and offers training recommendations for applied psychologists: ‘Future education and training should have a stronger strategic element and should include skills in communicating with a diverse range of audiences to enable influence on policy development with key stakeholders’ (BPS, 2018a, p.4). The BPS makes some attempt to comment upon policy, but there appears to be little in-depth critique. For instance, the BPS (2019a) commends the strategic aims set out in the latest *NHS Long Term Plan* (NHS, 2019) about strengthening the workforce, but it does not comment on the lack of any real progress on meeting the commitments made in the Five Year Forward View (NHS, 2014) – unlike others, who have directly commented upon this lack of action (Marzouk, 2019; Murray, 2019; The Health Foundation et al., 2018) and who have robustly challenged the NHS to create action from the plan (NHS Providers, 2019).

Counselling Psychology (CoP) sits alongside other applied psychologies in the NHS: Health Psychology; Clinical Psychology; and Occupational Psychology. Each has its own way of seeing the client and dealing with operational and political influences on their services. Part of the Division of Counselling Psychology's (DcoP's) vision in its strategic plan is: 'Leading and influencing the design and delivery of innovative policies and services' with a key objective to 'maximise the impact of psychology on public policy' (DCoP, 2018, p.1; p.2). However, there is little explicit guidance on how Counselling Psychologists (CoPs) could do either of these. DCoP's *Professional Practice Guidelines* allude to 'professional artistry' (2017, p.1), but again, there is no strategic guidance about how CoPs engage in leadership roles or policy development. A brief scan of the *Counselling Psychology Review* (https://www.bps.org.uk/member-microsites/division-counselling-psychology/publications) reveals few articles that relate to operational or policy issues, compared to the *Clinical Psychology Forum* (https://www.bps.org.uk/member-microsites/division-clinical-psychology/publications) or to the scope of Clinical Psychology publications (Division of Clinical Psychology, 2007a; 2007b; 2010). Despite an increasing focus on professional and practical issues in recent Counselling Psychology handbooks, there is little explicit description of Counselling Psychologists as managers and leaders in most of the literature base of Counselling Psychology.

There is recent recognition from the NHS that management structures need to include more clinical expertise and that cultural and organisational issues impede this (NHS Improvement, 2019a). The desire for psychologists to improve their skill set in leadership roles has been welcomed in these new guidelines, but currently the main citation for this is a Division of Clinical Psychology document on clinical leadership (2010). Specific Counselling Psychology leadership contributions are therefore not explicitly represented in this document. This is regrettable because CoP is seen to have a 'high level of self-awareness and competence in relating the skills and knowledge of personal and interpersonal dynamics to the therapeutic context' and strengths in 'anti-discriminatory practice, social and cultural context and ethical decision-making' (Lavender, 2005, p.42). This range of competence would appear to offer considerable transferable skills for managing people during the turbulence of organisational change, and for communication with a variety of health and social care organisations and stakeholders: CoP has much to offer debates about the medicalisation of therapy (Hemsley, 2013; Joseph, 2017)) and policy development (Orlans & Van Scoyoc, 2009), for example. CoP's research focus on social justice (Cutts, 2013a) and an ability to work pluralistically (Cooper & McLeod, 2011) aligns well with current organisational and political challenges. However, without a framework for translating these values into practical skills and competences, CoP may find it hard to contribute to leadership structures that are then able to influence service implementation and address the conflicts and challenges of ethical splitting previously identified.

Social Justice, socio-political action and the ‘rhetoric-action’ gap.

Although the relationship of CoP with social justice varies between countries and is rather loosely defined in the UK (Cutts, 2013a; Moller 2011), there is a broad consensus that person-centred therapy professions in the UK hold values generally in line with the social justice movement (Joseph, 2017). Whilst this is usually associated with socio-political impacts on client’s problems – such as welfare issues, Winter cites Crethar et al. (2008) in defining four principles of social justice: ‘equity, access, participation, and harmony’ (2015, p.56). Speight and Vera associate social justice with ‘social action’ and state that the work of a Counselling Psychologist requires a full commitment to engage with ‘public policy, consultation models, and oppression theory’ (2004, p.116) and involves a willingness to address wider issues such as service delivery, in order to ensure inclusive and equitable access for clients. This somewhat echoes the ideas of May et al. (2007) around ‘purposive social action’ within the healthcare system. Speight and Vera equate this commitment to ‘an expansive view of ethics’ (2004, p.113). However, Cutts points to a ‘rhetoric-action gap’ in Counselling Psychologists’ commitment to act upon their social justice values in the UK, speculating the possible reasons as a lack of clarity in CoP’s professional commitments to social justice and time constraints due to workload and burnout (2013b, p.150). Elliott and Zucconi suggest that it is an ethical duty for person-centered and experiential psychotherapy training to include a wide scope of practice-based research that includes ‘political, scientific, practical, and ethical goals’ (2006, p.82) to maximise benefit for clients in real-world contexts. I would argue that CoP’s lacuna with regard to leadership skills is part of the rhetoric-action gap, and agree with Henton’s (2012) observation of a general lack of practice-based research in CoP, that may limit its ability to address the ethical splitting experienced in real-world services.

A study by Thompson (2007), explored the reasons for a perceived a lack of interest in socio-political issues in Clinical Psychology (CP) training programmes, by drawing on concepts from Critical Community Psychology (CCP) to measure views of trainees. The study partially supported previous literature that individualistic treatment orientation – or '"professional socialization"' – in CP reduced socio-political tendencies (2007, p.68). However, it also reflected the findings by Cutts (2013b) about the pressure of work on clinicians making social action commitment a luxury, rather than a core commitment to daily practice. In addition, participants expressed concerns about how to practically enact socio-political values, and how any outward socio-political actions would be viewed by managers and the government – demonstrating the effects of top-down power dynamics.

If we consider the concepts of social justice and socio-political action, Thompson makes some interesting points about the relationship between politics and psychology in general, and the difficulties of finding 'practical and applied ways' to embed a socio-political awareness into practice (2007, p.81). The nature of working within the NHS – itself '"a political football"', according to one of Thompson's participants (2007, p.80) – means that dealing with political concerns may feel like an occupational quagmire for practitioners. For instance, Cotton also uses the idea of 'political football' to describe the 'cynical' box ticking management culture in the NHS (2017, p.4) which distract from the deeper issues of sustainable funding for services.

Winter attempts to make a contribution to the search for pragmatic ways to enact social justice in the face of these challenges, and argues that ethical guidelines are a key resource for enacting social justice concerns (2015). Whilst Thompson comments upon a general lack of reflection of what 'political' means in relation to psychology, it is perhaps worth pointing out that 'political' expresses itself in a multitude of ways. In a very visible sense, politics impacts client's environments via welfare cuts and austerity for instance, which might be met with advocacy and perhaps visible 'protest' on behalf of psychologists (for example, the group *Psychologists for Social Change*: http://www.psychchange.org/). However, as we have seen, politics permeates every structure with which we interact. In the case of service design, being part of the 'political football' – to use the terminology from Thompson's study – makes it hard to see who is kicking the ball, why it is being kicked and when or where the ball will hit. The complexity of being an employee of the state means that perhaps clinicians face being simultaneously: rescuers; perpetrators; and victims, to borrow from the *Karpman Drama Triangle* formulation. Light (1995) terms these forces 'countervailing powers', and suggests that being aware of them can help us better understand the relationship between the state, and the actions and decisions of health professionals.

For this reason, it is important that all psychologists, not just CoPs, understand the '"master political logic"' at play (Glynos et al., 2015, p.46) to identify where policy impacts service design, and the nodes of opportunity around political discourse. I would therefore argue that socio-political action and social justice must not only attend to those visible aspects of policy that create societal suffering for clients, but must also dig beneath the surface to address how psychologists themselves are being kicked around the political football pitch. Hunter suggests that the process of understanding political science can be 'uncomfortable' for scientific communities, especially those who gain security from 'objective' research methods such as Randomised Controlled Trials (RCTs), who are not used to the 'messy political reality' of the phenomena they seek to research (2015, p.2). CoP, perhaps with a lesser allegiance to the 'objective' sciences, may be less uncomfortable with the messy reality. However, current indicators suggest that it needs to get better at playing political football if it is to contribute to clinical leadership in the NHS and other statutory services.

One area of psychology that *does* attempt to engage directly with politics and to challenge existing power structures is Critical Community Psychology, as recognised in Thompson's study (2007). Whilst it is not listed as an applied psychology by the BPS, it is worth exploring in further detail how social justice is understood and expressed in this existing field, to provide a backdrop to the challenges raised by this study.

Perspectives from Critical Community Psychology.

> *Community Psychology is the applied psychology of working with communities, both whole communities and sections of communities, and with people in the context of their community*
>
> (Kagan et al., 2020, p.21)

Critical Community Psychology (CCP) adds a Marxist perspective to this basic definition of Community Psychology to challenge the existing social order, or at least perspectives that seek to offer '"another penetrating framework"…characterised by an attempt to look beyond appearances, beyond accepted expectations and rationalisations' (Kagan, 2020, pp.14-15). CCP is receptive to novel and inclusive approaches to generate, analyse and disseminate knowledge about collective human experience, that question existing narratives and frameworks that may be steeped in overt or hidden power dynamics. CCP breaks down established roles and identities to allow space for fresh perspectives on self, other and communities –.an interdisciplinary approach not unlike the spirit of openness and novelty espoused by Deleuze and Guattari's notion of the rhizome (Deleuze et al., 2013). This is nicely represented in reflections on the *Community Psychology Festival* by Desai and Hadjiosif, who cite Turner in describing the concepts of *communitas* and *liminality* during the group process that provide 'a state of "in-betweenness", such as when one identity has been shed before another has been adopted' (2019).

Moloney says that 'solidarity is often the only form of significant social power available to ordinary people – including Counselling Psychologists interested in community practice…' and suggests that a community approach might help to challenge problematic neoliberal trends in healthcare systems (2016, p.375). In a similar way, approaches such as CCP might help to mobilise a robust and cohesive discourse for Counselling Psychologists to view and re-view the taken-for-granted power dynamics embedded in the implementation and delivery of services, utilising CoP's ability to tolerate the messy and the shifting nature of relationships and identity. Counselling psychology may then develop a more nuanced real-world understanding of how therapy –.and to a certain extent other care services – have increasingly become hotbeds of hidden subservience to policy.

Challenges for Counselling Psychology in the enactment of socio-political action.

Hunter's reflection on the narrow orientation of the 'objective' sciences (2015) somewhat echoes Thompson's identification of the '"professional socialization"' in Clinical Psychology towards individualistic determinants of mental health (2007, p.68), and Cromby's suggestion that psychology professions (apart from more systemic and community approaches) have become 'a disembodied psychology of individual cognitions' (2006). We might presume therefore, that the relational stance of Counselling Psychology is less likely to individually pathologise a client's coping responses to political forces beyond the power horizon. However, with its foundations based within the humanist tradition, CoP may not lend itself to more systemic perspectives on psychological distress, because it has been predominantly focused on its applications to individual therapy process (albeit, an intersubjective process with the therapist). Despite Counselling Psychology generating some valuable qualitative research on the therapeutic process, research output, on the whole, tends to reinforce conventional individualistic perspectives.

Moloney laments these ‘traditional intra-psychic understandings of personal distress’ (2000, p.211) because they limit discourse concerning the factors outside of the therapy room that might affect psychological distress, and because – perhaps more insidiously – they promote an expert orientation towards the solutions to this distress. Alternative approaches to understand the nature of distress and power imbalance might use more culturally embedded research perspectives that relate better to real-world processes and experiences – see for example, a social constructionist study of the representation in pop songs of the power relations found within psychotherapy by Hadjiosif and Coyle (2017).

Borrowing from Lucy Johnstone’s seminal paper (1993) critiquing a rigid and self-referential biomedical model of psychiatric diagnosis, Moloney invites Counselling Psychologists to move towards a better understanding of their work as a form of ‘socio-cultural practice’, and briefly reflects on the limitations imposed within service settings on their ability to enact this approach (2000, pp.214-15). I would argue here that ‘socio-cultural practice’ embraces the concept of socio-political action, because it factors in the wider determinants and interpretations of mental health, more so than traditional intra-psychic approaches. This approach, therefore, should include the socio-political (or socio-cultural) context of service implementation, because the impacts of poor mental health are also directly affected by the effectiveness of real-world services – themselves impacted by socio-political factors, as described in the previous section.

The intra-psychic orientation of Counselling Psychology therefore risks reinforcing the existing power dynamics that focus on client’s individual responses *to* their circumstances (or service context) as the key problem rather than understanding client’s circumstances (or the service context) *as* the key problem. The latter more readily evokes a call to socio-political action, and perhaps this is one reason why CoP has found it hard to link up real-world client’s lives or service contexts to the negative impacts of power dynamics hidden beyond the power horizon for clients or clinicians themselves within the ‘messy political reality’, to use Hunter’s words (2015, p.2).

Whether this means that CoP does not fully incorporate a socio-political view of the client’s problems, or it fails to fully understand the operational and policy determinants of service effectiveness, there is fertile ground for CoP to address the lacunae in its socio-political discourse, to build upon its maverick and pluralistic identity.

Opportunities for Counselling Psychology in the enactment of socio-political action.

Returning to the space in the middle, and with a heightened awareness of the limitations of the intrapsychic traditions of Counselling Psychology within a complex and politicised healthcare system, how can the discipline address the splitting of ethical actions described earlier?

Howard reflects on the ‘twists and turns’ of working as a Counselling Psychologist and manager in real-world contexts (2018. p.233), and cites Blair (2009) on the importance of being a reflective practitioner in a ‘social, political, economic and **ideological** context’ [author’s emphasis] (2018, p.234). Aspirations for CoP’s potential to positively influence mental health services following the Department of Health’s *New ways of working* document in 2007 appear not to have materialised to date (Athanasiades, 2009) due to its failure to develop an effective socio-political discourse.

However, an increased awareness of the splitting of ethical actions, and of the varied contexts and processes that constrain or resolve them (the countervailing powers described by Light, 1995), can perhaps offer a better understanding of the socio-political impacts upon multiple stakeholders throughout the wider system. Blair recognises that addressing these challenges involves synthesising a range of skills and aptitudes that may be at odds with the humanistic and reflective focus of CoP (2010). There are a variety of tensions for Counselling Psychologists when working in the NHS and traditional healthcare organisations (Frankland & Walsh, 2005; Moller, 2011; Soth, 2007; Turpin, 2009). Nonetheless, whilst the identity and values of Counselling Psychology are prone to change and its ideology may lack focus compared to more established applied psychologies, such as Clinical Psychology (Pugh & Coyle, 2000), its identity in traditional health care settings continues to evolve (Mrdjenovich & Moore, 2004), and this may offer opportunities to increase CoP’s practical ability to inform the future design of services.

Moreover, there is perhaps some benefit of CoP’s slightly non-committal stance on socio-political action in the context of an evolving identity, that might enable it to more easily learn from other traditions – such as the systemic approaches of Community Psychology suggested by Moloney (2016), and the managerial mindset of Clinical Psychology – and apply its relational values and its creativity to the implementation and delivery of services in the real-world context of policy.

A reflective awareness of the practical skills needed to address the conflicts in service implementation and its policy context may create nodes of opportunity for ethical leadership, socio-political action and social justice. Blendon and Steelfisher (2009) argue that researchers should better understand the way that policy works in order to best influence its impact upon service design. I would extend this to scientist-practitioners who are working in real-world contexts and who need to use their awareness and expertise to evaluate complex service effects and respond to them. If CoPs can develop a language of engagement with policy together with pragmatic *and* ethical leadership, then perhaps they may better contribute their humanistic values to emerging models of care in PCPT. This is important if services are to be effective and meet the needs of the population, as Thatcher and Manktelow propose: ‘Psychology would need to embrace both a social and political agenda if it is to have any truly significant impact on mental health’ (2007, p.31). Hunter reminds us of the importance of challenging the power horizon as part of this endeavour: ‘The need for strong policy research that is prepared to speak truth to power rather than about it has arguably never been greater’ (2015, p.3). There is, therefore, a continuing need to develop CoP’s understanding of the impacts of policy because service contexts are likely to become increasingly complex and challenging. With a rapidly changing political landscape impacting the future models of care, it is worth reminding ourselves of the predictions made by Jordan in 2009 on the future of Counselling Psychology, to maintain a focus on the need for a more robust CoP policy discourse:

> *So the future is bright and varied for counselling psychologists, if we adapt to the opportunities the political situation provides us with, are prepared to operate at different levels according to our skills at the different aspects of our work and urgently foster and develop talented researchers and collaborative research* (2009, p.14).

This study is an attempt to identify the adaptations of clinical leaders at different operational levels in an emerging real-world policy landscape. It aims to incorporate these into a CoP discourse that will help Counselling Psychologists contribute to healthcare systems with an expanded skill set to make use of the space in the middle, where opportunities exist to address the rhetoric-action gap identified by Cutts (2013b, p.150). It will therefore now examine the importance of current PCPT services, their policy context and how they have developed, to inform the enactment of socio-political justice in this real-world context.

1.6. Mental Health Policy and Service Delivery: The Historical Context

Mental health problems in England are treated across different NHS services, including: Primary Care Psychological Therapies (PCPT) for Common Mental Health Disorders (CMHDs); secondary services (for more complex mental health conditions); inpatient care; and Child and Adolescent Mental Health Services (CAMHS). The Mental Health Taskforce states that nine out of ten adults with a mental health problem receive help in primary care services (2016, p.8).

The data on the prevalence of mental health conditions demonstrates increasing demand for quality mental health services, and in particular for PCPT (British Medical Association, 2018b; Quality and Outcomes Framework, 2017; Public Health England, 2019a; Stansfeld et al., 2014). A more detailed picture of the demographics relating to CMHDs in a government briefing paper breaks down the prevalence figures further into categories such as regions; specific disorder; age; and ethnicity (Baker, 2018). Other research adds to the data for different groups such as young people (Pitchforth et al., 2018). Despite variation in the data and the complexity of assessing need, the evidence suggests that the increasing number and severity of CMHDs is a growing problem that requires effective PCPT.

The causes of the changes in demand and the impacts upon different groups are likely to be complex. NHS Providers (2018) suggest that the increase in demand is due firstly to a reduction in stigma from campaigns such as *Time to Change* and *Heads Together*; and secondly, due to societal and lifestyle pressures and work stress. A survey by the *Mental Health Foundation* found poor mental health to be more common in lower socioeconomic groups (2017). These findings are confirmed by other research (Katikireddi et al., 2012; Meltzer et al., 2013) and indicate that stress from austerity may have contributed to the population’s increasing CMHDs and need for services, in particular the more severe CMHDs presenting to PCPT.

The increasing prevalence of mental health problems has considerable costs to society (Mental Health Taskforce, 2016; Stansfeld et al., 2014). Stress, anxiety and depression were the main reasons for absence from work in 2017 to 2018 (NHS, 2019). The economic costs relating to mental health problems in England are forecast to exceed £60 billion by 2026 (HSCIC, 2015, p.15). Furthermore, there are increasing costs for their treatment in the NHS.

To address the increasing prevalence and the impacts of CMHDs, successive governments have therefore introduced wide-ranging changes to the commissioning, organisation and delivery of PCPT, most recently in 2006 with the introduction of Improving Access to Psychological Therapies. Other changes in the wider NHS continue to impact the implementation of PCPT. To assess the effectiveness of the existing Improving Access to Psychological Therapies (IAPT) service and/or new models of care, it is first helpful to understand how the commissioning, organisation and delivery of PCPT services has changed in recent years, and how they have been impacted and shaped by the changing policy context.

1.6.1. Prior to IAPT services – Practice-based counsellors and psychologists

In primary care prior to IAPT, many therapists worked in GP surgeries. By 1992, nearly a third of GP practices in England and Wales reported having a counsellor working in the surgery. These so-called '"practice counsellors"' (Marsh & Bart, cited by Foster & Murphy, 2005, p.6) were often self-employed or had experience working in the voluntary or private sector, and had a status somewhat outside of mainstream NHS models of care. GP referrals in primary care could also be made to Community Psychiatric Nurses, psychiatrists or psychologists in secondary care where necessary for other treatments and therapy modalities such as Cognitive Behavioural Therapy (CBT) and psychodynamic therapies. However, there were typically very long waiting lists and access to these services varied widely between locations. Primary care counselling was therefore a way for GPs to address the need to treat CMHDs by a variety of trained psychological practitioners quickly and easily.

The Emergence of NICE and the dominance of evidence-based practice.

> *Since 1999, we have provided the NHS, and those who rely on it for their care, with an increasing range of advice on effective, good value healthcare, and have gained a reputation for rigour, independence and objectivity* (NICE, 2018).

A white paper entitled '*The new NHS: Modern, dependable'* (DoH, 1997) heralded changes in the ways that primary care was organised to provide more equitable access and consistent clinical governance at a centralised level. The paper promised a new 'National Institute for Clinical Excellence to give a strong lead on clinical and cost-effectiveness, drawing up new guidelines and ensuring they reach all parts of the health service'. To this day, the National Institute for Clinical Excellence (NICE) provides the standards against which NHS treatments are benchmarked, including those in IAPT. The original reference to 'cost-effectiveness' has changed to 'good value' in its current description (NICE, 2018) but, importantly, it should not be forgotten that these clinical guidelines were from the start associated with cost savings for the NHS.

The NICE guidelines relied predominantly on evidence-based practice in psychology (EBPP) (American Psychological Association [APA], 2006) to set a particular set of standards and definition of treatment quality. The scientific-rational narratives of certain aspects of psychology lent itself better to evidencing 'empirically validated treatments' such as CBT, with its research base of Randomised Controlled Trials (RCTs), enabled by structured and manualised treatment protocols. These themselves were in part developed to offer a convincing evidence-base for talking therapies to match the perceived rigour, independence and objectivity of the RCTs used by pharmaceutical companies (APA, 1995).

The assumed 'objectivity' and 'rigour' of NICE was to become the dominant narrative of quality in patient care, which meant that other standards of quality were de-prioritised. Whilst psychology clinicians most certainly held the same patient-centred ethics as counsellors, the link to 'cost-effectiveness' was more easily provided by the quantitative research base connected to CBT, rather than counselling approaches that Shean identifies as the 'idiographic approaches to therapy that do not lend themselves to RCT designs' (2014, p.1). Foster and Murphy (2005, p.15) cite a Department of Health (DoH) guide '*Improving Quality in Primary Care: A Practical Guide to the National Service Framework for Mental Health'* to reflect on changing evaluations of service effectiveness. The National Service Framework for Mental Health was set up in 1999 by the government to set quality and access standards for mental health services (NHS, 1999). Two main factors required for the selection of psychological therapies listed in the DoH guide are: firstly, evidence of effectiveness and secondly, patient preference. The requirements for rigorous objectivity and the evidence-based principles favoured by NICE was not at that time in line with the culture of counselling in primary care, even if patient preference spoke to counselling's effectiveness. Although some stakeholders might find the clarity and guidance of NICE reassuring and helpful (Davies, 2007), the narrow definition of what counts as evidence in EBPP and the research bias towards CBT is an ongoing topic of debate (APA, 2006; Cuijpers et al., 2010). However, the advent of NICE meant that the varied training paths of individual counsellors and the nature of the evidence-base for which counselling was deemed to be effective therefore no longer gave counselling a role in approved NHS treatment packages. It also meant that the epistemological basis of EBPP became prioritised over patient preference when assessing the effectiveness of services.

Top-down managerial culture over practice-based clinical judgement.

By 2003, the economic and political decisions based on the 'rigour, independence and objectivity' of NICE's recommendations (NICE, 2018) contributed to what Michael Dixon of the *NHS Alliance* described as a top-down managerial culture originating in Whitehall that 'effectively excludes the voices of front-line clinicians and lay people' (Dixon, cited by Foster and Murphy, 2005, p.5). Aware of the threat to the provision of counselling in primary care, a clarion call was issued by Foster and Murphy for counsellors to mobilise and create managed PCPT services in order to refocus on definitions of effective patient care derived from clinical experience and part of 'more integrated primary care mental health teams' (2005, p.21):

> *We are not in any sense advocating a crude management model for purposes of control, target setting and bean counting, but rather a service-orientated approach to the provision of specialist psychological therapy managed by clinicians who really know the nature of the therapeutic endeavour and who can build good working relationships with others* (Foster & Murphy, 2005, p.5).

This view of an effective PCPT service is a different one to that espoused by NICE; instead, it prioritises clinical knowledge of the relational and person-centred aspects of therapy over the objective measures of EBPP. This is a model that would allow for variety in types of therapy offered when designing a quality PCPT service to account for patient preference, as well as effective evidence-based therapies.

At this time, the DoH did acknowledge problems with the assumptions behind EBPP and the issues regarding homogeneity in developing services, but the resulting implementation of services was not balanced with these views. In assessing the best models for offering quality patient-centred care, the DoH publication *Organising and Delivering Psychological Therapies* (DoH, 2004) acknowledged that there are multiple possible models of 'effective care' and stated that:

> *Psychological therapy provision is a multi-professional and multiagency endeavour. Psychiatrists, psychotherapists, psychologists, counsellors, nurses, social workers, and many other groups are involved all of whom need to communicate and coordinate effectively with one another* (2004, p.4).

It also recognised the debates about the research base and 'everyday practice', and the difficulties of incorporating service-user feedback into NHS services. It called for coordinating different approaches to therapy by a local 'Psychological Therapies Management Committee (PTMC) in which inter-professional rivalries can be mitigated' (2004, p.2). In offering this vision of cooperative, coordinated care, it warns that the 'absence of a "right way" to organise services may be a cause of slow progress in some areas' (2004, p.4).

The publication refers to research on practice-based evidence by Barkham (2003)[1] on page 29 and to NICE guidelines to view the range and effectiveness of evidence-based practice to design equitable and cost-effective services. It states that NICE guidelines can help direct treatment but that comorbidity and complexity mean that services need to be flexible and work together to meet this need. It acknowledges that 'these go a considerable way towards providing a rational structure for delivering psychological therapies, but there are still significant gaps, particularly for people with more than one condition' (2004, p.29). This document clearly argued that practice-based evidence complements EBPP, and for pragmatism in the design of services:

> *Whilst evidence-based practice can be seen as the process of disseminating the best information on 'what should be done' in a service, practice-based evidence including audit asks 'has the right thing been done?' and 'has it been done right?' There are three main components to consider: service audit and quality improvement; service monitoring and 'benchmarking'; and routine outcomes monitoring.* (2004, p.29).

This echoes Henton's summary, citing numerous sources, of the original meaning of EBPP derived from 'evidence-based medicine' as 'good clinical decision-making' (2012, p.13).

Despite the aspiration for a pragmatic approach to PCPT design, fast forward to the introduction of IAPT and it appears that policy makers, who ultimately fund and authorise the implementation, adopted the epistemology behind NICE. The pluralistic, practice-based definitions of effectiveness – here onwards referred to as practice-based psychological

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[1] A corresponding reference is absent in this publication's bibliography; instead, a report by Mackay and Barkham (1998) is listed – it possibly intends a reference to Barkham and Mellor-Clark, 2003

practice (PBPP) – that were proposed by Foster and Murphy (2005) and the DoH (2004), have consequently been relegated to history, to be replaced by IAPT. According to Steen, IAPT is responsible for ‘forever changing the landscape of psychotherapeutic provision, both within and beyond the healthcare sector’ (2015, p.14).

1.6.2. Improving Access to Psychological Therapies (IAPT)

The Improving Access to Psychological Therapies programme (IAPT) was originally designed to provide cost-efficient and effective provision of Primary Mental Health services (see Clark, 2011; Layard et al., 2007). IAPT is seen by some as ‘the most extensive and centralized effort in the dissemination and implementation of EBPTs [evidence-based psychological treatments] to date’ (McHugh & Barlow, 2010, p.75). However, as previously described, the assumptions of the effectiveness of EBPTs are debated (Gambrill & Littell, 2010).

The current IAPT manual (National Collaborating Centre for Mental Health, 2019, p.8) lists three principles that characterise an IAPT service:

> - *Evidence-based psychological therapies at the appropriate dose: where NICE recommended therapies are matched to the mental health problem, and the intensity and duration of delivery is designed to optimise outcomes.*
>
> - *Appropriately trained and supervised workforce: where high-quality care is provided by clinicians who are trained to an agreed level of competence and accredited in the specific therapies they deliver,...*
>
> - *Routine outcome monitoring on a session-by-session basis, so that the person having therapy and the clinician offering it have up-to-date information on the person's progress. This helps guide the course of each person's treatment and provides a resource for service improvement, transparency and public accountability.*

The original IAPT specification for the pathfinder sites outlined a stepped care model that should be ‘evidence-based and value for money’ (DoH, 2008, p.3). This document was produced by two now defunct government bodies, largely charged with implementing the mental health improvements in line with government legislation (CSIP and NIMHE). Although it says that informed choice should be offered and states that ‘person-centred values and psychological awareness needs to be present in the entire workforce’ (DoH, 2008, p.8), there is no mention of counselling treatments in the document. It refers only to CBT as the High Intensity (HI) treatment. It also offers Low Intensity CBT (usually six sessions) delivered by a Psychological Wellbeing Practitioner (PWP) via telephone or face-to-face. The current IAPT manual states: ‘choice [of treatment] should include how it is provided, where it is delivered, the type of therapy and the clinician’ (National Collaborating Centre for Mental Health, 2019, p.27). Choice of treatment other than CBT refers only to mild to moderate depression, because for severe depression and anxiety, other modalities are not NICE approved treatments (National Collaborating Centre for Mental Health, 2019, p.14).

More recently, the ‘IAPT outcomes-based payment approach’ (NHS England and NHS Improvement, 2017, p.6) has been rolled out as the model of payment for IAPT. This was previously more commonly known as payment by results (PbR) and is defined as: ‘the transparent rules-based payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient’s healthcare needs’ (DoH Payment by Results Team, 2013, p.4).

IAPT has now become the predominant source of PCPT in England and is presented as a ‘strong brand’ with ‘an accreditation process’ to protect its ‘legacy’ (DoH, 2012, p.30). IAPT claims to have transformed services (Clark, 2018b; National Collaborating Centre for Mental Health, 2019) and has received unprecedented levels of funding compared to previous PCPT. Radhakrishnan et al. state that IAPT is ‘the biggest shift in policy’ affecting mental health provision over the last 50 years (2013, p.37).

The Political context of IAPT – New Public Management and Neoliberalism.

The design and ideology of IAPT has been argued to be a product of New Public Management ideologies (NPM) (Lees, 2016; Peacock-Brennan, 2016). The broader package of NPM policies was initiated by a Conservative government led by Margaret Thatcher, and created an internal market by separating the purchasing of public services from the providers (i.e. no longer purely state provision). Furthermore, the United Kingdom is seen to have spearheaded the use of NPM as a response to crises in national public finances (Simonet, 2015). NPM was first coined as a concept by Hood (1991) and is characterised by business-like models concerned with customer service and a focus on audit and accountability. Dalingwater summarises its ethos as ‘three Ms: Markets, Managers and Measurement' and claims that the NHS has undergone different versions of NPM ideologies, including policy which is described as ‘Post-New Public Management’ (2014). Dalingwater’s analysis of New Labour’s ‘third way’ (DoH, 1997) to address the problems of the purchaser/provider split, suggests that the core ideologies of NPM have ‘just been repackaged into a more acceptable discourse’ (2014, p.23).

In terms of analysing the extent to which ‘Markets, Managers and Measurement’ have contributed to IAPT’s identity, firstly, we might identify IAPT’s focus on the management of quality in adhering to EBPP approved by NICE, and strict supervision guidelines. Secondly, in terms of measurement, IAPT claims that Routine Outcome Monitoring (ROM) can be used to assess the progress (or otherwise) of a person’s treatment, but also ‘provides a resource for service improvement, transparency and public accountability’ (National Collaborating Centre for Mental Health., 2019, p.8). Third, due to the strict adherence to treatment protocols and assumed quality markers, IAPT can be seen as being marketed to a public ‘consumer’ (DoH, 2012, p.30). The current personalisation agenda (Bennett, 2014) and patient choice of treatment is intended to lead to ‘awareness of IAPT services and promoting self-referrals’ (National Collaborating Centre for Mental Health, 2019, p.40). IAPT says that choice is important because engagement will be better and outcomes improved. Providing choice also allows IAPT services to comply with CQC standards. In terms of the competition aspect of markets in NPM, although IAPT was borne out of Labour’s ‘third way’ that increased funding for mental health and de-emphasised ‘divisive’ markets, the initial design of IAPT does not appear to have been significantly shaped by the desire to increase efficiency and save money through competition. Arguably, it has been shaped predominantly by the measurement and management aspects of NPM.

The principles of NPM – and their correlates in service design – are not without considerable debate due to ‘significant undesirable side effects and misfits between policy announcements and NPM implementation’ (Simonet, 2015). For example, Charlton cites Jenkins stating: ‘the achievement of the Thatcher reforms was to make [NHS] management centralised and supreme’ (2000, p.16). Charlton claims that ‘NHS management is trying to create the illusion of a policy sausage-machine’ and is ‘outwitting the clinicians’ (2000, p.24; p.22). However, not all commentators are negative about NPM, and it may be that there are positive aspects for exploration to avoid throwing the baby out with the bathwater (Dan & Pollitt, 2015). Indeed, the focus of NPM research itself has shifted from critiques of its ideologies towards a more curious evaluative perspective, as well as an interest in themes around innovation, strategic management, human resource management and co-production (Osborne, 2017). Given that policy reforms can shape the very form of an organisation (Brunsson, 2009), it is important therefore, to evaluate the impact of policy on services to find out if – or how – the intended benefits actually materialise in real-world contexts (Mofidi & Marrow, 2017). If they do not, it is then important NOT to embed ineffective policy effects into future services.

This study assumes neither a negative nor positive stance on NPM, or other policy directives and their effects upon service design. It instead aims to offer a detailed evaluation of different policy impacts on PCPT, with a curiosity regarding their various effects within a complex system.

Evaluating IAPT.

Professor David Clark (the National Clinical and Informatics Adviser for IAPT) claims that through IAPT: ‘considerable progress has been made in developing effective psychological therapies’ where patients can ‘expect to receive a course of NICE-recommended psychological therapy from an appropriately trained individual’ (Clark, 2018a). Although IAPT *may* have increased access and made PCPT more equitable compared to the practice-based practitioner model, there are different appraisals of the overall effectiveness of IAPT in treating CMHDs, depending on who assesses its effectiveness (and why).

Nationally, IAPT itself reports regularly on its performance using a variety of measures. Although previously referred to as Key Performance Indicators (KPIs), NHS digital now uses various indicators to monitor and report on different aspects of the service, such as: treatment outcomes; waiting times; activity; efficiency; and data completeness (NHS Digital, 2013; NHS Digital, 2019). Some of these indicators measure effects for clients, and others monitor service effects. They are intended to give information to patients, therapists and services about treatment effectiveness. They are also used to assess individual services against national standards for access, waiting times, and recovery – as well as a basis for PbR.

Initial early reviews of the first rollout of IAPT had different foci and used different measures of effectiveness. Clark et al. (2009) used IAPT outcome data to claim IAPT as a success (however, it is important to note that the authors included the instigators of IAPT itself). Another study, which incorporated qualitative stakeholder feedback, acknowledged that demonstration sites ‘had to contend with the complexities of changing funding structures and success criteria’ and qualified their findings as initial marker points to inform the future implementation of services, suggesting that early claims of effectiveness were not as reliable as IAPT had indicated (Rick et al., 2010, p.9). A later follow-up to this study by Parry et al. (2011) assessed effectiveness in relation to a variety of measures to include: patient experience; organisational impacts; therapy outcomes; and the impact of demographics. It found that IAPT had increased accessibility to PCPT and presented some initial evidence of cost-effectiveness and clinical effectiveness, compared to previous PCPT models. Later studies explored the financial assumptions behind IAPT and highlighted variation in the actual costs and benefits to the programme (Radhakrishnan et al., 2013) and the importance of accurate costings to inform sound commissioning decisions (Griffiths & Steen, 2013a), therefore challenging IAPT’s claims of cost-effectiveness. Early scrutiny of the selection of the possible IAPT model formats from the demonstration sites was debated in the *Clinical Psychology Forum* in 2008, with mixed opinions that reflect the wide range of issues concerning IAPT’s overall effectiveness.

Studies that use the range of measures to evaluate real-world service effectiveness established earlier, offer a more detailed understanding about where IAPT might be considered a success, and where it be might be less successful. Qualitative evidence of general patient satisfaction from the early demonstration sites (Parry et al., 2011) reports client’s desires for choice and personalisation of treatment. A mixed methods survey of client experience of IAPT in London by Hamilton et al. (2011) also found an overall level of client satisfaction, but discovered that clients felt that the service needed more flexibility and less ‘“textbook”’ therapy, with a wider variation in appointment times and locations. Other reports have gathered qualitative data to examine patient experience for more specialised IAPT provision, such as severe mental illness and medically unexplained symptoms and broadly replicate findings regarding overall client satisfaction, with a desire for a patient-tailored service (see de Lusignan, 2013; Hann et al., 2015).

Doubts over IAPT effectiveness.

Despite some evidence to support its success, there is widespread criticism of IAPT’s dissemination and implementation. According to Public Health England, 14.9% of people with CMHDs accessed IAPT in 2018 (2019b). However, the Nuffield Trust state that since 2011/12, referrals to IAPT have increased by 62% from 887,452 to 1,434,000 in 2017/18, but whilst referrals are up, the number of people successfully finishing treatment has stayed the same (QualityWatch, 2018). Using IAPT data, Baker states that 3.1% of the general population were referred to IAPT in 2016-17 and approximately 40% of those people go on to receive a full course of treatment, which is defined in IAPT as two sessions or more of assessment and treatment (NHS Digital, 2018, p.19). It appears then that the access figures do not reflect the delivery of the treatment that many clinicians and clients would class as effective. The impact of IAPT on improved access might also be disputed: when comparing access of people with CMHDs to talking therapies in 2000, 2007 and 2014 in the *Adult Psychiatric Morbidity Survey* (APMS) the rate of increase in access since IAPT was introduced appears to be the same rate of increase as between 2000 and 2007 (McManus et al., 2016, p.22). During the same period, there has been a demonstrable steep increase in medication use however (McManus et al., 2016, p.22). Comparing different sets of data and interpreting the data is not easy, because various reports present different ways of assessing prevalence and access (percentage of whole population; percentage of those with CMHDs; total numbers of people accessing treatment; and so on). Even when the data is read with care however, there appears to be a mismatch between IAPT's claims of increased access to effective treatments and the actual *reported* experiences of the population of receiving effective treatments. The next APMS in 2021 may yet show a significant increase in the rate of access to PCPT which could be seen as attributable to IAPT, but the assumption that IAPT offers improved access to effective treatments more so than previous models of PCPT is not to be taken as self evident, despite the confidence and the 'public relations' exercise through which IAPT reports its effectiveness (Moloney, 2013, p.144).

The use of the IAPT database to prove its effectiveness as a PCPT is heavily criticised by some commentators for obscuring the actual figures. For example, Atkinson called IAPT 'a statistical light show' which is part of a game where 'statistics are essential to the political lie' that reflect a policy of 'contempt for mental health' (2014, pp.18-19). Despite the confidence behind its marketing and statistics, it is important therefore to critically assess the effectiveness of IAPT – and its associated policy directives – in addressing the problems of increasing CMHDs. For example, wider problems such as service upheaval, partnership working and co-production have been linked to the reduced effectiveness of IAPT (Parry et al., 2011). It is evident from the demonstration sites that the complexity of the new IAPT services required a high degree of strategic and operational resource (Rick et al., 2010). Benefits seen in PCPT via IAPT may therefore not be due to IAPT's design, but could instead be due to other service effects such as resourcing, partnership working, and outreach, for example (Rick et al., 2010). The concerns highlighted earlier about IAPT's use of Key Performance Indicators (KPIs) and its costings regarding the tariff (Griffiths & Steen, 2013a; Griffiths & Steen, 2013b; Radhakrishnan et al., 2013), together with doubts about the transparency of the data, mean therefore, that the real-world effectiveness of IAPT is to be questioned.

It follows then, that commissioning and delivering effective services through IAPT – with its embedded NPM ideologies of Markets, Managers and Measurement – will present challenges for clinical leaders.

A splitting of ethical actions? – a one-size-fits-all IAPT.

The management focus of the policy behind IAPT introduced centralised ways of working, such as stepped care, which were difficult to navigate for some of those responsible for implementing the programme (Lewis, 2012; Rick et al., 2010). The predominance of CBT led Gilbert to describe CBT as a 'dominant paradigm in psychotherapy' that was influencing the direction of training (2009, p.400). The conviction of clinical efficacy behind this dominant paradigm – underpinned by IAPT's allegiance to NICE – is disputed (Beck & Waltman, 2015; Johnsen & Friborg, 2015). According to participants in a study by *The Kings Fund*: 'it also served to dampen much of the creativity and innovation in the system' due to a rigid adherence to protocols (Gilburt et al., 2014, p.16). The one-size-fits-all model may not enable clinicians to fulfil their commitment to the best person-centred care and, thus, creates a splitting of ethical actions.

Numerous authors have challenged the theoretical assumptions underpinning NICE guidelines in the resulting design of the IAPT programme (e.g. Callan & Fry, 2012; Del Re et al., 2012; Guy et al., 2012; Samuels & Veale, 2009; Stratton, 2009; Rogers, 2009; Turner et al., 2015). Rather than 'outwitting clinicians' (to use Charlton's terminology, 2000, p.22) with a policy-aligned interpretation of science, Barkham, et al. call for a 'research paradigm…[to] incorporate both *evidence-based practice* (i.e., trials) and *practice-based evidence* (i.e., routine practice data…)' (2017, p.263) – where instead of top-down directives about the best treatment, clinicians can actively review the real-world efficacy of evidence-based practice within a wider set of evaluation methods. Much work has been done to present evidence to challenge the assumed superiority of CBT over counselling, for example (King et al., 2014; Saxon et al., 2017).

Despite the extensive debates, the evidence-based epistemology of IAPT and NICE – and its resulting allegiance to CBT – is assumed by some to be the ‘gold standard’ of psychotherapy (David et al., 2018). However, Woolf et al. (1999) suggest that clinical guidelines can be restrictive for clinicians and are just one determinant of quality care, not the *only* one. Marziller and Hall argue that quality clinical care requires an idiosyncratic approach: ‘We reject the one-size-fits-all, techniques-driven approach in favour of the virtues of initial psychological assessment, careful formulation and offering patients a range of options, amongst which therapy, CBT or otherwise, is just one’ (2009, p.399). Steen describes this approach as a ‘narrow, reductionist approach, born out of a biomedical understanding of mental healthcare’ (2015, p.15), also described by Guilfoyle as an epistemology that creates ‘an a *priori*, taken-for-granted political landscape’ (2019, p.105). Charlton goes further in challenging the use of guidelines and suggests that ‘NICE is not about science, it is about Government and managers attaining the statutory power to control doctors’ (2000, p.29). In IAPT therefore, we might consider a policy context that instigated NICE, to have normalised the one-size-fits-all approach over clinical judgement and autonomy, with NICE as its intermediary to deliver government norms (Davies, 2007).

Even if NICE guidelines *are* assumed to offer effective therapy, the top-down management focus of the IAPT model produces other negative effects. The British Association for Behavioural and Cognitive Psychotherapies (BABCP), a professional body for CBT therapists, claims that managers are being forced or are choosing to ignore NICE approved guidelines for quality care due to operational demands, resulting in a ‘bullying and coercive environment’ for therapists working with clients (2014). Similarly, Dalal attributes the ‘coercive controlling mentality’ and performance pressures in IAPT to ‘toxic organisations’ borne from neoliberal government policy (2018c). The BABCP calls for a ‘high level’ acknowledgement of this increasing problem, although it does not specify what ‘high level’ means (2014). Dalal presents the ideology behind IAPT as an ethical problem for both clients and staff (2018c) – who are all subject to the political football highlighted in Thompson’s study (2007). Whilst not offering any practical solutions, Dalal suggests that there is urgency for action because: ‘surely, continued compliance is not an option’ (2018b). However, with perceptions of IAPT and CBT as a ‘juggernaut’ (House, 2016, p.159) and a ‘tsunami’ (Dalal, 2018a), addressing the top-down management that contributes to the splitting of ethical actions in IAPT sometimes appears overwhelming.

A splitting of ethical actions? – IAPT and the ‘audit society’.

The focus on measurement in IAPT is a product of what Lapsley calls ‘an audit society’ (2008, p.88) which has translated into a culture of performance management and target setting in healthcare (Simonet, 2015). Layard and Clark assert that: ‘outcome measurement is probably the most important single feature of IAPT. It is really the only ultimate guarantee of quality’ (2014, p.205). However, doubts about the evidence base for CBT’s effectiveness challenge the meaningfulness of the measures used in IAPT (McPherson et al., 2009). Mollon goes further in criticising the narrow assessment of clinical effectiveness in the NICE-approved protocols used in IAPT, and argues that a lack of psychological thinking about the client in the available therapy models that favour ROM can actually slow down recovery (2009). When qualitative methods are used, such as reports of client’s direct experience of therapy rather than ROM, different measures of quality emerge (Binder et al., 2010). Furthermore, Tasma et al. (2016) suggest that even when ROM is in place, it is not necessarily applied to treatment plans in the intended way. Therefore, the existence of ROM alone cannot be assumed to lead to quality of treatment, even if we agree with the assumption that they *do* measure quality, as Layard and Clark (2014) propose (see also: Lambert & Harmon, 2018).

Of deeper ethical concern for many critics of the audit culture of IAPT, are the perceived hidden political agendas that may perpetuate the toxic managerial environment described above, and the government's ‘contempt for mental health’ that Atkinson proposed lays behind the statistics (2014, p.19). With outcomes being linked to PbR, this potentially creates a number of ethical conflicts where IAPT becomes a vehicle for money-saving and performance management, which de-prioritises the wellbeing of clients and staff.

Firstly, a perceived ideology behind the employment agenda causes concern for many clinicians about their role as therapists (Khanom, 2015). IAPT has still retained what some people see as a punitive and coercive route into therapy that is simply designed to slash the government's benefits bill (Scanlon, 2015). Conversely, Wesson and Gould (2010) argue that the back-to-work agenda does not necessarily have to interfere with the therapeutic alliance in CBT. Layard and Clark deny any underlying government motives and go further to suggest a rather grander identity for IAPT: ‘Is it basically a programme to push people into work? Not at all. It is a great humanitarian project, just like any other major health programme’ (2014).

Secondly, because ROM is used as part of payment by results (PbR) along with other targets set by NHS England, there is a risk of perverse incentives. NHS England and NHS Improvement state that PbR 'builds on the IAPT model and the data that all providers of IAPT services are required to collect and submit to the national IAPT minimum dataset' and that an outcomes-based payment model 'balances the need to pay for activity, taking into account case complexity and severity as a driver of cost, with the need to incentivise good outcomes' (2017, p.6). The degree to which PbR improves outcomes and patient care is questioned (Flodgren et al., 2011) and furthermore, PbR has been associated with risk for providers and commissioners (DoH Payment by Results Team, 2013). Binnie attributes negative effects on the quality of clinical care due to target pressures from commissioners (2015): Callan (2013) reminds us that evidence-based PbR in IAPT can be the 'tail that wags the dog' for services and should not replace rewards for practice-based evidence of success. Although IAPT condemns gaming and perverse incentives (Clark, 2017), it is not clear how providers address the underlying pressures that bring this about. Like Binnie (2015), Layard and Clark (2014) attribute the 'outrage' of suboptimal doses to the pressure of chasing targets from commissioners, but they defend the IAPT model itself. (DoH Payment by Results Team, 2013).

Griffiths & Steen (2013b) advise that commissioners need a more flexible approach to deciding which ROM represents good performance, rather than a simplistic reading of IAPT measures. However, given the pressures to achieve value for money, commissioners may be tempted by the transparency and simplicity of PbR – based upon ROM – as the assumed optimal way to improve services. Steen therefore believes that the crucial mediator for addressing inconsistencies in the quality of clinical care is how IAPT is implemented (2015).

Thirdly, the effects of pressure to gather and report data, may not only cause perverse incentives in treatment, but may also cause stress for the workforce. The New Savoy Partnership (NSP) explored the experiences of the workforce in IAPT. It surveyed staff and reported increasing stress from 'relentless pressure to meet targets with inadequate resources, as well as loss of autonomy, degrading of the professional role of psychological staff, and excessive managerial control' (2015). One respondent described IAPT as 'a politically driven monster' (The New Savoy Partnership, 2016). The marketisation of IAPT, a perceived disregard for the societal causes of CMHDs and competition for contracts are seen as the main cause of these mounting pressures (Cooke & Watts, 2016). Other research confirms the negative impacts of target culture on staff in IAPT, and other Mental Health services (Johnson et al., 2018; Steel, et al., 2015; Walklet et al., 2014; Westwood et al., 2017). The rigid adherence to top-down measures of effectiveness and the resulting organisational pressures, have been associated with poor client outcomes and are therefore likely to reduce IAPT's overall effectiveness (Delgadillo et al., 2018).

Even though the stress from targets is clear, there does not seem to be any significant solution to the problems of burnout or investment in alternative measures of effectiveness to challenge the IAPT database. To address problems of stress on staff in IAPT, the *NSP/BPS Staff Wellbeing Charter* call for 're-setting the balance between managerial targets and staff wellbeing' (The New Savoy Partnership, 2015). Gyani et al. assert that 'compliance with the IAPT clinical model' is the main marker of good patient outcomes (2013, p.597), but make no mention of the effects of the target culture on staff. It has been perhaps left to clinicians and researchers themselves to robustly acknowledge and name the very real problems imposed by the top-down management culture of NPM, as Cotton identifies: 'targets are politically motivated, passed down from ministerial to management levels without due consideration of local needs and resources' (2016, p.9). The evidence is clear that the policy-informed drive towards ROM, and its associated effects on staff and clients, contribute to a further splitting of ethical actions.

A splitting of ethical actions? – the marketing of IAPT.

Fisher defines marketisation as 'a system where relationships and behaviours are driven by competition and profit' and furthermore, suggests that competition for resources and 'customers' changes the culture of public services towards one of commodification (2013). Rizq (2014) believes that IAPT represented this move towards commodification and sees IAPT as a 'perversion of care' (Rizq, 2012a) for treating clients in distress. IAPT workers are seen to collude with each other to protect the system against criticism or the acceptance of their own powerlessness, so that 'good clinical work becomes confused with its auditable surface' (Rizq, 2014, p.217). Similarly, Strawbridge and Woolfe fear that therapy, as it is marketed by IAPT with its focus on the individual, might be a cover for underlying socio-political injustices (2010).

According to Layard and Clark, the ever present drive towards value for money – that could be perceived by some as a hidden political agenda embedded within the design of IAPT and

NICE – might lead to commissioners ‘dumbing down quality’ (2014; see also Glover-Thomas, 2013). Binnie agrees that the real-life complexity of quality therapy might be over simplified in IAPT but, whereas Layard and Clark would say this is not an inherently IAPT problem, Binnie borrows from Ritzer (1993) and argues that IAPT is a ‘McDonaldization process [where] everything is supposed to be manualised to the point of the idea of the “interchangeable therapist”’ (Binnie, 2015, p.82). Binnie believes that IAPT has therefore undermined what good quality person-centred CBT represents, echoing Leader, who suggests that CBT – as it appears in IAPT – is ‘[a] quick fix for the soul’ and represents a ‘triumph of a market-driven view of the human psyche’ (Leader, 2008). Despite IAPT marketing the quality of its evidence-based therapies [N.B. *therapies* in the plural], *The Mental Health Foundation* criticises the range of treatment options available that are appropriate to the client (2016) and the APMS suggests that one in ten clients with severe CMHDs have not received the treatment they wanted in the previous twelve-month period (Lubian et al., 2014, p.23).

With its standardisation, audit focus and perceived McDonaldization, House suggests that IAPT’s ‘control-fixated “manualisation” mentality’ fundamentally damages ‘the very essence of effective therapy’ and instead, proposes ‘an embodied, grounded approach’ (2016, p.147). Like Rizq, House believes that the neoliberal paradigms behind IAPT are ‘uncritically embedded...in the very psyches of managers and policy makers’ (2016, p.147). Together with the emotional splitting described by Rizq and its prescribed training model, we might then view IAPT in the same way that Norcross described manualised therapies as ‘disembodied therapists performing procedures’ (2002, p.4).

Furthermore, as IAPT becomes integrated into surgeries and healthcare settings, the expectation of ‘therapists in primary care [to] carry within themselves the tools required to undertake therapy in different physical locations’, leads us to a vision of the ‘portable therapist’ (Howard, 2012, p.93). Whilst in some ways the return to the GP practice echoes the practice-based counsellor model prior to IAPT, Howard suggests that IAPT’s culture has increased the experience of a therapist being ‘part-object’, who experiences increased isolation and stress when working remotely from their team in a medicalised setting, especially when working with increasing complexity. The IAPT manual speaks of the ‘co-location’ of therapists and indicates that IAPT will be working with Long Term Health Conditions (LTHCs) and within secondary care (National Collaborating Centre for Mental Health., 2019, p.60). It recognises that: ‘the greater the complexity of the presenting issue, the more substantial and multi-professional the package of care needs to be' (National Collaborating Centre for Mental Health., 2019, p.9), but there is little detail about how support for therapists will be delivered in the IAPT model, or if the caseloads will be adjusted for this person-centred aspiration for therapy. The co-location of services does not necessarily equate to an integrated service if the therapists are portable; arguably, they are then also dispensable and *less* integrated into the health care system. Here again, the notion of a disembodied therapist expected to deliver a one-size-fits-all treatment – but at the same time expected to be patient-centred, flexible and integrate with different teams – might be an example of 'the tendency for IAPT services to systematically disavow feelings of loss and vulnerability in both staff and patients' (Rizq, 2012b, p.319).

Taken together, the top-down bureaucracy, audit culture and marketisation have contributed to the disembodiment of therapy in IAPT and created a splitting of ethical actions for clinicians and clinical leaders who aspire to person-centred and sustainable services. IAPT is one model of provision and, due to its considerable political backing, it wields power over alternative models. It is therefore important to see the current version of IAPT not as a natural end point or the pinnacle of effective services, but as a staging post to help us reflect on what works – and what might not work – to enable the best quality person-centred PCPT in an evolving policy context. The current study offers insight into the flexibility of clinical leaders in evaluating the performance of existing IAPT services, and their adaptations to its evolving policy context. This includes Any Qualified Provider, but can also be applied to future policy impacts on services.

1.6.3. Any Qualified Provider

As part of this continually evolving policy landscape, the directive Any Qualified Provider (AQP) was a product of the Health and Social Care Act (HSCA, 2012), and the act's preceding NPM principles. It was an extension of New Labour's 'Any Willing Provider' policy, and renamed as 'Any Qualified Provider' in 2010 (DoH, 2010b). Any Willing Provider itself grew from the principles that had been operating around choice in elective care since (DoH, 2003) and the vision in the white paper *The new NHS modern . dependable* that: 'the internal market will be replaced by a system we have called "integrated care", based on partnership and driven by performance' (DoH, 1997). By 2011, the principles of 'choice, co-operation and competition' were seen to be central to NHS reforms by the government's *Co-operation and Competition Panel* (https://www.ccpanel.org.uk/about-the-ccp/index.html), together with a focus on efficiency and competition in the white paper *Equity and excellence: Liberating the NHS* (DoH, 2010a).

AQP itself does not outwardly refer to competition but promotes *patient choice* 'to empower patients and carers, [and] improve their outcomes and experience' (DoH, 2011, p.4). The policy directive requires that: providers meet quality and safety standards; commissioners set local pathways; referrers provide information on choice; and competition should be based on quality – not price, because providers receive a fixed price for delivering interventions, usually via PbR. In IAPT, the tariff is based on mental health currencies (care clusters) that were mandated by The Health and Social Care Act 2012 (Monitor [now NHS improvement], 2013, p.4).

Commissioners were required to commission at least three primary care services, out of a choice of eight, using AQP (DoH, 2011). This list of services included PCPT. Commissioners are no longer required by the government to adopt AQP, but can choose to use it or not (NHS England, 2013). It has been suggested that the policy itself is waning (Williams, 2014) and indeed, AQP is not mentioned in the Five Year Forward View (NHS, 2014) or the *NHS Long Term Plan* (NHS, 2019). Some reasons for this may be found in the difficulties of the policy experienced by providers and commissioners (Baker, 2014; Griffiths et al., 2013) and in the practical and economic barriers to the implementation of AQP experienced by commissioners during a time of considerable structural change in NHS governance (Naylor et al., 2010). Notwithstanding, a search of NHS contracts reveals that AQP is still being used (UK government contracts finder website: https://www.contractsfinder.service.gov.uk/Search). Despite the apparent lack of popularity of AQP, it offers an insight into what might be seen as a loosening of other policy directives, as the guidance document states: 'We are seeking to support flexibility within the national framework to enable a commissioner-led process, relevant to local priorities, whilst maintaining consistency' (DoH, 2011, p.6). It also says that it seeks to learn lessons from each stage of its rollout.

AQP can therefore be summarised by five features: choice; competition; PbR; expected quality standards (including existing NICE and IAPT governance); and top-down governance (including NHS directives and government policy). Clearly, these categories interact with each other and may be in conflict; as noted earlier, the policy landscape is fluid and IAPT services are operating in a complex system. ‘AQP’ in this study will refer to the policy itself or to providers delivering under the AQP policy.

Although AQP was only adopted by around twelve Clinical Commissioning Groups (CCGs) to commission IAPT services, and some have since discontinued it, AQP was still being used to commission IAPT services by at least eight CCGs between 2015-16. In providing extended patient choice by increasing the number of qualified providers, AQP increases the diversity of provision in IAPT. Many of the organisations providing psychological therapies as an AQP are from the charitable, non-profit and non-statutory sector – also sometimes referred to as the ‘third sector’ – and often represent a service-user led ideology (Griffiths et al., 2013). Whereas the one-size-fits-all model of IAPT is seen as rigid and controlling by some, there is some suggestion by Griffiths and Steen that through AQP: ‘the “pure” model of IAPT is increasingly being diluted as commissioners make pragmatic, evidence-based adjustments to the model’ (2013a, p.153). AQP may therefore be an example of how different strands of policy create opportunities to re-evaluate – and perhaps challenge – the core principles of service design from earlier strands of policy.

Existing research on AQP.

There is very little research into the experiences and processes of AQP in general, and even less on AQP in IAPT. AQP represents a fairly contentious topic and is subject to emotive debate, perceived by some to be part of the NHS ‘privatisation’ agenda (Pym, 2014), although others claim that this has not materialised (Ham et al., 2015). There are numerous consultation and scoping documents from around the time that AQP directives were issued (see for example, NHS Cheshire, Warrington and Wirral, 2011), and local audits of AQP experiences, such as Musculoskeletal Services (Hounslow and Richmond Community Health Care NHS Trust, 2013), and in IAPT (Little et al., 2015).

Detailed studies to understand the experiences of different stakeholders are few. Pryce et al. (2016) investigate how patients exercise choice in an audiology AQP in one geographical area, but it does not analyse the policy itself. Walumbe et al. (2016) investigate narratives and the process of change for managers and clinicians implementing AQP in musculoskeletal services. Osipovič et al. (2016) use AQP as part of a study on commissioner’s and manager’s perceptions across several geographical areas, of top-down changes in competition and cooperation. A DoH funded study from Monitor (2015) reports several (but slight) significant differences in positive patient experience of choice in audiology between AQP and non-AQP sites. It gathered survey and qualitative data from a wide geographical area and investigated commissioner's experiences of implementing using AQP, but it is limited on the feedback from providers.

Studies into AQP in IAPT services are fewer still. A report by NHS England and NHS Improvement looked at case studies that used AQP to inform PbR in IAPT, but predominantly looked at how the payment model impacted KPIs (2018). Concerns and debate around this topic suggest that the perception of AQP is viewed with caution (Sainty, 2015). Other studies explore experiences of clinicians adjusting to change in AQP as a secondary finding to primary concerns, such as the transfer of IAPT training skills (McGonagle, 2015) and the expansion of family therapy in IAPT (Smith et al., 2017).

Very few studies explore the experiences of commissioners and providers of AQP in IAPT. The major existing study is Griffiths et al., which looks at qualitative data from three commissioners and ten providers (one NHS trust, and mix of not-for-profit and private providers) – four of which went on to deliver services under AQP (2013, pp.12-13). This report came out at the very start of AQP in IAPT, and generally pointed to the challenges and difficulties experienced. In contrast, a different study of providers and commissioners to investigate AQP, that included IAPT services, suggested that participants were generally positive about AQP (Jones & Mays, 2013). Additional anecdotal reports and opinion about AQP can be found in *The Journal of Psychological Therapies in Primary Care* (see for example, Keefe, 2013). I am also informed by findings from my own qualitative research into provider's experiences in one area's implementation of AQP (Baker, 2014). Possibly because of the scarcity of research into AQP/IAPT, there are no studies that evaluate established AQP services in IAPT. The current study addresses this gap in the literature and reflects on the experiences of those implementing IAPT with AQP.

1.6.4. Beyond IAPT – new models of care?

Current and future policy context.

A major policy milestone for the NHS emerged in the form of the Health and Social Care Act in 2012 (HSCA 2012). The white paper that preceded it, *Equity and Excellence: Liberating the NHS* (DoH, 2010a), was intended to extend the ways that the NHS could purchase services and goods. Within it, Andrew Lansley refocused the NHS onto four main areas; putting patients and the public first; improving healthcare outcomes; autonomy, accountability and democratic legitimacy; and cutting bureaucracy and improving efficiency. A key principle of the act was to embed the existing principle of quasi-markets into healthcare (Timmins, 2018). Quasi-markets were seen to promote efficiency and responsiveness via competition, while the state maintained top-down regulation (Le Grand, 1997).

The restructuring of the NHS has been described as ‘perpetual cycles of redisorganization’ (Oxman et al., 2005, p.563) and is seen by some to destabilise it (Oliver, 2018), evoking language such as deception and despair (Davis & Tallis, 2013; Davis et al., 2015). With the creation of ‘Arm’s Length Bodies’ (ALBs), the HSCA 2012 might be seen to have had a hidden agenda of distancing the government from the mounting problems in the NHS, and it has been criticised for a lack of transparency and intelligibility (Timmins, 2017b). For example: the numerous renaming of regulatory bodies – such as Monitor (now *NHS Improvement*) – makes it very hard to know who is who, and who is accountable to who (House of Commons Public Administration Select Committee, 2014). Furthermore, these changes have been proposed as instrumental in opening the doors to privatisation due to increased marketisation (Krachler & Greer, 2015), while the principles of competition within the act are also seen to increase fragmentation (British Medical Association, 2018a; Giovanella, 2016). The process of marketisation after the enactment of HSCA 2012 is characterised by a complex and fragmented regulatory environment (Krachler & Greer, 2015; Mofidi & Marrow, 2017). We have seen how NPM principles have influenced the design of IAPT; we now explore how policy pressures – including performance-based payment approaches – have impacted the commissioning of services.

The influence of policy on commissioning regimes.

Commissioning models play a highly significant role in the implementation of PCPT in this complex regulatory environment, and are also subject to policy change. Commissioning of statutory services is not simply purchasing: it reflects a ‘broad set of linked activities including needs assessment, priority setting, procurement through contracts, monitoring of service delivery and review/evaluation’ (Ovretveit, cited by Smith et al., 2010, p.12). Commissioners have used different approaches, including: evidence-based commissioning (Clarke et al., 2013); practice based commissioning [‘practice’ as in ‘GP practice’, not clinical practice] (Curry & King's Fund, 2008); and ‘Outcome-Based Service Commissioning’ (Bovaird & Davies, 2011). In these commissioning models, we see similar tensions for clinicians between patient-centred values and the policy drive towards standardisation, measurability and cost-effectiveness.

Just as practice-based evidence in clinical practice can resolve some of these tensions, drawing on Fulford’s notion of values-based practice (2008), Heginbotham (2012, p.viii) proposes and defines values-based commissioning as: ‘the reflection of our values in a discussion of the evidence’. It attempts to help commissioners put the patient at the centre of service commissioning as they ‘struggle with governments’ change programmes at a time of austerity [to] achieve a better and more responsive health and social care programme acceptable to all patients and service-users’ (Heginbotham, 2012, p.ix). This model potentially allows commissioners to seek the wider range of measures of service effectiveness explored earlier, rather than those offered by the dominant political paradigms behind EBPP, such as a simplistic payment by results model. Whilst this notion sounds attractive, values-based practice is not without debate due to the very real and practical barriers facing healthcare systems (Loughlin, 2014). The need for a move away from simple activity-based contracts towards a radically different way of commissioning services in the wider healthcare system is emphasised by the Care Quality Commission (2018). However, delivering ethical values and effectiveness in the current policy environment poses many challenges for the joined-up commissioning of services that hold different – and sometimes competing – principles (McCafferty et al., 2012).

Geyer uses complexity theory to examine the decision-making styles of commissioners in the context of public health reforms, and suggests that they are operating in a zone much more complex and disordered than previously (2013). Like providers, commissioners may have to perform organisational acrobatics in order to attempt to fulfil as many competing needs as possible – what Geyer terms a ‘balancing process’ (2013). These needs lie both within themselves and in their relationships with different stakeholders (patients; clinicians;

managers; CCGs; NHS England; DoH; the public purse; etc.) and with the continually changing top-down targets and directives, such as the Five Year Forward View and CQUINS (Commissioning for Quality and Innovation, which are payments intended to locally incentivise quality improvements; see NHS England, 2018). The complexity of future integrated systems – Sustainability and Transformation Partnerships, for example – mean that commissioners must choose between different contractual models, and balance their advantages and disadvantages for each particular setting (Addicott et al., 2015). Models that are taken-for-granted – such as outcomes-based payment models – can have unforeseen consequences, and involve trade-offs between cost-savings and quality improvement (Appleby et al., 2012). As we have seen, these policy-driven trade-offs are of key importance to clinical leaders.

Sustainability and Transformation Partnerships and integrated healthcare systems.

In addition to pressures towards outcomes-based commissioning models, another current change likely to impact PCPT are Sustainability and Transformation Partnerships (STPs). STPs are likely to transform into Accountable Care Systems (ACSs) or 'Integrated Care Systems' (ICSs), with the potential to become Accountable Care Organisations (ACOs). These joint bodies are envisaged to link the provision of healthcare beyond the primary domain of the NHS with other social care providers, such as local authorities. This shake up of the NHS is intended to 'to mobilise collective action on "health creation" and service redesign' (NHS England, 2017a, p.32). What this means however, is not clear. Does this mean that the players in the political football game (including clinicians) might be able to to set more of the rules? In the emerging landscape of integrated working, the involvement of clinical leaders in service redesign would be welcome to help balance the dictates of top-down policy, outlined previously. The current research offers insight into the extent to which this is possible, bearing in mind the various trade-offs that impact the delivery of real-world services.

As we have seen, this real-world context of partnership working is complex – and STPs are not without debate. Some fear that the NHS is being manufactured into an American model of healthcare, with the loss of core NHS values and qualities (Alderwick et al., 2018; Pollock & Roderick, 2018). This would not lead to harnessing 'the renewable energy' or to the 'collective action' of its stakeholders, as claimed by the NHS (2014, p.9) but – according to Hudson – would instead, take power away from them (2018). Whilst the HSCA 2012 aimed to increase efficiency, the opening up of the healthcare market to a wider range of providers as seen with AQP for example, also introduces a fragmentation that seems to contradict the Act’s pledge for patient-centred care across sectors (British Medical Association, 2018a). There is doubt about whether or not STPs can remedy this, without reverting back to ‘monolithic provision’ (Timmins, 2017a). For Cotton, the restructuring brought about by STPs represents a blunt and brutal reduction and localisation of public health services (2017).

Furthermore, how these new health systems might look or operate has not been made clear. Whilst there is an overall desire to preserve NHS values in partnerships of publicly accountable bodies – rather than US style ACOs – the STP vanguard sites are trialling different ways of integrating services (Public Accounts Committee, 2017, question 83; West, 2017). Priorities for implementing change will be ‘cancer, mental health and the strengthening of primary care’ (Simon Stevens, Executive of NHS England, Public Accounts Committee, 2017, questions 93 & 95 respectively). There is considerable uncertainty however, with STPs reportedly being described as ‘sticky toffee puddings’ by those working within healthcare, and being likened – in reality – to fudge (Iacobucci, 2018). As yet, there is no legislation or formal policy attached; the changes implemented by the NHS are changes in governance structures and interorganisational communications. There is a pragmatism in parliamentary debate about the limits of these changes, given the existing quasi-market system being used in the NHS, and the real-world costs and effects on patient care; for example, problems associated with social care providers going out of business and the negative impacts of zero-hours contracts (Public Accounts Committee, 2017, question 83).

Jeremy Hunt has said that ‘these models weaken the “internal market”, or purchaser-provider split, to allow integrated and joined-up care’ (2017). Although currently there is no policy directive for STPs, the apparent implications for change to existing policy is clear (Timmins, 2017a). *The Economist* (2017) sees this as a ‘Policy transplant’ with potential to address the problems of fragmentation and silo culture within the NHS, citing Collins’ suggestion that STPs represent ‘a complete reversal of the Health and Social Care Act of 2012’. This is tentatively heralded as a move away from the worst aspects of the previous NHS market reforms towards a new era of cooperation between healthcare providers, putting the patient’s whole health at the centre of care.

We can see how policy is messy and therefore might offer opportunities for adapting models of delivery as well as instigating them, as with IAPT. This research investigates any potential for clinical leaders to *use* policy – rather than simply be controlled by it, as is frequently assumed.

New models of care in Primary Care Psychological Therapies?

As we have seen with IAPT, policy reforms and directives become translated into service redesign, and may also change the core principles driving them. The increasing pressure on the NHS as a whole has resulted in documents such as the *Five Year Forward View* (FYFV) and the *NHS Long Term Plan* that outline the principles by which services should change (NHS, 2014; NHS, 2019). These documents are designed to help services – currently, and in the future – to meet increasing demand for NHS services, to improve efficiency and to ensure adequate funding. With an outward commitment to public consultation, the FYFV states that: ‘we have not fully harnessed the renewable energy represented by patients and communities’ (NHS, 2014, p.9), but this is seen as sham consultation by some (Hudson, 2018). The more recent *NHS Long Term Plan* goes further than the FYFV in its recommendations for changes in legislation to promote integration, reduce bureaucracy and ‘remove the overly rigid competition and procurement regime applied to the NHS’ (NHS, 2019, p.10). Even when previous policy directives are implemented, the healthcare system is constantly evolving as Hunter (2015) suggests. This *may* offer scope for more involvement of key stakeholders; alternatively, perhaps the top-down nature of policy is too established for any meaningful bottom-up change.

The *Five Year Forward View for Mental Health* (FYFVMH) recognises the increasing problems facing mental health provision, and states: ‘there is now a need to re-energise and improve mental health care across the NHS to meet increased demand and improve outcomes’ (Mental Health Taskforce, 2016, p.5). It draws upon public consultation to suggest ‘new models of care’ (Mental Health Taskforce, 2015; 2016, p.19). It presents service-user feedback that prioritises: ‘prevention, access, integration, quality and a positive experience of care’ (Mental Health Taskforce, 2016, p.3). To deliver this, the document sets out many objectives and commitments to ‘deliver improved access to high-quality care, more integrated services’ in a ‘triple approach’ to ensure parity of esteem with physical health; investment in the workforce; and enough funding to sustain effective services (Mental Health Taskforce, 2016, p.5). The FYFVMH used public consultation and represented a wide range of stakeholder's views, including staff and clinical leaders. NHS England's Implementation plan for the FYFVMH provides the actions that are proposed to fulfil the FYFVMH's recommendations (NHS England, 2016).

When assessing to what degree the new models of care proposed by the FYFVMH might address the splitting of ethical actions that we have seen in IAPT, the implementation plan appears to have lost some of the focus that appears in the FYFVMH on co-production that includes clinician's voices and the wellbeing of staff. The plan also fails to reflect the complexity and challenges of payment models that is acknowledged in the FYFVMH itself, but instead focuses on existing 'outcome-focused, intelligent and data-driven commissioning', with the assumption that the existing 'well-developed data collection' of the IAPT model – which is a significant source of ethical tension for clinical leaders as described previously – provides robust enough data for benchmarking and quality improvement (NHS England, 2016, p.5; p.19).

Any potential for more effective new models of care sits within the constraints outlined above, and within a nexus of clinical and political practices. The HSCA 2012 was intended to loosen NHS bureaucracy and stimulate competition and efficiency – resulting in the 'policy experiment' of AQP. Commissioning models have balanced multiple priorities concerning patient's needs and top-down policy pressures. STPs have been heralded as the answer to system fragmentation that will refocus on patient-centred care; however, the uncertainty surrounding STPs raises fears of large and unaccountable organisations that may not hold the core values of the NHS and may not guarantee the efficiencies or improved quality of care that they are intended to deliver. Despite the lack of clarity about how to resolve the different tensions in this evolving policy landscape, the NHS have proposed guidelines for the shape of future services, and their core values in the FYFV and the *NHS Long Term Plan*. The FYFVMH offered a vision for new models of care for mental health services, but many questions remain about how clinical leaders might balance competing pressures in the co-production of services. Therefore, this research may shed light on the overall ability of clinical leaders to influence new models of care in this complex and evolving policy environment.

1.6.5. Rationale

AQP and new models of care.

The new models of care suggested by the FYFVMH are envisaged to address the problems of delivering mental health services in the new landscape of integrated working in Sustainable Transformation Partnerships (STPs), with an ever increasing pressure to save money. AQP represents a shift in the existing policy principles of IAPT services – some of which cause a splitting of ethical actions for clinical leaders. In the new models of care described above, the flexibility of AQP in relation to policy may offer opportunities for PCPT, as the healthcare system and the policy that influences it, evolves. An investigation into AQP in PCPT is of wider interest to other mental health and care services, because it shares some features with the ongoing changes in policy that are shaping NHS models of care – such as joint working, and the use of different ways of commissioning and paying for NHS services (for example, payment by results). This is an under researched area, but an important one for investigation given the current demand for – and the challenges facing – the delivery of quality patient-centred PCPT services in England. It is hoped that learning from this study might inform the future design of PCPT in a changing policy landscape.

Therefore, the key research questions are: firstly, how does AQP compare to existing IAPT services as part of new models of care to address the problem of increasing demand for effective PCPT? Secondly, what are the underlying policy assumptions of clinical leaders, and how do they shape the commissioning, organisation and delivery of IAPT under AQP? The second question is important for the development of the most effective new models of care in PCPT. The research questions are viewed from a Counselling Psychology perspective, with a view to potentially developing a Counselling Psychology oriented discourse on leadership and politics.

2.0. METHODOLOGY

> *Rather than a set of general rules, the knowledges (in the plural) relevant to care practices are as adaptable and in need of adaptation as the technologies, the bodies, the people, and the daily lives involved*
>
> (Mol et al., 2010, abstract)

2.1. Epistemological and ontological position of the researcher

As a researcher, I consider myself to hold a critical realist ontological position (Bhaskar, cited by Rogers & Pilgrim, 2003, p.8). My epistemology contains elements of social constructionism, pragmatism and contextualism. I acknowledge that my own engagement with the research process is constructed from my interpretation of the data, but also from the deliberate questions generating it. For example, I interpret the data from my own social constructions, constructed from a variety of positions that include the counselling profession, psychology, academia, and as an employee of an NHS organisation. My research questions are influenced by other positions outlined in the reflexive statement in the introduction, and are reflected on further in the discussion section. I cannot separate myself from these social constructions, and understand that neither can my participants. The social constructions are therefore an integral part of my enquiry, and I accept that there will never be one essential ‘truthful’ picture from this study.

Notwithstanding my understanding of constructed perspectives, I also recognise that healthcare systems are, to some extent, predictable and able to be understood by ‘common sense’. I therefore utilise a pragmatic lens in how I understand real-world health contexts which operate with tight budgets that may limit practitioner’s capabilities. Long (2002, p.40) defines epistemic pragmatism as ‘an epistemology that emphasizes the primacy of practice or practices’ or in other words, citing Putnam, as ‘an epistemology with a human face’. This study is designed by – and for – its real-world setting and therefore incorporates contextualism, which is defined by Braun and Clarke as an epistemology that is ‘local, situated and therefore always provisional' (2013, p.31). However, they also recognise that some sense of 'truth' can be generated from research, so long as it is viewed in relation to the context from which it is inferred. The shifting complexities of the healthcare system under study therefore requires an epistemological approach that is not restricted by a narrow realist *nor* by a constructionist reading (Willig, 1999). I believe that participant's interpretations and responses – like my own – are partially created from social constructions and partially from a pragmatic response to their engagement with very real tasks and limitations in a changing world.

I agree with Cutts (2013b) in the argument against assuming a rigid linear relationship between ontology, epistemology and methodology in a research study (see also, for example, Bradbury-Jones et al., 2017). As a Counselling Psychologist, I use different parts of my identity to understand and engage with the world: as a scientist-practitioner, I value reliable evidence to examine phenomena (Nicholson & Madson, 2015); as a reflective practitioner (Schön, 2013), I incorporate my subjective identities, roles and interactions; and as a critical practitioner (Fraser & Matthews, 2008), I engage with the reality of unknowns, injustices and limitations to my own and other's contributions to real-world problems. Therefore, I argue for methodological pluralism, so that my findings are not not artificially limited by any particular research paradigm that blindside me to discovery.

I have already outlined my pragmatic viewpoint and cognitive style in the introduction. My commitment to the applied functions of psychology and my awareness of the complexity of health systems have therefore influenced my choice of study design, its communication style and its intended audience. The study therefore embraces the practice-based research attitude advocated by Henton (2012).

2.2. Design and Analysis

The design of this study attempts to address the 'rigor versus relevance dilemma' (Mårtensson & Lee, 2004, p.508) of research that is reliable and valid, but also applicable to the real-world problems of treating mental health within a complex policy landscape. Whilst I am not an applied researcher who has been commissioned to conduct a quality improvement study, my motivations for researching AQP come from my position of practising and supervising within the AQP/IAPT policy context, and my experience as a manager. There is consequently an element of action research in my research design (Costello, 2003). However, because I am interested in the theory behind real-world practices, my study also acts as ‘dialogical action research’, utilising an iterative process of reflection and interpretation between roles of researcher and practitioner and highlighting ‘knowledge heterogeneity’ (Mårtensson & Lee, 2004, p.507), with the difference being that I embody both roles in one person.

The study aims to inform CoP theory as a way to improve practice; and because it aims to address a gap in CoP literature relating to political engagement, it uses a transdisciplinary lens, as Bammer describes: ‘Transdisciplinary research aims to support policy and practice change, usually through an engaged approach with end-user policy makers and practitioners, seeking to involve them in the development of the framework and interpretation of the results’ (2013, p.251). The topic is intended to be of interest to policy-makers and practitioners; therefore, the study participants (commissioners and managers) were deliberately selected to reflect this aim.

Whilst there are differences in the scope and definition of transdisciplinary, interdisciplinary and crossdisciplinary studies, the concerns for appropriate rigour in respecting discourses within each discipline being used, is addressed by observing some core principles in research design. For example, Szostak (2012, p.9) suggests five major steps: 1) To identify an interdisciplinary research question; 2) Identify appropriate literature and methods; 3) Identify conflicting disciplinary ‘insights’; 4) Identify common ground between disciplinary insights; and 5) Integration, understanding and dissemination of findings. In this study: the first step identifies the problem of the impact of policy on PCPT; the second step establishes AQP in a complex background of evolving policies and clinical practices in IAPT; the third step raises questions relating to conflicts between policy and clinical practices in PCPT; the fourth step looks at how policy and clinical practice might be able to interact; and finally, CoP discourse – based on its social justice commitment – is proposed as a vehicle for understanding and addressing the real-world problem under investigation.

To improve the dissemination of my findings to an appropriate audience, the design and reporting was informed by submission guidelines from the *Quality and Safety Journal* (https://qualitysafety.bmj.com/pages/authors/#original_article) and by consulting relevant guidelines to ensure the quality of my research for an applied setting. These included: COREQ guidelines for interviews (Tong et al., 2007); SQUIRE guidelines for quality improvement reports (Ogrinc et al., 2015); STROBE recommendations for improving observational studies (von Elm et al., 2007); and recommendations on the reporting of qualitative research (O'Brien et al., 2014).

AQP/IAPT is an example of a transient and disorganised policy that interacts with other layers of policy (such as NPM), which impacts the implementation of mental health services in complex ways. This study takes advantage of the brief window of opportunity to investigate the under researched area of AQP policy in IAPT. Because I seek to generate applied knowledge, I am informed by methodology used in case studies for their value as 'vehicles for discovery' of real-world processes (Morgan, 2012, p.671), and to offer a '*situated* analysis, rich in detail' [author's emphasis] (Ruzzene et al., 2014, p.16). To extend the study's generalisability, perspectives are sought from a cross-section of stakeholders in different geographical areas so that learning from this study may inform the responses of a variety of clinical leaders to new and existing policies. Multiple examples of the use of AQP make generalisations across individual cases rather than within a single locality, which offers a 'spatially – and relationally – informed understanding of context' (Bartlett & Vavrus, 2017, p.10). That is to say, I am not stating that all participants can be said to have the same experience of AQP, but I am looking to identify – across the participant pool – common experiences of the practical adjustments and responses to the broad policy effects introduced by AQP.

The research context of AQP – a complex messy healthcare system – requires an approach that accounts for the multiple responses to policy (Holmes et al., 2012) that impact the clinical effectiveness of PCPT services. The complexity of AQP requires an understanding that knowledge is situated (Gherardi, 2008) within the nexus of practices of a variety of stakeholders, discourses, resources, perspectives, and so on (May & Finch, 2009; Steen, 2015). Palinkas suggests that an 'emergent design' of iterative, qualitative research ideally suits the fluid nature of mental health contexts (2014, p.855). A practice-based research methodology that incorporates this complexity can link real-world practice with theory, as Henton proposes (2012). A cross-sectional study of the practices of clinical leaders – as the people most likely to engage with policy – can generate knowledge that is readily accessible to other clinical leaders and provide practical applications to service improvement.

Steen suggests that the complexity of service implementation indicates that ‘cross-sectional analysis’ is not sufficient to capture the variance of impacts, and advocates more detailed analysis (2015, p.86). However, the ‘rigor versus relevance dilemma’ means that there will always be a trade-off when a researcher spends time gathering the details, but does not then have the resources to capture the essence of the broad overview. It was the relevance issue that prompted this study as a follow on from my first study in one local area (Baker, 2014), to enquire if there were broad themes that might generalise across different geographical areas.

Whilst the study’s primary aim was to identify broad policy-related phenomena and promote reflection on service effectiveness, its second aim was to stimulate debate on the need for a discourse on policy in CoP, and to offer preliminary reflections based on the real-world applied benefits of such a discourse. In view of my limited time and resources as a student researcher, a pragmatic decision was made to attempt a broad overview that adds relevance and generalisability to the findings, but preserves a spirit of methodological pluralism to generate theoretical material that might stimulate CoP discourse, similar to approaches used in social sciences (Keating & della Porta, 2010; McLeod, 2011). Methodological pluralism was not used as a ‘splatter approach’ in the hope that something will make sense; but instead, to acknowledge that any proposed ‘pure’ or specifically directed form of research methodology may bring its own form of bias, as Silverman and Marvasti note: ‘many apparently technical choices are saturated with theoretical import’ (2008, p.158).

After consideration of alternative methods of analysis, Thematic Analysis (TA) was therefore chosen for its epistemological flexibility (Braun & Clarke, 2006); it offers a broad engagement with the situated nature of AQP within a system of practices, the study’s applied aims, and the need for some degree of theory generation. This flexibility addresses some of the pitfalls of ‘monomethod’ research, because it increases the degree of ‘significance in evaluation research’ (Onwuegbuzie & Leech, 2004, p.771) – which also allows the research to be applied across mental health disciplines, and perhaps even across policy disciplines.

Thematic Analysis incorporates different types of reasoning (for example, inductive and deductive strategies) that are used within flexible epistemological viewpoints – which suits the exploratory nature of inquiry into the under researched practices found in AQP, and also the need to work from existing knowledge and hypotheses (Braun & Clarke, 2006). TA therefore offers a rigorous analytic method without shaping the conclusions themselves, as might occur with a method designed to investigate particular types of effects, such as Interpretative Phenomenological Analysis (IPA), for instance. The use of contextualism is particularly useful to generate applied findings without having to obtain consensus across the data, and for its tolerance of complex real-world phenomena (Madill et al., 2000). The epistemological flexibility of TA allows me to incorporate a constructionist lens to interpret the constructions used by the different participants – and the researcher/s – and to generate an ‘interpretive understanding of subjects’ meanings’ (Charmaz, 2000, p.510). For instance, my own identity constructed by my CoP training might lead me to interpret some aspects of the data negatively, or to form allegiances with participant’s views. Similarly, I am alert to limitations and interpretations of the data associated with some participant’s allegiance to an identity constructed from NHS values and perspectives.

The design needed to be ‘dynamic and process-oriented’ to capture the complexity of the subject matter and avoid ‘mechanistic’ reading of the commissioning process (McDaniel et al., 2009, p.191). Since the rationale for this study is to inform future policy change and the application of Counselling Psychological knowledge of PCPT in the NHS, the research process focused on conceptualisation and theory generation, and engagement with existing theory – which in turn directed the research (Kislov, 2019). This informed the CoP discourse element of this study. Whilst some elements of my epistemology (such as the use of a constructivist lens and some degree of theory generation) are shared with Grounded Theory (GT), the range and flexibility of TA was chosen to maximise the application of knowledge beyond the scope of AQP and PCPT.

2.3. Participants

The study used purposive sampling to identify participants to represent a range of perspectives on the topic of study; Palinkas et al. define purposive sampling as ‘the identification and selection of information-rich cases related to the phenomenon of interest’ (2015, p.533). This study interviewed seven clinical managers of providers, and five commissioners who had experience of the AQP policy in PCPT, across a wide geographical area. Two participants – one manager and one commissioner – had considered delivering IAPT though AQP, but did not proceed. These views have been included to represent a range of responses, positive and negative. This might correct for any form of social desirability bias (King & Bruner, 2000) where participants may offer biased views, because they have committed to implementing the policy. The providers interviewed have a variety of organisational structures and backgrounds including third sector, charitable status, and the NHS. TA does not require an exact sample size (Mason, 2010), but recruitment was limited to a great extent by the small population of CCGs who were known to have chosen or considered AQP. Sample size was appropriate for a doctoral thesis, and guided by theoretical saturation of the data at a point when the range of participants was judged to generate sufficient data to explore the topic (Braun & Clarke, 2013).

In representing the demographics of the participants, I will be deliberately non-specific, to preserve participant confidentiality. However, participants represent perspectives from at least eight geographical areas, and included NHS providers, large national third sector organisations and smaller local third sector organisations. Some participants had experiences or overviews of AQP/IAPT and/or non-AQP IAPT services in multiple geographical areas. I obtained a commissioner view and/or a provider view from most geographical areas operating with AQP. Since I was not seeking to cross reference responses within geographical areas, this data was treated independently in the analysis, but with some awareness of shared demographics in the reading of the data. For example, where there was hostility between providers known by myself to be in the same geographical area, some allowance was made for this when interpreting commissioner’s responses.

Whilst the research question has considerable relevance to staff (as outlined in the introduction), I chose not to gather data from staff because it would skew the focus of the study’s aims. There is a considerable existing body of literature that represents these experiences, that the current study would not augment significantly.

2.4. Participant recruitment, interviews and data collection

My background research identified geographical areas that had opted to implement IAPT using AQP. Because no definitive list of AQP/IAPT sites exists, sources of information included the study by Griffiths et al. (2013); searching the internet; an extensive search of government contract sites (see for example, Crown Commercial Service, 2019); personal conversations; and a general literature search. As obtaining contacts with people in senior management positions is known to be difficult (Barker et al., 1994), to ensure that I recruited enough participants for the research I used a variety of methods to identify and recruit appropriate participants including: using personal contacts; following up participant’s suggestions, such as a contact name at Monitor; contacting other researchers familiar with the topic area; and direct contact. However, I was mindful of bias in the recruitment process which could skew the results, so I ensured that my strategies for recruitment were varied. I compiled a table to record approximately forty five potential contacts, and noted any relevant information. Initial contact was made with CCGs or providers by telephone to identify contact details for clinical managers and providers delivering PCPT under AQP, to introduce them to the study, and to obtain their email addresses. Approximately twenty respondents that replied positively were emailed participant information sheets (see appendix 1). I allocated a participant number at this stage, which then carried over to the corresponding recordings and transcripts. A summary of participants, their leadership role and sector is presented in table 1.

Responding participants were interviewed on a rolling basis until theoretical saturation was considered to have been reached, in consultation with my supervision team. Four interviews were conducted in person and eight by telephone. Flexibility in data collection methods was offered due to the wide geographical locations of participants and time constraints for the researcher. Interviews were conducted with mindfulness of the potentially emotive and politically sensitive nature of the research question, and ranged between 39 minutes and one hour 27 minutes long. If the interview was conducted by phone, I asked participants every ten minutes if they were willing to proceed to ensure full consent, and consideration for fatigue and time pressures (see interview transcript in appendix 2). Semi-structured interviews were used as ‘an open and flexible research tool’ (Banister et al., 1994, p.49). Open ended questions were used to allow the participants to express any issues that were relevant to their experience of AQP in IAPT, with further question prompts to explore their meaning. Brief field notes – whilst good practice in qualitative research (Phillippi & Lauderdale, 2018) – were also used to assist in obtaining relevant data because I did not want to seek follow-up questions, due to the participant's workload. The interview schedule was adapted in subsequent interviews, and restructured in accordance with the possible themes identified by the research team.

Table 1. Table of participant's pseudonym, role and demographics relating to delivery.

Pseudonym	Leadership role
Mark	Commissioner
Paul	Commissioner
Emma	Commissioner
Sophie	Commissioner
Priya	Commissioner
Abdul	non-NHS provider
Trisha	non-NHS provider
Bridget	non-NHS provider
Rachael	non-NHS provider
Nick	non-NHS provider
Liz	NHS provider
Peter	NHS provider

2.5. Analysis

The process of thematic analysis followed Braun and Clarke's six stage method (Braun & Clarke, 2006).

Stage one: Data Familiarisation.
The recordings were transcribed by myself following the transcription notation system given by Braun and Clarke (2013), which records non-verbal responses, such as laughter. Any terms that I did not understand were noted. I used colour codes for each transcript and linkages with data from other transcripts, to identify initial codes (see appendix 2 for transcript extract example). This allowed me to fully immerse myself in the data.

Stage two: Generating initial codes.
Each transcript was annotated to identify interesting features and described by a word or short

phrase as potential codes (see appendix 2 for example of data coding). Coding was done on a semantic level and a descriptive level (Braun & Clarke, 2013). Because a theoretically informed TA was used, a selective approach to coding identified codes relevant to the implementation of policy and the practical responses of participants.

Stage three: Searching for themes.

Initial codes were then gathered together, using the corresponding colour coded data extracts, in a table to represent potential initial themes, as the transcripts were transcribed (see appendix 3 for example of incremental code identification). At this stage, little conceptual arrangement was conducted. As subsequent interviews were coded and added to the table, new codes were added to the master categories to ensure that the initial themes were staying faithful to the data, rather than confirming the categories that I had already created. According to Braun and Clarke (2006), a theme should represent a significant feature of the data in relation to the research question, so efforts were made to use data extracts where possible to represent themes.

Stage four: Reviewing themes.

The table of codes was then transposed, and groups of codes were reorganised into possible themes. To ensure maximum fidelity to the data, each participant’s transcript data extracts corresponding to the codes were tabulated (see example of theme development in appendix 4). These possible themes were further refined and data extracts edited, preserving transcript colour coding (see appendix 5). Codes only were summarised in a printed hard copy, and cut up to help with reorganising the codes into themes (see appendix 6). Whilst the research question directed the analysis, several different ways of organising the data were considered at this stage to keep the interpretation of the data as rigorous as possible (Braun & Clarke, 2013). Mind maps and paper labels were used to organise and rework concepts (see appendices 7-11). The complexity of the data and its interpretation was evident, therefore final themes were chosen with care.

Stage five: Defining and naming themes.

A final theme arrangement was decided upon, after triangulation with academic feedback in the research process, and cross-checking of all previous theme arrangements to see if all important features identified in the data were fully represented in the final theme arrangement (see appendix 11). The final theme table was then compiled (see results table 2, section 3.1.).

Stage six: Producing the report.

The results of analysis were presented as a unfolding, complex narrative (Braun & Clarke, 2006), structured according to the theme arrangement and using extensive participant quotes to stay close to the rich data. At all points during write up, I cross-referenced with original transcripts, and conducted word searches to ensure that my use of the data extracts maintained fidelity as far as possible to participant's intended meanings. The overall structure of the thesis was also mind mapped and planned in other ways to help with the conceptual overview (see appendices 12 & 13).

2.6. Ethical Considerations

Because of the unknown and potentially controversial implications of the study's findings, the identities of the participants and the geographical area were anonymised. Participants had the opportunity to choose a pseudonym, or to be identified by randomly assigned names. All information provided was treated confidentially at all times, and any personally identifiable details kept separately from the data. Data was stored securely on a hard drive kept in a locked filing cabinet, and any data stored on a computer was password protected. Risk assessments for any site work were completed to comply with any health and safety procedures of participant's workplaces where relevant. I received all the necessary UWE ethics approvals and relevant NHS R&D assurances (see appendices 14-16).

2.7. Reflexivity

As previously outlined, I bring my own responses (which is also data) that have subtly, or not so subtly, influenced my reading of the interview data. Having previously conducted a research project in this field (Baker, 2014, see appendix 17), I entered the research with some prior knowledge and collegiate relationships with my participant pool. I conducted background research to understand basic processes of commissioning (Lempert, 2007) to avoid wasting the valuable time of busy professionals, and thus facilitate optimal data gathering in organisational contexts where getting access is already challenging (Barker et al., 1994). I therefore needed to use, what Willig terms, ‘*Epistemological reflexivity*’ [author’s emphasis] (2001, p.10) to account for my prior experiences and research biases.

3.0. RESULTS

3.1. Condensed summary of all themes and table of results

Analysis of the data that explored participant's experiences of AQP identified four main themes of: *Alligators: Resources and AQP delivery*; *Cats: Partnership working in AQP*; *Elephants: Bureaucracy in AQP*; and *Sopranos: Patient experience in AQP*, (see table 2).

The first superordinate theme, *Alligators: Resources and AQP delivery* represents the prominence of finance and resources in the accounts of many participants. Low tariffs in AQP were identified as a significant threat to stability, and even survival. Unsurprisingly, the increased pressure to improve efficiency was experienced as highly stressful, and recognised as shaping practice in deleterious ways – but also as a driver for both innovation and improved performance. These finance and resource related experiences and responses are gathered together into three subthemes: *Financial instability in AQP; Effects of financial model on clinical treatments*; and *Developing a business model.*

Participants also talked about their experiences of working alongside multiple providers in the AQP model; represented by the second superordinate theme, *Cats: Partnership working in AQP*. Participants identified differences in organisational culture between different providers, and reflected on the barriers and solutions to joint working. What was perceived to be a more fragmented local IAPT service – compared to a single lead provider – meant that a key priority was maintaining clinical governance across the joint system in the face of the challenges of AQP. The responses are represented by three subthemes: *Silo Culture in AQP*; *Operating in partnership with AQP*; and *Delivering clinical governance in partnership.*

Another topic that occurred throughout the data was participant's experiences and perceptions of power and autonomy. Conflicts and frustrations with top-down directives and the burden of administrative pressures made most participants reflect on the impacts – positive and negative – of targets and governance on clinical practices. Whilst juggling different priorities, there was some reflection on the wider political drivers influencing practice. These responses are presented here under the superordinate theme *Elephants: Bureaucracy in AQP*, and corresponding subthemes of: *IAPT governance and AQP*; *NHS* *administration and AQP*; *Experience of power hierarchy in AQP*; and *Political agenda of AQP*.

A significant thread running throughout the data was how the directive of AQP impacts clients. Participants shared what they think choice means to clients in AQP, what care they need, and how this interacts with what is possible to give clients in the real-world service context of AQP. Although these views also appear in preceding themes, the central importance of patient experience to participant's practices is represented by a separate superordinate theme of *Sopranos: Patient experience in AQP*, and its subthemes, *Patient choice in AQP* and *Patient care in AQP*.

These themes are summarised in the table on the following page and will be presented in further detail in the subsequent sections, using data extracts to illustrate shared or contrasting experiences and perceptions across the participants.

Table 2: Summary of superordinate themes and subthemes

Superordinate themes	**Subthemes**
Superordinate theme 1. ***Alligators: Resources and AQP delivery***	**1.1.** ***Financial instability in AQP***
	1.2. ***Effects of financial model on clinical treatments***
	1.3. ***Developing a business model***
Superordinate theme: 2. ***Cats: Partnership working in AQP***	**2.1.** ***Silo Culture in AQP***
	2.2. ***Operating in partnership with AQP***
	2.3. ***Delivering clinical governance in partnership***
Superordinate theme: 3. ***Elephants: Bureaucracy in AQP***	**3.1.** ***IAPT governance and AQP***
	3.2. ***NHS administration and AQP***
	3.3. ***Experience of power hierarchy in AQP***
	3.4. ***Political agenda of AQP***
Superordinate theme 4. ***Sopranos: Patient experience in AQP***	**4.1.** ***Patient choice in AQP***
	4.2. ***Patient care in AQP***

3.2. Superordinate theme 1. *Alligators: Resources and AQP delivery*

> *'if you are up to your neck in alligators, it's hard to remember that you are there to empty the pool'* (Trisha)

The first overarching theme speaks to a tension between delivering quality client-centred therapies and organisational survival in a severely resource-restricted environment. Trisha explains what is meant by the analogy of being '*up to your neck in alligators'*:

> *Emptying the pool is providing the service and helping people to get better. And if you are losing [...] K a year, all of your [...] K a year, all of your focus, is on protecting what you have got,…it's hard to remember that really I am here to provide a service so all that energy goes into inwards, rather than outwards, if that makes sense?*

In this example, Trisha refers to an NHS culture of protectionism where '*every action they take is protection, firefighting, building walls around themselves so they don't look bad'*. Whether organisations are protecting reputation or financial survival, managing the pressures of AQP caused universal challenges for all participants – the threat of the alligators in Trisha's analogy – which are presented in the first subtheme, *Financial instability in AQP*. Due to the nature of the working relationship with the NHS provider and the financial implications on her own organisation, Trisha lamented that '*our hardest decisions are whether we are going to be continuing or not, instead of how can we improve what we are doing'* – the emptying of the pool. The perceived impacts of low resources on the therapy service in AQP are shared by other participants, and are reported in the subtheme *Effects of financial model on clinical treatments.* However, the focus on survival and delivering a therapy service was not a passive process, and prompted participants to adapt their services in different ways – reported in the final subtheme, *Developing a business model.*

3.2.1. Subtheme 1: *Financial instability in AQP*

> *It's really tight. It is very tight* (Rachael)

This section concerns the difficulties of operating within the low tariff, Payment by Results (PbR) model of AQP. AQP uses an activity-based payment model, where payment is broken down per treatment delivered (similar to an 'episodic' or 'cost and volume' contract) rather than a capitated model, where average care costs are estimated across whole populations (NHS Improvement, 2019b). In IAPT generally, the PbR approach specifies payments for 'Cluster-Based Activity' and a 'Quality & Outcomes Premium' (NHS England, 2015) – in other words: a basic payment component for seeing a client, and an additional component for outcomes such as recovery rates and wait times, measured by a variety of national and local indicators (e.g. ROM and KPIs). The additional outcomes-based payment is received when expected outcomes are achieved. This system is assumed to improve the quality and efficiency of patient-centred care, and to respond to perceived criticisms of the lack of transparency and accountability of block contracts which fund a whole service (including costs such as overheads), rather than individual patient treatment packages (NHS England and NHS Improvement, 2016).

Per-session payment in AQP is augmented with outcomes-based payments (PbR) on treatment completion. However, the unit-based payment model of AQP focuses the payment of treatment episodes to each a single session delivered. Although detailed analysis was not made in this study of the tariffs, most of the payment derives from the number of sessions delivered, and varies between implementations. Unsurprisingly, since provider survival depends on adequate income, money – based on numbers of sessions – became a key feature of concern for providers.

The low tariffs that make the operational aspect of providing under AQP '*very tight'* for Rachel, were unanimously challenging for providers. Concerns around financial survival have caused '*massive pressure'* according to Trisha. Participants identified the struggle of trying to deliver a quality service without enough money to pay for premises, staff, overheads, and so on. This concern was also echoed by commissioners, who recognised the importance of business stability for providers, as Paul questions: '*how can they work within a very tight financial model? and expand*?'. In some cases, providers are seen to be unable to compete within this model, as Nick points out: '*we have seen an awful lot of trusts disappear within that market because they just couldn't afford to provide within that market because they just couldn't afford to deliver'*. Like Nick, commissioner Sophie fears the loss of services due the lack of security in AQP, because '*it is probably tougher to try and grow as a service and be a secure business compared to other models,...we don't want services to disappear either, so I think getting the balance for AQP is potentially a bit more tricky'*.

Although commissioner's survival did not significantly feature in the data, they were all concerned about the financial challenges facing providers, as this significantly impacted the success of the commissioned service under the scrutiny of NHS England. Perhaps some level of threat for commissioner's employment security was indeed apparent when commissioner Paul jokingly suggesting '*Jobless*' on being prompted to choose a pseudonym for the study.

Many participants believed that the lack of stability from low tariffs was also due to not having the predictability of a block contract. Paul suggested that lack of block funding contributes to staffing problems: '*There is nothing up front, it is very difficult for [AQPs] with no guaranteed income to spread, to employ staff when you have no idea really where the money is coming from'*. In contrast, adequately funded block contracts are seen to offer more financial stability. Nick makes a link between this stability and the ability to meet targets, to highlight the difficulty of meeting targets in AQP contracts, echoing Trisha's observation about emptying the pool (delivering services):

> *the general rule of thumb is that those services that were appropriately resourced as a block contract at the start, tend to be the ones who are more stable. They found it easier to deliver to targets. I am saying the ones that are appropriately resourced, because there are plenty that aren't.*

The financial pressures of AQP are perceived to cause stress on providers and their staff, but commissioners in this study did not report personal stress due to finances. For providers, the challenges of financial viability created stress, as Liz recounts: '*there was a lot of anxiety about survival. Because all the AQP providers were in survival mode'*. Some participants reported that non-NHS contracts felt less secure for existing staff compared to pre-AQP services (mostly NHS staff). Abdul reflected on the difficulties within AQP to plan for workforce stability, given the fears and lack of predictability concerning AQP:

> *I think there are those in this world that can sit with that kind of uncertainty, but personally there are plenty of people who can't and want the security of a job, of a stepped salary, and you can't do that if you are not sure you are going to get the referrals in.*

Trisha feared that pressure on managers also impacts staff: '*and I think there is a bit of contagion of our anxieties going down the line, I'm pretty sure that's what it is. And I feel some responsibility for that'*. However, as identified above, the financial strain was experienced differently by non-NHS and NHS providers. Liz and Peter felt supported by the financial back up of their NHS trusts, and Liz empathised with the pressure of survival on smaller AQPs, and reflected: '*if it was just me, there have been times that I would have had kittens from the stress'*. Stress in AQP is due to a variety of pressures, and will be explored further below, in superordinate theme 3 – *Elephants: Bureaucracy in AQP*.

While most commissioners did not report personal stress from the instability of AQP, the precarious line trod by commissioners in getting value for money and the financial modelling required of AQP, results in serious ethical conflict for Mark:

> *the other difficulty is the ethical element of it,...we shouldn't be, as the NHS, the biggest employer in the UK probably,…imposing zero-hour mentality and zero-hour operational functioning onto the providers we commission. It's not fair because as a result of AQP, lots of our providers...have the counsellors and the workers...on zero-hour contract. It's not ok.*

Liz also refers to the ethics of the NHS employment practices, which she associates with social values, rather than business concerns: '*I like the way it stands up for people's employment rights, even though it's a pain in the neck when you are a manager sometimes, ultimately I like that kind of socialist kind of thing'*.

However, some participants saw zero-hours contracts to be acceptable, and did not feel that a zero-hours payment model inevitably led to instability for staff. For instance, Priya remarks on the tradition of the therapy professions and says: '*Freud had a zero-hours contract'*, and Abdul sees benefits for staff in flexible working arrangements '*to integrate personal life with professional life'*.

3.2.2. Subtheme 2: *Effects of financial model on clinical treatments*

> *we are not buying widgets, we are not buying computer bits. We are buying psychological therapies* (Mark)

Participants were mindful of the constant tensions between business and clinical imperatives, as Mark explained when clarifying his '*buying widgets'* metaphor: *'People...have psychological problems, so we need to be a little bit sensitive about that, and you need to look after the people who are in the service and who are delivering the service'*.

Because PCPT is a clinical and relational service, the ethical tensions for staff and providers in managing financial instability also led to tensions around the ethics of clinical priorities in AQP. Whilst most participants successfully negotiated the challenges of operating within a different financial model, and some participants did not proceed with AQP due to difficulties with the local implementation or unviable low tariffs, conflicts arose between clinical priorities and these operational pressures. Trisha points to an uneasy shift in professional attitudes for therapists and stakeholders who are required to deliver therapy within the AQP model:

> *so the tension is very much around putting a business model in conjunction with a clinical model, and to be honest, that tension is very much still around. We are managing it, but our therapists needed to go through a conceptual/perceptual change in what it is they are dealing with.*

The tensions relating to clinical and therapeutic values will be revisited in subsequent themes.

Part of the reason for the ethical conflict is due to adverse effects of the financial modelling on clinical provision. For example, Rachael identified that '*probably the most controversial difference from the therapist, from the clinical perspective, is that...AQP can be, in my experience, be more prone to pressures to have suboptimal doses'*. Trisha felt aggrieved by another AQP, perceived by her to be motivated by profit rather than patient-centred treatment, when in a meeting she recalled: '*the lead commissioner said: "but what about the needs of the patients?", [the private provider] replied: "as I said, that is not my problem...my problem is my business*"'. Peter reported cherry-picking by organisations perceived to be driven by profit, and not maintaining Peter's own patient-centred value system:

> *we have that kind of ethos around helping people and making sure that people don't fall through the net...the perspective is a lot bigger than if you are just a private company you just pick and choose who you want to see and then you get the payment. It's a bit different.*

None of the providers in this study directly revealed an interest in earning profits from AQP. Sophie believed that AQP was not at risk from profiteering because, she said: '*I don't think it's possible for [private companies] actually to create a profit'*. Instead, financial pressures in AQP were seen as problematic because they contribute to gaming and perverse incentives, an existing problem for IAPT highlighted in the introduction.

AQP was seen by some participants to inhibit innovation because – in the absence of adequate funding – organisations cannot divert resources to wider aspects of delivering quality care that meets the needs of the local population. Several participants talked about the difficulties of financing rooms to deliver therapy, as, Trisha points out: '*we have spent a fortune on opening treatment rooms'*. Emma summarises the effects of low tariffs on wider innovation:

> *I think just from the constrictions on being able to be quite maverick and going off and actually creating exciting things and take a risk, because at the moment, they can't take a financial risk, especially the non-NHS providers. The money.*

Paul agrees with Emma, and recognises that lack of funding for activity outside delivering core treatments makes AQP incompatible with new directives for joint working: '*it stymises training and innovation, it limits providers for what they can do and in the new world of STP and place-based working'*.

From a commissioner's point of view however, PbR and the payment model also offers benefits of the ability to measure, scrutinise and monitor the performance of each AQP service, and was seen by several commissioners to have improved the quality of the service, as Mark explains:

> *it's very visible what your financial spend is on, what the level of delivery is, the number of service-users that are coming through, the number of people that are being seen, what kind of therapies they are having. Really, really measurable on a month-to-month basis, what's going on in a service.*

Liz contrasted this transparency with the lack of monitoring in secondary care, and also believes it is good for the service: '*I feel that the AQP model, it's kind of faulty, but at least it makes people monitor the activity of their services and notice what's happening...if you are an AQP provider you have to know...what your staff are doing'*. The scrutiny and measurability means that the IAPT database becomes central in AQP, by linking payment with performance and activity, as Emma reflects: '*the amount of data we get, just around the invoicing...which you wouldn't get from any other contract. It's around numbers'*.

3.2.3. Subtheme 3: *Developing a business model*

> *you are payment by results, so it's that business model* (Peter)

Despite the threat to stability and the potential adverse effects on clinical treatments, the financial modelling of AQP is seen by almost all providers to drive improvement in how services operate. However, improvement arises for different reasons – dependent on the different characteristics of each provider, and how they responded to the particular challenges of AQP. The perception of the advantages and disadvantages for different organisations varies from the participant's vantage point: providers were curious about the pros and cons for other types of providers, whilst also reflecting on their own. For instance, large providers envied smaller provider's ability to mobilise and innovate; yet small providers envied the financial stability of the larger organisations. The improvements in operational performance were identified as developing a 'business mindset', and is associated in AQP with: competition; a unit-based payment model; performance management; efficiency; and responsiveness to change. There were also some perceived advantages for staff (see below). Low tariffs and lack of stability however are seen to inhibit the effectiveness of developing a business model. Some participants commented that NHS providers are less open to the business model, and also feared profiteering from private organisations, as mentioned in the previous subtheme.

The financial focus of the per-unit, PbR basis of AQP is perceived to promote a business outlook with rigorous financial modelling, with Abdul describing AQP as: '*per-unit provision, and it means that whatever you provide, you are paid for'*. The resulting link between performance and payment requires a pragmatic and intentional shift in mindset to attract more clients and improve quality, as Rachael reflects, '*[AQP] draws out the sales person side of you...you have got to be enthusiastic, and highlight, in a way that doesn't put other providers down, but highlight why you have been commissioned to bring something new to the mix'*. Most participants agree with Rachael and believed that AQP incentivises improvement in service provision, as Priya explains: '*so it is effectively, you get business, you don't get business, it depends on word of mouth, the quality of your advertising, your relationships with other people and in the end, the quality of your service'*. Paul believes that the business orientation of AQP promotes a better clinical service as a result of improved performance, observing that: '*the private providers who are much more business-like do* *slightly better than our NHS ones because they are a different culture, and [patient's] outcomes are better'*. Nick disagrees however, and feels that AQP has not improved quality through innovation – because of the low tariffs: '*I think AQP, whilst it should have improved service, has potentially facilitated the race to the bottom rather than the development of quality services with competition'*.

As well as the internal incentive for improved operational management, AQP was also associated by Nick with '*introducing competition into the marketplace'*. Whilst linked to increased patient choice, this '*vibrant marketplace'* of AQP (Priya) also means that providers compete against each other for business. AQP however is a quasi-market, and represents semi-competition – not direct competition – because providers are also working in partnership (see the following superordinate theme, *Cats: Partnership working in AQP*). Competition itself influences providers in several ways.

Many participants believed that traditional NHS culture is averse to competition. Whilst block contracts are valued for the stability they bring, the same stability and lack of competition is seen by all commissioners to reduce incentives to change operational attitudes. Priya puts this down to a complacent NHS culture, where '*you are working in a culture where people are unused to the notion, you get paid for what you do'*. Nick gives an example of resistance to change where: '*the NHS providers have went: "oh no, this is too hard" and just given up. I have seen that in several areas'*. Like most other participants, commissioner Mark believes that the competition element of AQP has incentivised NHS providers to improve: '*you know, there's...nothing better than a kick up the bum for a business than someone else'*.

Improvements driven by AQP include: performance management; innovation; and responsiveness to change. Commissioner Paul believes that the introduction of organisations with new and responsive business models in AQP: '*drove efficiencies, because the private provider that we have does do a lot of performance management with their workforce'*, and this set a precedent for the existing provider. Emma explained that the proactive mindset of the non-NHS providers, who do not '*have the backup of the trust being able to bail them out financially...has ensured our non-NHS providers were very creative, they would seek out business'*. Despite not having the stability of the NHS or a large organisation, smaller organisations are seen by some participants to be at an advantage because '*they are lithe on* *their feet and they are kind of nimble'* (Liz) and '*manoeuvre quickly'* (Rachael). Two larger providers used the word '*envy*' when describing this responsivity and autonomy, recognising that larger organisations give stability, but reduce freedom to make changes quickly.

However, whilst Emma thinks the backup of the NHS inhibits creativity, commissioner Sophie, fears that smaller providers – without the protection of financial and operational backup – are more vulnerable to the instability and unknowns of delivering under AQP: *'it is difficult for some businesses, especially if they are small providers and they are competing against bigger providers*'. Two smaller providers described this as not being on a '*level playing field'* with NHS providers. The expertise and resource required for smaller providers to enter into the IAPT market via AQP is considerable and requires changes in their approach to delivery, as Abdul describes:

> *a very different operational mindset [and] what is so different about delivering in the NHS is that you are open to all, and the volume is massive, and as soon as you have massive volume, you have to deliver differently*.

Non-NHS organisations are seen to be more able to compete under low tariffs, described as *'lean'* operations by Nick: '*we are probably one of the only organisations that have been able to persist with the tariffs because they were set so low,…because we are very flexible and very lean*'. Even though tight finances cause providers stress, efficiency is seen as valuable because it gives '*good value for money'* (Trisha). As the previous subtheme demonstrated, clinical values are prioritised by all providers in this study – and operational improvements are seen to drive service improvement. Therefore, Rachael sees the business mindset as a positive choice:

> *but thankfully, and this wasn't like we felt forced to do it by market forces...and I am speaking not as a clinician obviously in this conversation, there are two aspects to your pitch, which is that we have got a very innovative [named, service-specific approach to delivering therapy].*

Despite the perception by most participants that the NHS is resistant to a business mindset, both NHS providers in this study were concerned about the need to save money in the NHS. Liz valued the flexibility, commenting that AQP '*gives you that little bit of leeway*' to bring more money into her budget. Peter explains how he has embraced a business mindset from the competition in AQP:

> *what I like about the AQP is that people are always thinking about: 'ok, how can we make our service better or more appealing?'; 'what new things can we offer to make people come to ours?'. It's like a business, I don't know if this is right, but we have moved into this business model, not sure if it's good or bad, but having worked for the NHS for [x] years, I am not sure if it's good or bad. But I am just saying there is something nice about that as well, because you get paid by results. If people come back, you get paid for that bit of work, if you get good PEQs, you get paid for that. So yeah, there is that healthy, that's what I mean by competitiveness, there is that healthy kind of motivation amongst providers.*

In a different CCG, Paul believes that the adaptability of the NHS provider is due to prior experience of more competitive business models: '*I think a massive factor is that [the service] was already established in...semi-competition, so they were already reasonably up to speed anyway*'. It is clear that working alongside other providers with very different cultures appears to have changed the outlook of both NHS and non-NHS providers – and increased their mutual understanding to adapt their own business models. For small non-NHS providers, Abdul thinks that AQP '*has opened their eyes to what it is like to deliver an NHS service, and to see the need for something different*' recognising that: '*they are both valuable ways of delivering...they are complementary, rather than the same thing*'. This perception of difference can be seen to encourage providers to try something new, especially if it will increase revenue and stability for the organisation.

While providers use a business mindset to survive in AQP, commissioners see performance improvements as part of fulfilling NHS mandates (access targets, governance, etc.) within a budget. Abdul sees clear financial incentives for commissioners: '*the finances of AQP are highly beneficial to commissioning. Highly, highly, highly, beneficial'*. Commissioner Emma is clear that finance was the main factor for the CCG choosing AQP: *'so now we are getting more activity for less money, then they are not going to go back to block contracting'* – although other aspects of AQP, such as the measurability of the unit-cost model, also lead to quality improvement, according to most commissioners. Paul was keen to highlight this quality assurance aspect of the commissioning process: '*we didn't just go on price, we work on quality, price, efficiency, reputation, all those other things'* – reflecting the desire to preserve core NHS values, alongside efficiencies and money-saving. Given the awareness of the challenges of AQP, commissioners tread a precarious line between horse trainer and horse groom – making sure that providers perform effectively, but also making sure they don't collapse before the finishing line.

Despite the fears for staff stress and unstable working conditions, the competitive model of AQP was seen to work in favour of staff by several participants. Rachel believed that '*staff can circulate between the...providers, which actually puts them in quite a position of power*'. Commissioner Sophie thought that organisations are incentivised to invest in staff as a valuable commodity:

> *[AQP] really pushes providers to look after their staff, to recruit well and retain staff and, you know, create really good environments as well. So I think it is good,...it can have a very positive effect as well for a service.*

However, the mobility of staff in AQP can also cause problems, as Sophie continues, reflecting again on the precariousness of the AQP model:

> *but I think it is a risk then if things start to go haywire for a service, and they start to lose staff and it can end up in a kind of snowball effect, where they could just sink then if they are relying on that income, but they haven't actually got the people to do it.*

The superordinate theme of *Alligators: Resources and AQP delivery* shows the many different impacts and consequences of the operational aspects of AQP – and the complexity of these effects on service delivery. The next superordinate theme addresses further experiences arising from the competition/multiple providers element of AQP.

3.3. Superordinate theme: 2. *Cats: Partnership working in AQP*

> *it's a little bit like herding cats* (Mark)

AQP/IAPT differs from other NHS non-IAPT AQP services because, as outlined in the introduction, IAPT itself is designed as one coherent national 'brand' against which, each CCG is directly benchmarked. This means that each CCG has a responsibility to offer a local

IAPT service that delivers these national targets. AQP, on the other hand, is designed to introduce diversity of providers via competition. This results in conflict for the joint local IAPT service, with the tension for providers competing as separate businesses to improve choice and quality of treatment (as summarised in the first superordinate theme), but also expected to be part of a joint service that needs to deliver nationally mandated targets. The nature of the care pathway in IAPT also sets up links between providers in some areas, because the stepped care model of IAPT means that clients may choose different providers for different stages of their treatments. Therefore, safe and ethical service delivery requires some degree of joined-up clinical work between multiple providers.

This superordinate theme explores participant's experiences of delivering this joint service in the model of multiple providers under AQP, highlighting the differences from delivering as a single provider. Commissioner Mark describes this as '*a little bit like herding cats'* and goes on to explain the benefits of variety that competition brings, and the corresponding difficulties of joint governance that comes with multiple providers:

> *I don't really want to herd the cats together because the cats are such a lovely diverse bunch of cats, that I quite like them wandering around and all going their own way. I do like that about them, and letting them do their speciality stuff that they are good at and being niche, but it does make it less cohesive.*

Participants talked about the traditional models of commissioning, how AQP challenges the silo mentality of statutory services, and the operational problems of working as part of a joint service. They also explained how AQP brings new attitudes to partnership working and reflections on their existing attitudes, especially concerning clinical governance and patient experience. These experiences are presented in the following subthemes: *Silo Culture in AQP*; *Operating in partnership with AQP*; and *Delivering clinical governance in partnership*.

3.3.1. Subtheme 1: *Silo Culture in AQP*

> *well, how do we work together with the commissioners and with other partners so we can begin to coordinate the service provision, rather than having these silo commissioned, silo delivery services that barely talk to each other?* (Nick)

Somewhat echoing sentiments in the previous superordinate theme about resistance to change of large NHS organisations – in the quote above, Nick summarises the perception by some participants that statutory services are not flexible enough to work in partnership with other organisations. Three participants talked about ‘silo mentality’ in the NHS, which includes IAPT itself and NHS governance in general. Silo mentality is seen as a barrier to joint working. How participants experience these barriers is relevant to the future landscape of STPs, because of the importance of bridging organisational cultures to deliver joined-up care.

Patient choice in AQP promotes a diversity of providers, and introduces differences in delivery that would not be so apparent with a single provider. Nick thinks that managing the joint provision of a local AQP/IAPT service is harder, due to the focus on individual target chasing rather than cooperative working: ‘*services tend to deliver in silos, because their targets are set individually for their services’*. Paul also believes that the targets set for IAPT – as an example of a silo service – do not address patient’s varied needs: ‘*You know, for so long health and social care has been trying to work in silos...and we know that patient’s problems don’t manifest themselves in silos*’. Abdul describes silo mentality as: *‘you only think through the glasses that you have got [and] focus on one thing, but disconnected to everything else*’. Like Paul, Abdul goes on to doubt whether IAPT can address wellbeing needs in the wider community, because it is ‘*mirroring what’s out there in society*’ by reinforcing fragmentation within society, rather than promoting social cohesion. Abdul’s fear is that the therapy profession has been recruited into a divisive individualistic narrative: ‘*one of the major dangers...is that we become, um, well to use the word perpetrators is a bit provocative, purveyors [perhaps]...or the encouragers and supporters, inadvertently, of a very individualistic society’*. Paul shared Abdul’s misgivings, adding that chasing IAPT’s access targets might become an end in itself, rather than focusing on improving people’s social conditions to the point where they don’t need IAPT. Nick also commented on the silo culture of IAPT and saw the integration of IAPT as much more than the co-location of therapists in GP surgeries, and ‘*almost being the conduit’* for secondary care, rehab, and a range of other care services.

Despite frustrations with disconnected statutory services, and despite the differences between the stakeholders' ways of working (between types of provider, and between providers and commissioners), the variety of organisational cultures in the local AQP/IAPT system was seen as positive by every participant. NHS manager Liz values how the variety of providers can offer something different to traditional IAPT services and noted how smaller, non-NHS providers have fewer constrictions, saying: '*I really like that, because they are community based, and they operate differently'*. AQP was seen by most participants to open up IAPT and the NHS to smaller non-NHS organisations with different organisational cultures, that had potential to challenge existing services in a way that would not happen with single service contracts. Priya saw implications beyond the use of AQP in IAPT:

> *yeah, and I think that AQP as a model, and even if you move away from AQP and talk about the notion of framework agreements or [a] lead provider, they all have the same potential component, which is you have a range of different providers to provide the same thing.*

It should be noted however, that the number and types of provider varied across implementations, with some areas contracting specialist providers or a lead provider for specific treatments or an assessment service, but with other areas requiring each provider to deliver the complete stepped care package. These varying requirements will impact the perceptions of the advantages or disadvantages of the diversity of organisational cultures across the participant pool, because factors arising from the implementation may affect the willingness of providers to cooperate.

3.3.2. Subtheme 2: *Operating in partnership in AQP*

> *I think competition in talking therapies actually makes it harder to do the cooperative bit...they are going to be your competitors in the next bid* (Abdul)

If *Silo Culture in AQP* represents participant's reflections on organisational culture and its impact on joint working, *Operating in partnership in AQP* represents the practical impacts on joint working of operating in competition.

Whereas the business model of AQP has incentivised internal innovation to win new business (see section 3.2.3), competing against other providers against the backdrop of survival fears brings mistrust and opposition – and inhibits joint cooperation, as Abdul summarises in the quote above. Although Rachael aspires to operate '*in a way that doesn't put other providers down'*, many participants felt that competition increased fragmentation, as Peter reflects: *'[due to] different ideas, different vested interest, conflict of interest, [providers] are just thinking about themselves, rather than the whole picture. So it becomes very fragmented to do anything'*. In a context of limited resources, commissioner Emma explains that providers *'are in a competitive market place now, they really didn't want to talk about innovation and things they were doing in case somebody else copied it'*. Competition in AQP evokes strong emotions that makes communications challenging and sets up combative working alliances between providers; for instance, Liz recalls, '*the AQP [meeting] was like warfare,...really unpleasant and competitive, and not very nice'*. Commissioner Mark described his impression of the joint working in another CCG, with just two providers, as a '*really scratchy relationship'*.

However, as suggested in the subtheme above the ease of joint working depends considerably on the local implementation design. Mutual mistrust was not only due to commercial competition and the threat of survival, but also from reduced clinical autonomy due to top-down constraints. The complexity and challenges of implementing AQP had the potential to increase mistrust between providers working in partnership, demonstrated by Abdul, who reflected: '*I was dubious about [the CCG] choosing that model'*. In a context of high pressure and uncertainty, emotions ran high for some participants. Existing silo culture and the perceived uneven playing field created by AQP, deepened divisions for some providers. For instance, when asked about her experience of working in partnership with the local NHS trust, Trisha answered: '*well, there is only one word. Angry. Absolutely angry. I am. Because I just feel we are two very different organisations trying to do two very different things'*. The is potentially disruptive for the delivery of a joint service because of – as Nick identified – the importance of good relationships to bridge the gap between providers, reflecting that: '*it is all built on trust'*.

Given the potential for '*warfare*' (Liz), commissioners attempt to build trust and joint communications between rival providers. Sophie, believes that the success of AQP depends on breaking down the barriers between organisational cultures, explaining that: '*some teams in organisations...are not very flexible and...some teams...are very, very open and will try to be flexible and get good outcomes. So it's the culture of teams and organisations...are probably the biggest drivers actually'*. Mark observed that '*often, it's just down to* *personalities and organisational culture'* and invested a great deal of brokerage to build good working relationships between providers with different ways of working:

> *the partnership element is good and it's taken a lot of working out, it's taken a lot of time to pull together, but the partners working as a partnership rather than individual, some of them work a bit more individually, some of them are better at partnership.*

However, the financial constraints and unit-cost model of AQP mean that providers do not get paid for building working relationships, so Emma was mindful of the out-of-contract costs for this aspect of working as part of a single IAPT system: '*it is very rare we get clinicians [at meetings] because they [have] productivity targets, so taking their day out will impact then on their access targets. No, it is really difficult to get clinicians round the table'*. Unless providers have funding for co-producing local systems, this aspect of effective service design is not prioritised in AQP.

Despite co-production not being factored into the commissioning model, the uncertainty and unknowns of AQP encouraged mutual learning for providers and commissioners. Even though Emma thought that lack of resource inhibits joint working, Sophie believed that creative thinking could help systems to work better: '*often, people tend to think the solution to everything is extra money. And it may not be that. It may be that the current service needs to work differently or more jointly'*. Many participants enjoyed the freedom to try new things, as Peter reflects: '*you can learn from your competitors...or you can come up with new ideas yourself. I think we have done a little bit of both'*. Mark described the process of learning at the CCG level, as a constant process of experimentation, and commented: '*we are still all trying to find the right answer'*. In order to learn from AQP and provide an effective service, Mark said: '*we need to respect the culture of learning'* but wanted to hold the bigger goal in mind of patient care, with a willingness to reject a course of action if the experiment doesn't work because '*we always have to...say, "is this going to benefit service-users. Patients. Is this going to benefit them? Or us?". Because if it's not, then we probably shouldn't do it'*.

Mark's central focus on patients and staff was echoed by all participants in their concerns about joint governance, for similar reasons that they were concerned about the impact of finances on clinical treatments, as described in section 3.2.2. This clinical focus is explored in the following subtheme.

3.3.3. Subtheme 3: *Delivering clinical governance in partnership*

> *we are all mucking in together and there is something nice about that. But the shadow side of it, is that it is very hard, the governance of it* (Liz)

As well as learning to navigate organisational differences and develop operational solutions, participants, such as Liz, were mindful of the importance of joint governance. The fragmentation of AQP is a challenge on different levels. Whether or not participants thought about the wider integration of IAPT, problems concerning governance within IAPT across the multiple providers in AQP were identified. Regarding communication for instance, Sophie said: *'I certainly think that everybody having their own IT system is always a challenge'* – although it should be noted that in different implementations, some providers shared the same IT system. Rachael raised issues of managing risk and complexity across the care pathway: '*The downside is that it is not connected to Rio, or anything that secondary care or GPs use, so that can be a challenge'*. Within some implementations of IAPT where AQPs do not use a joint IT system, clients could potentially be seeing multiple providers at the same time, as Emma recounts:

> *I was laughing yesterday about an anecdotal story from one provider who said that they assessed somebody and had started their CBT, and the patient said:'well, the other person doesn't do it like that'. And when they said, 'what do you mean?', the person said, 'Oh you know, I am having CBT with service A over there' ((Emma laughs)). And because we don't have access to patient identifiable data, we can't actually look and pull out those patients, so we could be paying double for patients because they can just refer themselves to both.*

This highlights the fact that many of the challenges experienced by participants were not shared in all geographical areas, because each area were implemented slightly differently – which adds to the complexity of understanding AQP. This complexity impacted the client experience according to Bridget, who, because of the nature of the care pathway in her local area, lamented: '*there were lots of hoops for the client to be jumping through'*. Even though the different approaches and power dynamics were hard for some organisations (and NHS organisations were perceived to carry an additional burden due to cherry-picking of easier clients by other providers), many providers worked together to ensure local governance to meet patient's needs whilst still in competition with each other. For example, Rachael reached an agreement with another AQP to redistribute clients to address joint waiting targets.

According to Liz, another consequence of the fragmentation of AQP/IAPT is that '*the workforce never gets together'*. Liz believes that more integration of the workforce would help to address the problems with whole service governance:

> *I think it would give the whole thing a bit more of an identity and also, people would get to meet each other and you would know who they were, and what everybody did. In theory, you could do CPD and make sure everybody is trained up to standard.*

Liz refers here to IAPT governance standards, which will be explored further in section 3.4.1. below: *IAPT governance and AQP*.

This aspect of clinical governance and staff support was negatively impacted by profit motives according to Trisha, who describes a non-NHS competitor '*as sharp as they come'* and '*if you work for [them], you don't get any professional development'*. Nick, on the other hand, was impressed by the way that local stakeholders had enabled joint governance: '*I really do think that innovation and improvement has come from really quality work between stakeholders, service providers and commissioners as well'*.

While AQP offers some insight to the complexities of partnership working, Paul was uncertain about how AQP could work in the landscape of STPs, because it increases fragmentation for patients rather than offering continuity. Like Paul, Peter did not feel that AQP had relevance to any larger integration agenda, and identified integration as '*a bit more multidisciplinary, so maybe a little bit broader than it has been with just PWPs and HI therapists, more integrated with working in partnerships with other organisations'*. Although he sees a future for PbR models, Nick thinks that '*AQP is dead in the water'* as a commissioning model in integrated systems, but when asked about delivering in partnership with AQP, he said '*I certainly think it has accelerated that process, and I think it has kind of pushed providers together who would not normally even know about each other'*. Sophie points out that communications between AQPs already takes place within the wider commissioning landscape of integrated services, and at the AQP meetings she says: '*we invite other services and other commissioners to attend...So we do try and increase joint working, definitely'*. Perhaps the kinds of organisations intended for STP working are not considered to be the smaller providers who have entered the market in AQP, which is why AQP is not seen as particularly relevant to STPs by participants.

Like Priya, Nick believes that multiple providers could only work with a larger provider coordinating provision in '*a prime and subcontracting model'*. Nick believes that integrated systems create a new form of joint governance:

> *I think we will see a shift from commissioning responsibility towards a wider kind of joint responsibility between commissioners and providers across the whole spectrum...and a much more integrated and kind of strategically adept approach to delivering and commissioning.*

This vision of joined-up working requires co-production amongst clinical leaders. Several participants, such as Abdul, think that the joint offer should involve GP practices more in patient's treatment packages: '*the pivotal point for Primary Care Therapies, I genuinely believe, should be the GPs, and I think they are the ones who...have the most capacity with the patient sitting in front of them to think holistically about that patient'*. Emma goes further to include GPs and CCGs in the meeting of targets to ensure quality in AQP/IAPT:

> *I have passed that baton back to CCGs and said, it's not just my responsibility, it's not just my provider's responsibility, it's practice's responsibility, it's CCG's responsibility, and as a collective, we will all work together to achieve it...CCGs need a corporate buy-in to IAPT and promoting it, and make sure that practices are aware and information is disseminated.*

Peter felt that AQP was positive because it offered *'shared ownership of the problem'* and disperses pressures on providers, but perceived that it also increases frustration for commissioners *'because there is no one person they can say "right, you haven't done this"'*. Paul deals with governance issues across the whole service with quality assurance meetings to deal with the tensions of delivering in AQP: '*various groups...between the providers and the commissioners [discuss] quality [and] how that impacts on what they can contractually deliver, how that's impacting on the quality of the service that is being delivered'*. A similar meeting in Priya's CCG resembles Emma's description of '*very frank discussions'* between colleagues as respected peers, and reflects an acknowledgement about the lack of coherency and challenges of delivering under AQP: '*it's frighteningly honest conversation, and minutes to not reflect what we say, they reflect what we agree'*.

The issue of the complexity of the AQP system and the difficulties of joint governance is not only due to the multiple provider model however. The following superordinate theme addresses the pervasive concern for participants with the challenges of bureaucracy in AQP.

3.4. Superordinate theme 3. *Elephants: Bureaucracy in AQP*

> *there are all those elephants in the room and the dots haven't been joined up*
> (Rachael)

The theme of 'bureaucracy' represents participant's experiences of different layers of top-down directives. These layers include: IAPT's targets; NHS administrative structures; and wider political directives.

Whereas local meetings between stakeholders reflect an honesty about the difficulties of delivering under AQP, most participants feel that the top-down, target-driven directives of IAPT are not compatible with real service contexts. This is what Rachael means by: '*those elephants in the room and the dots haven't been joined up'*. Rachael perceives a disconnect between the governance of IAPT and sustainable service delivery in AQP: '*it feels like the very top doesn't knit very well with the very bottom...it is being rushed, so it has not been sufficiently thought through how the changes are going to affect service delivery'*. When asked how this felt, Rachael replied *'not good'* and cited the example of being at a conference where new prevalence targets of 25% were introduced, at the same time as the topic of staff wellbeing. Rachael felt that the process of target setting was non-negotiable, but there were no answers for how to manage staff burnout. For Rachael, the elephants are the impossible targets, and the dots not joining up is the lack of explicit acknowledgement of the impossibility of meeting the targets whilst being expected to fulfil IAPT's governance.

The previous superordinate theme presented what happens when AQP funnels organisations with different cultures and practices together to deliver one IAPT service. This superordinate theme presents participant's experiences and perceptions of governance structures with which these different organisations must comply, in order to fulfil the terms of their NHS contracts. Like Rachael, all participants struggled with managing the complexity of the directives of AQP, as Paul explains: '*there are more plates to spin I think now for providers than there used to be'*. Due to the variety of organisations in the multiple provider model of AQP, these NHS and government directives impact participants in a variety of ways. The subthemes chosen to represent these experiences were: *IAPT governance and AQP*; *NHS administration and AQP*; *Experience of power hierarchy in AQP*; and *Political agenda of AQP*.

3.4.1. Subtheme 1: *IAPT governance and AQP*

> *patient-centred care might not mean a NICE approved approach* (Paul)

This subtheme presents a selection of participant's reflections on delivering IAPT's governance in AQP. This section also explores participant's thoughts on NICE guidelines and general clinical targets in the NHS, that are not necessarily IAPT specific.

Whilst monitoring of performance, robust procedures and evidence-based treatments are valued as part of quality improvement by all participants, many questioned the necessity of some of IAPT quality standards. These reflections echo many of the general criticisms of IAPT presented in the introduction, so I will focus here on those parts that are amplified by AQP. For instance, part of the experimental nature of AQP was a chance for IAPT to trial PbR, and Rachael identified AQP as a precursor to the upcoming national rollout: '*every IAPT service is shadowing payment by results, outcome payments…which are essentially the same as AQP tariffs'*. The challenges from low resources in AQP – as outlined in the first superordinate theme – therefore, make the PbR aspect of IAPT particularly relevant.

As presented in the theme on partnership working above, AQP increased the diversity of organisational ways of working. This has challenged the one-size-fits-all debate within IAPT. Both Nick and Abdul used the IAPT database to challenge NICE guidelines that indicate CBT to be the most effective treatment for depression. Abdul points to the effectiveness of counselling as an important part of delivering effective services, and laments the EBPP underpinnings of NICE:

> *I would want to see the position of counselling changed because NHS England now has data from services across the country that is indicating that counselling is equal to CBT for depression...But for years they have believed that counselling was not the effective treatment because of the way that they were measuring.*

Due to the increased scrutiny of outcomes with AQP, commissioners and other providers could measure the benefits of AQP's more flexible approaches to treatments, compared to the standard IAPT specification. Even though providers were contracted to deliver IAPT-compliant therapies, they are also required to improve service choice and quality. Paul reflects on the restrictions that IAPT puts on providers and their '*inability to innovate and work outside of NICE'* and points to a tension between the rigour of EBPP and the flexibility required to give patient-centred care, commenting that '*patient-centred care, might not mean a NICE approved approach'*.

As Emma identified earlier, the ability for providers to innovate and adapt IAPT governance is a necessary by-product of the low tariffs in AQP. Nick uses the practice-based evidence of the IAPT database to argue that counselling offers greater cost-effectiveness in IAPT than the existing CBT based model:

> *I think inevitably when you have rock bottom and payment by results tariffs, you are not able to retain and offer the NICE compliant therapies, so we have a lot greater reliance upon counselling, and not specific counselling for depression*.

Most participants valued counselling as an effective therapy and many had been counsellors themselves or experienced pre-IAPT PCPT. Liz however valued the rigour of IAPT training, and recognised that it is harder to know what is being delivered with counselling, saying: '*one of the problems with counselling is that it is very disparate [and] hardly any of the counsellors out there have actually done the depression training'*, adding that it '*leaves us at some point possibly vulnerable [for not complying to IAPT governance]'*. Nick agreed with these sentiments to a degree, and did not want to return to the non regulated pre-IAPT provision, where '*previously it was piecemeal...and actually you had nobody really regulating it at all'*.

The importance of basic clinical governance to support staff delivering therapies – such as training and supervision – is highlighted by Rachael: '*therapists have to know that there is somebody who has their back, who they can ask any question to, who wants to help them provide the best quality care for their clients'*. However, ensuring this support means investment and support from managers, as Abdul reflects: '*quality actually does depend on how much you can gather your staff together...for them to have the relationships with each other, with their team, and through that have a relationship to standards of practice'* – which also means a trade-off with productivity and income. Trisha was highly scathing about a rival, who she said '*is making millions'*, gave suboptimal doses, and did not to offer professional development opportunities to staff. The governance of IAPT therefore comes at a cost, and is not adequately resourced in AQP, according to most participants. We see here that the variety of organisational cultures in AQP/IAPT challenges rigid definitions of effective treatments by NICE, but scrutiny and regulation *is* valued as part of robust governance, even if it was perceived by Trisha and others not to prevent unethical practices from some providers.

Another aspect of IAPT's governance challenged by participants was its audit culture, and the degree to which the standards and targets set by IAPT actually measure quality clinical outcomes. The focus on cost-effectiveness in AQP highlights any non-essential clinical activity. For example, Trisha commented on the weekly scores collected for the IAPT database: '*the measures we use are GAD7 and PHQ9...they are nonsense...totally subjective'*. Likewise, Sophie believes that IAPT's measures are over simplistic: '*you can record and measure things to the end of the days, but it is not always a very good actual measure of exactly how complex something is*' and suggests that the national targets should better target local demographics, rather than national standards. Frustrated with the pressures of chasing targets, Priya suggests that the IAPT database is meaningless because:

> *the questions we need to ask are really simple, they are not on the IAPT database, because the database gives you lots of information but no knowledge about the service at all...what should I need to know about a service we commission for somebody who is anxious is: 'are you less anxious?', because if you are less anxious...that's your problem solved*.

Like Trisha, NHS manager Liz also sees the target-driven agenda of NHS England and IAPT as '*nonsense*'. After an IAPT workshop on productivity, Liz felt patronised and frustrated by the presenter, and thought to herself: '*you are a statistician, you are not a therapist'*. However, the other NHS manager in this study, Peter, had attended similar workshops and felt they were helpful in '*sharing experiences across providers nationally, what's working and what's not*'. This could be another example of variance in organisational culture (either existing natural variance within the NHS for example, or influenced by the diversity of AQP). Given that there is no tariff allowance to enable non-NHS providers to engage in this kind of national IAPT governance training, it is likely that non-NHS AQP providers may be less socialised to the IAPT model (to borrow from CBT language). The definition and measurement of patient-centred quality care is further explored in the final overarching theme of *Sopranos: Patient experience in AQP*, highlighting existing debates around a 'disembodied IAPT'.

Furthermore, perverse incentives driven by target pressures in IAPT weaken mutual trust amongst providers (identified in *Cats: Partnership working in AQP*), as Peter suggests:

‘*people manipulate the data...So you have to read underneath that. So that comes in with the competition and the scrutiny’*. Wider NHS targets, such as waiting lists, result in box-ticking activity rather than good client care, as Paul suggests: providers ‘*are trying hard to get people in within that six week time frame, but then patients are waiting for weeks for their second appointments – but they have ticked the box’*. Paul also disputes the rationale behind the waiting list targets in IAPT using local outcomes data, saying: ‘*there is an assumption that not waiting is better quality, and I am not sure it always is’*.

The target driven culture IAPT is associated with wasteful bureaucracy that negatively affects clinical work. The following subtheme explores other aspects of bureaucracy that impact non-clinical aspects of services, but – as argued in the introduction – clinical work is always impacted by service effects.

3.4.2. Subtheme 2: *NHS administration and AQP*

> *the NHS often use these sledgehammers to crack nuts* (Mark)

IAPT governance and NHS governance are not the same, but they share the similar centralised ‘command and control’ features seen in NPM government reforms. This subtheme continues to look at participant’s experience of governance; but, whereas IAPT directs clinical judgement, wider NHS governance directs operational decisions. In the same way that diverse providers highlight the wastefulness of IAPT’s governance, participants here share their responses to wider NHS systems and governance structures. Just as aspects of IAPT’s governance are seen as positive, NHS governance is associated with robust statutory service provision and NHS values. Rachael identified operational benchmarks as an assurance of quality: ‘*so as part of getting the licence to begin with, you have to provide all of the information about the risk and assurance policies departments, and how they work’*. Priya pointed out that ‘*you need to sign up to the NHS information governance toolkit’* in order to pass the benchmark to qualify as a provider.

However, the issue of bureaucracy in ‘*an over governed NHS’* (Priya) was predominantly seen as a wasteful barrier to promoting quality and innovation by many commissioners and providers. Several NHS and non-NHS managers and four commissioners, were critical of their perceptions of an inefficient and non-responsive NHS culture (part of the silo culture referred to in section 3.3.1) that became more evident alongside non-NHS providers. For example, Emma thinks that bureaucracy is responsible for the lack of competitiveness identified by many participants in the first superordinate theme: '*NHS providers seem to be so bound in the red tape and bureaucracy. It's the culture within the NHS unfortunately. And I think why the NHS is losing out on lots of contracts across the entirety of the NHS'*. Smaller organisations without '*carrying the weight of the NHS infrastructure'* – as Nick describes NHS bureaucracy – were seen to be at an advantage in AQP by Paul, who reports that '*smaller organisations were saying, "well, we can make it work because we don't have the kinds of cost pressures that larger NHS organisations have"*'. However, even though small organisations may not have the overheads of larger organisations, Mark identifies how the burden of bureaucratic demands – where the NHS sledgehammers used to crack nuts – feels '*quite kind of heavy handed on smaller providers*'.

For instance, the application process was seen as a disincentive for smaller providers coming into AQP. Trisha gave an example of the barriers facing her organization in applying for AQP, as having to '*jump through massive hurdles that take months to complete to get accepted'*. Bridget attributed the tendering process and uncertainty of AQP as a direct cause of anxiety for staff in existing services: '*I mean it is still very, very unsettling, and it does have a knock-on effect on staff, but it was made a lot worse by being an AQP model'*. The stress and uncertainty from the complexity of AQP is echoed by Abdul, who says: '*I think it is very hard for you to understand the complexities [even] when you are actually in it'*.

According to Sophie, the existing administrative barriers to new providers posed by the audit culture of IAPT, '*can be quite demotivating to people that are new into this system'* and are further magnified by the complexity and design of local AQP/IAPT implementations. Participants from three different locations reported struggles with implementation-specific challenges, as well as the wider NHS requirements. The complexity of AQP therefore, whilst offering leeway for local adaptations, creates significant challenges for organisations of all types.

All participants spoke about NHS targets – in combination with specific IAPT targets – as personally challenging, as well as causing stress for staff doing clinical work. For example, Peter described the increased number of variables in a AQP: '*it's like juggling balls or whatever, you are on the go all the time with the targets and making sure that everything,* *that the pathway is smooth. So it's challenging*'. Peter describes the impact of these challenges as '*very tiring'*. Rachael separates out the IAPT standards from other NHS targets:

> *when IAPT started, that set up the kind of core offer, [has]never actually changed. What has changed is all of the demands and pressures about the KPIs, prevalence, and now we are looking at financial penalties, CQUINs. All of that has changed enormously. But the core of it, which is where the culture kind of is, has never changed. And that is about trying to give the best quality of care to the highest number of people at the same time.*

Mark also describes the emotional impact of the burden of continually changing targets and wasteful administrative systems, explaining:

> *it just gets to the point where you roll your eyes and say 'not another one'. It's quite frustrating, it's annoying, it's frustrating because you say the same thing to different people, to different departments to people in the NHS, in the NHS England, at different times.*

Both commissioners and providers described the array of NHS targets as potentially feeling punitive, although commissioners and providers perceived different consequences. The importance of the professional standing of organisations was cited throughout the data in different ways – which meant that constant and impossible top-down targets were described by Paul as a serious threat, because: '*reputationally, you don't want to be a failing organisation'*.

The external pressures of meeting relentless targets together with the speed of operation in IAPT, were also seen to negatively impact staff morale. This caused Trisha considerable concern: '*I am closely monitoring the morale of our clinicians and admin staff, and I am beginning to get quite worried'*. Nick believes that pressure from commissioners to achieve access and waiting list targets and to hit recovery rates, is challenging and '*cannot fail to put pressure on front line staff to try and get as many people through service as possible'*. The pressure for meeting access targets and maximising income in AQP can therefore be a trade-off with quality of client care. The stress for staff also presents Trisha with an ethical dilemma: '*There is no point us going out delivering wellbeing…if we don't do it ourselves'*.

Resolving the ethical and practical dilemmas facing participants like Trisha, Rachael and Mark, requires a pragmatic engagement with power structures, which is explored in the subtheme below.

3.4.3. Subtheme 3: *Experience of power hierarchy in AQP*

> *it doesn't feel like a two-way process* (Emma)

A desire to maintain control whilst delivering a professional and ethical service, was frequently a source of tension in the complex and hierarchical system of AQP, as expressed by Emma's comment above. Participants spoke at length about their experience of negotiating this system, and the power relationships within it. IAPT and the NHS are two power structures that impact clinical and operational functioning, as explored in participant's perceptions in the previous two subthemes. This section focuses on participant's responses to these perceptions and the ways in which they rationalised and negotiated their place within the hierarchical structures – including managing client relationships and attitudes towards the power dynamics with NHS England.

Participants in this study were aware and very active in finding ways to manage challenges and blockages. For example, due to dissatisfaction with the nature of EBPP used in IAPT, one participant reflects:

> *I don't feel as though I have any power at all when it comes to NHS England...I don't know if I have got the stamina for it, but I have wondered about getting onto the NICE guidelines committee because, then, you could have some influence.*

A desire to deliver the most effective patient-centred care and address stress for staff demonstrates a primary concern for stakeholders at the point of service delivery, rather than a desire to uphold top-down governance for its own sake. However, despite the above participant's hope to have the stamina to engage with NICE to represent practice-based, clinical perspectives, commissioner Mark is less hopeful about the power of local stakeholders: '*I don't think the NHS changes from the bottom up. The NHS has to change from the top-down. It is never going to change from the bottom up. Patients aren't going to make the NHS change'* – and presumably, for Mark, this also means clinicians. This is somewhat in contradiction with the aspirations presented in the FYFVMH or the *NHS Long Term Plan* for co-production in mental health services – which may therefore appear to be lip service, if real-world clinical leaders feel they have no meaningful input to top-down service design.

The lack of local clinical judgement in top-down service design is criticised by Abdul, who believes that separating PCPT from GP care has weakened the aims of patient-centred care, and says: '*I don't think NHS England has got any chance at all of taking a holistic view of the patient that the GP has'*. The silo culture of IAPT therefore risks disconnecting services from the needs of clients, and the lived realities of staff delivering services in very challenging conditions. Most participants felt they had no influence to address this disconnect, and its consequential negative effects on services.

On a local level, the perceptions of power relations between providers and commissioners varied. Whilst most managers did not see commissioners in the same way as they viewed NHS England or IAPT directorates, the pressure of meeting targets was seen by some managers to be imposed by commissioners. While commissioner Paul is sensitive to the potentially punitive experience for providers of targets coming from NHS England, manager Peter expressed his resignation and frustration: '*It's just never ending, isn't it? It's just never ending'*, and identifies the scrutiny from commissioners as the immediate cause of his stress:

> *It's quite exhausting to keep up with the change of targets, deliver each month, to have your commissioners then tell you: 'why haven't you achieved this, why haven't you achieved that? Aren't you stupid!'. Well, they are not that bad, but that is what they can do, that is what they do do, if you are not reaching your target.*

Trisha agreed with Peter, saying: '*there is not a lot of empathy from commissioners if you are struggling to deliver for all the best reasons'*. However, one participant – who had experience across different regions – identified local variations in the receptiveness of commissioners, and pointed out: '*[it] depends entirely on the commissioner. You'd be amazed how much that varies commissioner to commissioner'* and felt that commissioners *were* responsive to the difficulties for providers, but could not challenge the top-down directives because '*they are under the same gun we are'*. Despite her own experience of pressures from commissioners, Trisha also sympathised with the pressures on commissioners: '*I don't blame the commissioners, as I know they are getting chased by NHS England to get these figures, these numbers, treated'*.

The commissioner's changing role with providers in the AQP/IAPT system has been presented briefly (section 3.2.2). The role of commissioner as scrutineer, purse-holder and peace-broker has meant that commissioners '*micromanage way more than you would do for the local health trust contract or the other provider's contract'* (Emma). Commissioners also delicately balance the needs of NHS England with the needs of patients, staff and providers, as Paul reflects: '*it is difficult. It is difficult for them and it's difficult for us ((laughs awkwardly)) because...we are trying to enforce the quality and the targets, whilst maintain an ethical sort of relationship'* – a example of the ethical splitting presented in the introduction. Even though Paul identifies himself as '*an officer of the NHS'*, he tries to resolve the power gradient with a deliberate effort not to micromanage clinical decision-making – to reduce some of the frustration that providers experience from not being trusted to operate an effective clinical service. For instance, rather than following a rigid, top-down stepped care blueprint, Paul says: '*we would let the experts within the organisation decide which step the patients should be at'*. Furthermore, Rachel wonders if the multiple provider model has led to commissioners co-producing the local implementation in line with new provider perspectives: '*they get feedback from different providers, so it can help them to stay more within a consensus?'*

AQP has resulted in a change in commissioner's relationships with providers compared with relationships in standard block contracting, as Sophie explains: '*sometimes the relationship between provider and commissioner isn't as dynamic as it would be with AQP, or payment by results'*. Overall, despite some perception of unhelpful pressure of scrutiny from commissioners, the increased dynamism of relationships in AQP is seen to improve communications, as Nick says: AQP '*may have increased the input of the commissioners in the services and, as a consequence increased the communication, which would be a positive'*. The investment in nurturing collegiate relationships is seen as fundamental by all commissioners, and the majority of providers. Commissioner Paul believes that the success of AQP was because: '*we spent a huge amount of time supporting and liaising and communicating with our providers'*, whilst Emma highlights the importance of long term professional relationships that enable: '*very frank discussions, because I have worked with some of these staff…for over [x] years'*.

Mark sees the commissioner's role as protective from top-down pressures, which is especially important with smaller non-NHS organisations in an AQP service: '*commissioners can protect organisations from the NHS culture...Top-down, KPIs and targets'*. Despite efforts from commissioners to protect providers, Sophie says '*I do think there is maybe a bit of disengagement at times from the providers'*, and tries to address any confusion for providers about how and why targets are set:

> *so, I think in general they are fine with directives, and guidance is always welcome, but sometimes I think it is making that link between the daily work, and what they have been asked to do by commissioners and NHS England.*

Emma and other commissioners also identified a similar dual role of protector and enforcer with GPs in the wider partnership system, to encourage joint responsibility:

> *getting the GPs to understand what the choice is, and where the figures come from in terms of the KPIs, because a lot of GPs just think I pluck them out of the air and then demand that they are met, and don't really understand that they are a nationally mandated target that then drip down to CCGs, and also drip down further to practices. So, everybody has an understanding that everybody has a role to play.*

As well as being protectors for stakeholders, commissioners act as a '*conduit*' – as Nick described – for top-down directives, which increases the sense of disconnect from NHS England, as Emma describes: '*[its] like a through process, and so I very rarely get direct feedback from NHS England'*. This position is not a neutral one however, with commissioners finding ways to manage their feelings – such as Mark expressing feelings of frustration with the constant target setting in the NHS that feels '*quite whimsical'*, and Emma's identification of the attitude needed to address the challenges: '*it's very frustrating – but I'm quite stubborn, so I always have a determination'*. Sophie, on the other hand, feels less frustration and appreciates her relationship with NHS England:

> *I think they can give a bigger view again of commissioning, of CCGs across a whole area, so they can be very supportive and give some good information of what they have seen work in a different part of the country.*

This reminds us of what Rachael and Mark have pointed out – that the relationships and dynamics between stakeholders are very much influenced by personalities, as well as external directives. Despite personal frustrations with the rigidity of NHS England templates and punitive targets, a similar sense of empathy of being '*under the same gun'* that Rachael identified between providers and commissioners, was felt by commissioner Paul with representatives from top-down power structures: '*to be fair, NHS England, the regional people that we meet, they do understand it, but it is a mandate at the end of the day – but there is only so much you can do'*. There is some sense here of the creators of these mandates at the 'high level' – even above NHS England – that are criticised by the BABCP in the introduction, who are ultimately holding the reins of top-down control.

The frustration of some participants – either with the pressure of targets or frustration with the audit culture of IAPT, or with the complexity and unpredictability of implementation – is offset by strong relationships within their teams. This applied to both providers and commissioning teams. For instance, commissioner Priya reflected on the moral and emotional support she took from her colleagues, echoing Liz's sentiments about having *'kittens'* from the stress, if handling it on her own:

> *it turned from 'oh my god, this is a massive task' to something which would be collective and it took us a lot of effort, took us the best part of, from start to finish, including the formal procurement, I reckon the best part of two years to get our model up and running. And there were all kinds of hiccups along the way. But on your own it would have been thankless, so I think [it helped] having a group of people who every so often you can go and bang your head on their desk, as things were not going as you had hoped.*

On a local level, participants have found a sense of shared identity within the challenging top-down hierarchy of AQP, as Liz recalls from an IAPT event:

> *there is a kind of camaraderie ((laughs)) about having to sit through it all and you meet all the other service leads, and you are sitting there and all, like 'that was nonsense, wasn't it?' ((laughs loudly)). There's something nice about everybody meeting. The adversity.*

In some sense, the frustrations and the lack of autonomy have been offset by strengthening local communication and support. Perhaps the difficulties of AQP/IAPT have brought about a level of mutual understanding and respect between stakeholders within the system, that may not have otherwise existed.

3.4.4. Subtheme 4: *Political agenda of AQP*

> *the government doesn't give a damn about people having mental health problems* (Trisha)

The above subthemes show that many participants felt shared adversity against top-down bureaucratic structures, alongside a range of other stakeholders, even up to the level of NHS England for some commissioners. They held respect for governance systems, but sought moral support to negotiate the difficult balance between personal survival, fulfilling their professional roles, and managing joint responsibility. However, across the data there was a powerful sense of disconnect when it came to perceptions of the political drivers of AQP/IAPT, most bleakly expressed by Trisha's quote above.

Most participants in this study accepted that there were few options other than to take on the challenge of AQP – which was associated with inevitable policy change, as Abdul realised: '*the landscape was changing...which winds us forward to 2012, and the Health and Social Care Act which was passed by the coalition government'*. Participants knew that IAPT was one of a selected number of NHS services earmarked for AQP by the government, and some were dubious about the motives behind AQP/IAPT. Bridget saw AQP as coercive and reported that commissioners '*felt that they didn't make a choice to go on that AQP list, they described it as being put on it'* and Nick believed that the timing of AQP was opportunistic: '*at the back end of everyone being made redundant, so I think it was kind of slipped in'*. This meant compromise, as Paul said: '*you have to do things in a tight timescale and get things through the best you can'*. This meant for Bridget, that a model based on a low margin market model was not compatible with IAPT's principles and governance: '*I don't think that some of the people making the decisions had that understanding that this was a training model to work longer term with providing a sustainable mental health service in primary care, they didn't have that overview'*. In addition to top-down policy lacking an understanding of IAPT, Priya identified a general lack of logic and coherency with government directives, commenting: '*it's not uncommon for major planks of government health policy to pull in entirely opposite directions'*.

However, whilst all commissioners expressed at least some frustration with top-down directives, some felt that they could embrace and adapt national directives to fit local commissioning contexts: for example, Priya designed a local implementation because '*that's what we wanted to do, not because we were ticking a box because somebody at the department had told us'*, echoing the determination and stubbornness of Emma in the previous subtheme.

The complexity of implementing AQP in IAPT is reflected in the variation of responses countrywide, as Emma pointed out: '*we have all done it really, really differently in terms of what we had commissioned'*. The challenges of AQP however – perhaps seen as a political experiment in IAPT – have proven too great for most CCGs and providers, evidenced by the low uptake of AQP for IAPT. For instance, Bridget believed that the design of her local implementation under AQP deterred providers from applying, stating: ‘*most people just walked away when they saw the [local implementation] and the financial landscape’*. When asked why he thought most other CCGs did not adopt AQP in IAPT, commissioner Paul explained: ‘*I would imagine it is in the “too tricky box”. Mental health automatically looks like it is too hard’*. With AQP being based on a quasi-market model, we see that providers of PCPT did not take the decision to apply for AQP lightly, given their commitment to whole service effectiveness to ensure ethical and quality treatments for patients.

As far as having autonomy to manage and deliver quality services, most participants identified wider aspects beyond their control, as Sophie points out: ‘*there [are] always more influences and factors going on than we can actually understand’*. She sees the impact of policy as an explanation for the often-perceived lack of responsivity of NHS providers:

> *I mean, the NHS providers are generally very easy to work with in the sense that they want to improve things. I think often...it is the external factors that slow things down, like changes in government policy, changes to how things are funded.*

Whilst the rigour of IAPT is valued for its use of evidence-based practice and solid governance, the top-down policy directives behind IAPT, NHS England and Department of Health are not seen to be primarily driven by clinical values, but instead by political power, as Abdul says: ‘*I think NHS England is being ruled by whatever government is in power’*. Therefore, if the government’s ideology is driven by neoliberal values such as NPM, these values will also seep into the culture of AQP/IAPT. Similar to Binnie’s vision of the McDonaldisation of IAPT (2015), Trisha interprets the political agenda of IAPT’s audit culture ultimately as a money-saving directive:

> *there is a big chunk of money given to NHS England and the government says to them: ‘right, you use that money to deliver mental health...and we are going to measure this by the way, we are going to want to see an improvement in our economy’.*

Whilst Trisha was the most overtly suspicious of political agendas, which echo Atkinson’s appraisal of the government’s ‘contempt for mental health’ (2014, p.19), other participants expressed concerns about creeping privatisation and threats to the core values of the NHS constitution. Rachael shared Trisha’s perception of the money-saving agenda, but accepts the necessity of adapting to new times and lack of power:

> *so the big decisions are all about saving the NHS a billion pounds of cash and commissioners are looking for ways to claw back some money to reinvest in other things, probably not even mental health, and...we are all just trying to make the best of the situation, but we don't set the ground rules for any of it.*

There were reports of strong feelings about privatisation as a political agenda from at least half of the participants – either their own, or the reported feelings of others. For example, commissioner Emma identified ideological objections to AQP: '*One of my clinical leads particularly, is absolutely anti, against privatisation in the NHS because there are private companies coming in to take over. So that is quite challenging'*. Trisha also described similar resistance of stakeholders in her non-NHS organisation to the perceived government agenda: '*[they] didn't want to be part of IAPT. They said: "we are doing the government's job for them", bla, bla, bla'*.

However, Sophie did not feel that privatisation in IAPT is problematic, saying: '*I think the future is going to be a mixed economy of healthcare anyway, and private companies have been operating in the NHS for a long time'*. She acknowledges that emotions run high but thinks that the issues are poorly understood, remarking:

> *there is always the element of privatisation of the NHS, which is very divisive, more driven by politics more than the stuff on the ground. It's a big issue really, but it's difficult to pin it down, exactly what some of the problems are.*

Priya expressed fears about '*scary*' American companies when she advertised her AQP contracts – imagining a fundamental shift away from traditional NHS provision and corresponding values. Priya, like Sophie, also felt that emotive arguments about privatisation obscured the potential to reward positive values-led work in the NHS through the process of challenging inefficiencies with market-type reform, as the section *Developing a business model* suggests.

The openness to change and willingness to adapt to new challenges (for example – the business mindset, creativity and innovation of AQP) was important in order to address some of the blockages identified in traditional NHS services. Emma, along with other participants, feels that the variety of providers and organisational cultures in AQP – what Sophie calls the '*mixed economy'* – has helped introduce better services, and this has changed her view of privatisation in the NHS:

> *I have worked in the NHS all my working life and very protective of it. But actually, witnessing how different non-NHS providers work in comparison to NHS providers, actually, I can see why non-traditional NHS services are achieving so many contracts...I really like non-NHS providers coming in because it complements, it doesn't take over, it complements.*

The complementary nature of AQP – also recognised by Abdul – is valued by Liz, who reflects on the learning and opportunities from AQP:

> *I think I will probably look back on this really fondly, a bit like the coalition government, which I hated at the time, but actually...some of the people who are being seen would probably have not been seen if we were operating a strict IAPT model.*

Despite a conflict of personal values in relation to perceived privatisation for several participants, the primary commitment to delivering services motivated providers, as Abdul explained: '*we wanted to preserve the service, the quality that was [there] already'*. So, fulfilling his ethical commitment to PCPT meant adapting to the new market environment, despite ideological objections:

> *I am completely against privatisation of the health service, so politically I have not been in tune with providing under AQP at all, which is why I set up [my organisation], because that was the closest I could get to NHS values established within the governance of the organisation.*

Most participants agreed that the low tariffs in AQP/IAPT acted as a protection from profit motives in PCPT – with clinical values seen to be the primary driver, as Liz suggested: '*on the whole, [providers] don't get into this line of work if they are not interested in people'*. An exception is Trisha's perception of the private provider in her implementation. Peter sums up the ethical decision-making behind the application for AQP for most providers in this study:

> *We still wanted to be able to cater for the population of [our region], so we went for it. Even though it wasn't the most lucrative contract, but I think there was kind of an ethical, values driven thing. That we should be part of this. Yeah. I remember that very clearly.*

Managers and commissioners drew upon their personal values around patient-centred care to help manage the ideological challenges of AQP/IAPT. Over half of the participants described their motivations and that of their colleagues using emphatic terms such as '*passionate*', '*dedicated*' and '*committed*' to delivering a quality service to improve public mental health and wellbeing. For example, Nick describes the core ethos of his organisation:

> *we are an organisation that is truly values led. We have got [very senior staff] who are out and out around delivery of quality services, and if we are not doing it to the best of our ability, we would question why we are not doing that.*

This pervading focus on patient-centred care throughout the data will be explored in more detail in the final superordinate theme below, *Sopranos: Patient experience in AQP*.

3.5. Superordinate theme 4. *Sopranos: Patient experience in AQP*

> *And actually what you think you want is something really different again, because you've been watching 'The Sopranos', and you have seen Tony Soprano having therapy, and you think you'd like a bit of that. Do you know what I mean?* (Liz)

This theme reflects participant's responses to the idea of patient choice within AQP. All participants felt that AQP benefitted service-users by offering quality of service with more patient choice as a result of multiple providers, as Liz comments: '*the variety of what they can get offered is really huge, compared to what we could offer at [the previous local service]'*. However, the enacting of true choice of therapy was not as simple or straightforward as suggested by the policy rhetoric of the benefits of AQP. Choice in AQP, by default of the model, is provided via competition. As previous sections have shown, quality care needs: cooperation between providers across the local system; enough financial resourcing for adequate governance; and not too much scrutiny so that perverse incentives reduce the quality and range of access for a diverse client cohort. Therefore, choice arising from a competitive model, brings disadvantages.

Even if patients can notionally make an informed choice, as assumed by AQP, NHS manager Liz does not believe that there is a true choice, because IAPT services are inherently limited in what they offer:

> *I think, and this is just my opinion, and it is probably politically not what people want to hear at the moment, but patient choice is causing more trouble. You know, the whole idea of people having choice about their treatment. It's a great idea, but it kind of sows the seeds of destruction really for the whole system because the bottom line is, we have got what we have got on offer and there is an evidence-based for what works, and what doesn't work.*

Liz acknowledges here, the inherently limited nature of NHS therapy provision. With increasing demand – which is exacerbated by the current socio-economic climate – she likens the notion of choice to a fantasy, akin to '*watching The Sopranos'*. Other participants talked about the complexity of patient need within a model of 'choice' in conjunction with IAPT, and about how therapy can be marketed and delivered within a business model with limited resources. However, the biggest message to come through the data, was the necessity of delivering real-world services that help real-world clients.

The two subthemes in this section that represent participant's perceptions of how the client is impacted in AQP/IAPT are therefore: *What is patient choice in APQ?* and *Patient care in APQ.*

3.5.1. Subtheme 1: *What is patient choice in AQP?*

> *[A] kind of trip advisor approach* (Priya)

What Priya describes as the '*trip advisor approach'* of AQP, in theory, would offer improved patient choice from amongst multiple providers. However, some implementations had more providers and were implemented differently to others – with lead providers, and so on – which means that choice did not operate as imagined. Abdul explains his disappointment of the local model, that did not enable him to compete on a level playing field: '*I thought, the way AQP had been described before [the announcement of the local implementation model], that it would be that you would have lots of organisations providing, and patients would choose which organisation they wanted to go to'*. When referring to choice in AQP then, *what* can be chosen, *how* it is chosen and what is *desired* by clients, needs to be understood.

There are several factors that influence what patients choose. Across the range of CCGs using AQP (not necessarily in this study), choice in AQP ranged from just two providers delivering the same range of treatments (assessment, Low Intensity CBT [LI], High Intensity CBT and High Intensity Counselling) to up to fifteen providers delivering a range of specialised step 3 treatments, with a gateway provider for assessments and triage. Referral pathways also varied between implementations. The more providers there are – the more choice of treatment types there could be, as Mark observes: '*there is huge choice, there is a massive choice'*. Depending on the implementation however, and where services offered compatible care pathways, increased choice was not simply associated with type of treatment or provider. Choice of location or between waiting times (which in theory could be provided by a responsive single provider) improved aspects of effectiveness beyond clinical effectiveness; for example, Sophie described the advantages to clients of '*increasing the availability and the access to services'*. The superordinate theme *Cats: Partnership working in AQP* demonstrated how the increased range of providers has extended the boundaries of NHS PCPT practices, and changed how existing providers operated their services when in semi-competition with each other to try to improve their service. Whilst choice via competition in AQP is seen as positive in theory, real-world choice is affected by the multiple factors presented in previous themes, and will be expanded upon below.

Some participants felt that the referral pathway potentially limited or enhanced choice. In common with the IAPT model, clients are encouraged to self refer – but as commissioner Sophie points out '*quite a lot of referrals come through our GPs'*, and some participants questioned the notion of true patient choice due to the influence of GP's recommendations, given the traditionally close relationships of GPs with patients in primary care. Whilst Abdul felt that GPs should be part of the referral pathway because they know the patient best, commissioner Emma explained difficulties in getting GPs to use the expanded provider model of AQP: '*It is really difficult to get GPs to think about referring to a different provider that is not the old block con, because it took quite a long time to change their way of thinking'*. Therefore, new providers who do not have established relationships with GPs may not get equal referrals, compared to existing providers. Building up relationships with GPs was consequently seen as advantageous by several participants.

The challenges for receiving referrals emphasise the need for innovation and marketing in AQP. This is why Rachael talked about offering '*something new to the mix'*, because she felt that referrals would not come by offering the same as existing services. However, Priya questioned how choice, in reality, should be marketed to patients in PCPT: '*if this is a part of healthcare, but it is not a traditional market, how do you advertise the market to customers to enable them to make a choice?*'. Marketing a PCPT service to patients as a business is challenging. Paul felt that with the complexity of AQP, '*there are all those real complexities about marketing and advertising and giving patients the right information about the services, because it is a moveable feast'*. Priya cited assumptions about patients having access to the internet for example to highlight the importance of truly accessible referral systems, because the demographic in her area was financially disadvantaged and many people lacked access to information technology.

There were also numerous practical barriers for providers in offering choice, even when the conceptual willingness to invest in marketing as a business existed. For instance, accessing rooms – as well as costly – was also challenging for several participants, as Paul explains:

> *as soon as AQP came in, then GPs started charging, or turfing them out. So that was a big, big, problem. So suddenly, we had a situation where GPs wanted their rooms back because they were under pressure to provide rooms.*

Understanding the complexities of offering choice and being flexible enough to respond to the different priorities for choice, as desired by patients, was important to participants. Trisha believed that choice of location in rural areas was most important to clients. Rachael, on the other hand, said: '*The thing that people hate the most is waits'*, and that offering a short waiting time would mean that her service was a desirable choice. However, workforce planning, the lack of a secure income, and no guarantee of business, meant that addressing waiting lists was fraught with risk. In this way, the low tariffs of AQP mean that choice is limited because the resources required to offer choice reduce income to unacceptable levels for many participants. Cherry-picking is an example where if a provider does not have to offer additional services because they know another provider will step in, they might be incentivised to offer the easiest and cheapest option, in the absence of penalties. One solution offered by commissioner Paul was to offer a tariff component for activity that rewarded local targets: '*our providers are really trying hard to increase the access to different groups of people, with more complexity and yes, there is a tariff incentive for that...that is what galvanises organisations, because they are businesses now'*. This highlights the importance of commissioners being in genuine dialogue with local providers, to ensure that the best range of services are offered using the range of local incentives, such as CQUINs, to support providers in making improvements to local service provision; as Emma says: '*we don't look at it in black and white'*.

For many participants, the flexibility required in real-world AQP/IAPT was in some ways in conflict with the IAPT model. The acknowledgement of the restrictions of delivering AQP/IAPT meant that participants were more pragmatic about making local compromises to quality and IAPT protocols. The subtheme *IAPT governance and AQP* showed that participants used PBPP to identify counselling as a cost-effective and desirable choice of therapy. Along with other pragmatic compromises that – according to Bridget – '*ditched that culture of IAPT'*, participants attempted to find their own definitions of choice, quality and cost-effectiveness. For instance, Priya said: '*meeting the IAPT targets was not high on our list of priorities because part of what we wanted was to meet local need'* and Nick was critical of IAPT's rigid definition of quality treatments over pragmatic local decisions: '*whilst we have moved towards commissioners identifying reliable improvement, our national targets are still based on recovery'*.

The expectations of IAPT, and the disconnect with the reality of offering choice in AQP/IAPT is another example of Rachael's '*elephants in the room'*. This highlights the divide between top-down governance structures and the clinical focus of local services; Priya explains:

> *it was very difficult with the initial IAPT model to offer choice, because IAPT assumes one or two providers at most, maybe one High Intensity and one Low Intensity. But actually, in quite a lot of parts of the country, IAPT was provided by a single organisation, so kind of 'do choice' was nowhere near, it didn't seem to fit. And the other one was at the time mental health by results, the notion of clustering....it was like speaking two different languages*

Nick however sees potential flexibility within IAPT for delivering choice, overall cost savings and addressing more complex need. Even though AQP offers flexibility to address complexity outside of IAPT's prescriptive model, low tariffs mean that the capacity cannot be offered with AQP, as Nick suggests:

> *the real value for IAPT is the ability to be able keep people with severe depression and anxiety within primary care, because the cost benefits to the rest of the system are immense. However, if you then couple that with the low tariff based on AQP, immediately it makes it unviable for a person who is going to need 16-20 sessions of intensive therapy.*

Nick also thinks that even adequately resourced IAPT block contracts do not necessarily offer quality services: '*I still think there are areas where it is inefficient, and not particularly delivering on the prescriptive model in the first place'*.

The impact of different NHS targets also means that providers had to refocus their efforts on what aspect of service quality was being scrutinised at the time. Priya thinks this acts against patient choice:

> *so what happened was that you got a distorted model where the flow of patients…, although theoretically there was a choice, actually because we had imposed a wait time target, that choice was being directed to those people who could make sure that waiting times hit again and again and again.*

Mark also felt that the '*whimsical*' pressures of different targets on CCGs and providers took resource and attention away from offering local choice of quality provision. The situation begins to resemble providers being on a hamster wheel of responding to targets, rather than being able to attend to patient choice.

Aside from the fantasy and impossibility of delivering choice according to a prescriptive NHS/IAPT model, the appropriateness of patient choice in the commissioning of PCPT was questioned by several participants: Priya recognised that healthcare is '*not a traditional market'*, Mark recognised that he is not buying '*widgets*' and Paul recognised that mental health was complex, and in the '*too tricky box'* compared to other NHS services. Choosing a therapy service is a complicated process in the real world, as Liz explains: '*if you went with a different kind of illness, phlebotomy is a good example, it would be much clearer what you were going to get. You wouldn't try one thing and then try another'*. Paul summarises the challenges of patient choice in PCPT, agreeing with Trisha that location is more important to patients than wait time:

> *I do think it's difficult for patients, particularly with mental health, with all these, you know, different names that services have got, some people call it counselling, sometimes it's called talking therapies, IAPT, Primary Care Psychological Therapies. It's so many different names, and patients don't really know what they are getting. They don't know they have got a choice, I think in the main. They will go to whoever is the local provider who is nearest to home, even if they have to wait a bit longer.*

The tension for therapy organisations between looking after client's care needs and offering choice will be explored further through the responses of participants about patient care in the final section below.

3.5.2. Subtheme 2: *Patient care in APQ*

> *if someone is making a choice about which wheelchair they want, then allowing them to choose where they go and buy their wheelchair is very different from if someone is in psychological distress* (Bridget)

Following on from the questions about the appropriateness of choice in PCPT, this subtheme gathers together comments throughout the data as they relate to the central concern for patient-centred care.

Bridget felt that there was a lack of clinical sensitivity and a disregard for clinical leaders at policy level: '*lots of people were very disgruntled about [AQP/IAPT] at a national level, because it felt that there was not an understanding of what psychological therapies was'*. Like other participants, she recognises the needs of vulnerable patients and felt that offering a choice of therapy was not the same as choosing a wheelchair, so it was not clinically appropriate to say: '*over to you. You decide where you get that treatment from'*. Mark recognises that commissioning therapies is not like *'buying widgets'*, because therapy is a relational process, and has to be treated with relational sensitivity. Therefore, the relentless pressures and stress revealed in this study (seen also in general IAPT debates) highlight the potential impact on the therapeutic relationship of top-down policy, such as NPM and AQP.

However, this analysis has shown that participants have at least some degree of autonomy in AQP, with freedom to tailor local implementations within the rigidity of top-down NHS governances. Nevertheless, low tariffs reduce innovation and threaten basic quality standards – as providers juggle organisational survival with patient-centred care. In the absence of adequate resourcing to fully comply with top-down governance, commissioners and providers placed trust in their own clinical governance models (in whatever form the model might take, i.e. a policy directive, clinical practice, or informal meeting). Some – like Liz, Bridget, Peter and Sophie – valued the structure and guidance of the governance structures of IAPT in directing robust and effective treatments. Even though at times IAPT's model is seen as prescriptive, it was valued for improving access, setting quality standards, and fulfilling social justice, as Peter said: IAPT's introduction meant that PCPT '*was an equitable service'*. Others, like Abdul, Nick, Priya and Trisha – those providers who perhaps felt less embedded in NHS systems – had full trust in their own organisational governance models to deliver effective, quality services. The topic of good clinical governance appeared throughout participant's experiences of AQP and equated to ethical and effective patient-centred care. Trisha, like others, asserts that her AQP/IAPT service offers '*a very strong clinical governance model'*, despite perceptions by Liz and Bridget that some AQP providers weakened clinical governance. Bridget explains that rigorous NHS policies and procedures (not just those related to information governance) mean: '*clinical governance for the patient. You know that you have got good patient care'*. Whether clinical governance is guided more by NHS structures, or an organisation's own clinical governance models, the responses in this study show that conflicts from business pressures are to some extent offset by this clinical autonomy, because: '*any decision made by clinicians overrides any managerial decision'* (Trisha).

One of the most striking features of the data, were the sentiments displaying the deep dedication for clinical care, seen at the end of the section *Political agenda of AQP*. This was protective for participants and their clients on a number of levels. Clinical values helped them to manage the different aspects of AQP that made delivering effective services more difficult: emptying the pool (despite the alligators), acknowledging the elephants and managing the lovely wandering cats. Whether evidence comes from narrow readings of EBPP or from pragmatic reading of the IAPT database (PBPP), IAPT attracted '*people that were passionate about evidence-based practice and putting the patient at the centre of care and ensuring that that person's care was meeting their needs'* (Bridget) and people who '*all spoke the same language, because we are all experienced in IAPT'* (Rachael). This language means different things to different people, and although Priya felt that the language of IAPT was different to AQP or the payment model, there was a broad commitment by all participants to delivering accessible and effective NHS therapies (i.e. using a common clinical and ethical language). This commitment is summed up by the NHS values that Abdul aspires to: '*a quality service free at the point of access, equally accessible to all'*.

Even though target chasing is seen to negatively impact services, clinical values can help providers manage the stresses of scrutiny. Abdul sees the performance focused nature of AQP as a chance to use self monitoring and comparison to improve outcomes and overall service delivery:

> *I do feel the pressure to meet the targets, but that is more because...I know we are offering something of good quality and I want to have it demonstrated, and the fact that you are part of an AQP and part of an overall service is almost irrelevant to me*

> *because I benchmark against ourselves, and it is good to benchmark against the average of all the AQPs, and if we were below the average, I would be worried.*

Participants were able to detach, to some extent, from the top-down targets because they measured benefit to clients in ways meaningful to them. For instance, Emma recognises that treatment:

> *may not be able to get them to recovery, because of everything else that is happening in their lives, but actually it has enabled them to go away and feel a little bit better and more able to deal with debts and housing issues.*

For Liz, even though she says AQP *'[is] a nightmare in terms of recovery'* and does not bring financial reward for an IAPT service, she sees great benefit for a client if '*they might keep their kids or get out of an abusive relationship'*. Nick talks about the pride in helping people, even if the performance figures for the service did not look good: '*but around that person's quality of life, you know you would walk away as a clinician going, "I have achieved something really special here"'*.

Alongside the perception of operating within rigid top-down protocols, some providers questioned the kind of care that is meaningful and helpful for clients. Rachael identified that a therapy service might simply mean offering speedy emotional support:

> *it is a bit cynical, [but] I sometimes think if you were to say: 'we will just provide somebody who will just listen to you and not say anything to you, but you can see them tomorrow', there would be no recovery rate at all, but that service would be booked up within days ((laughs)).*

Mark believes that ease of access is the most important thing for clients, who are not interested in how it is implemented (AQP or otherwise):

> *if I was a patient and I needed some help, I wouldn't care. I just need to get what I need to get. I need to get somebody to help me with my anxiety and my depression. I don't care about AQP. I don't care about block contracts. I don't care. I just need to see somebody at 6 o'clock on a Tuesday night because that's the only I can get away, and I'd like a one to one please.*

The needs of complex clients caused concern for several participants. Liz ranks patient need above patient choice in PCPT, suggesting that the question '*what do you want*?' should be reframed as '*what do you really need?...But the more choice you put into the equation, the* *more difficult that becomes'*. Liz echoes Rachael's comments, and identifies problems meeting the needs of complex clients in resource limited AQP/IAPT:

> *[choice] is quite often at odds with what people think they want, which is to be looked after. They want, quite often, especially the more complex people, what they want is a care coordinator, which is what they probably always had until they were discharged by secondary care, somebody to sort of look after them and listen to them, which is absolutely fine, and care for them…this system isn't engineered or geared in any way, shape or form to offer that.*

Even though NHS providers were seen as uncompetitive in AQP, they were valued because they were seen to address cherry-picking or the challenges for many AQPs of treating complex patients. Perhaps because NHS providers are more closely linked to secondary services, they are seen to fill gaps in provision, as Peter explains:

> *We do take on difficult people...maybe because we are an NHS trust...Yeah, we don't pass the buck. So if there is a gap, we might take them on and this is what the other providers maybe aren't willing to do...They also don't have the confidence in working with more complex people.*

Liz feels that non-NHS providers have idealized expectations of her NHS AQP/IAPT service:

> *I've spent an awful lot of time discussing...with other providers who don't think they should be [seeing complex clients]...they think: 'well, why don't you send them into the CPI [Complex Psychological Interventions team]?' Because there isn't a CPI. But they don't know that.*

Despite the challenges of fragmentation in AQP/IAPT identified in the superordinate theme *Cats: Partnership working in AQP*, providers with different sets of practices and knowledge-bases learn about each other's ways of working. The resulting '*consensus*' of provider's voices (Rachael) sets up a sense of shared responsibility, as Mark observes: '*it…forces a group of providers to try and form some kind of really strong operational partnership, that they are all working towards a common goal and all have to take collective responsibility'*. Priya says that this '*cooperative, collaborative'* approach promotes inclusivity of practices: '*even single handers can get a sense of support, can get a sense of being part of the broader service offer'*.

As well as shared responsibility, some providers felt closer due to sharing adversity, as Rachael explains: '*we are all under the same pressures...We all have much more in common* *than different'*. Priya believes that AQP increases connection, investment and mutual learning within a single IAPT service and improves patient-centred care, saying: '*there is a strength in AQP, in saying "you are all in this together"'*.

A large part of the shared identity comes from the shared core clinical values, which are trusted to protect the quality of the service. Even though Peter had a perception of some AQPs avoiding complexity, and other participants were scathing of suboptimal doses and gaming the data, the peer scrutiny in AQP can provide quality assurance, as Rachael reflects: '*it's actually about the culture of therapists really. Therapists will rate each other if we perceive that we are doing something ethical'*. Where this respect might disappear, she continues, is: '*if we think that the balance is wrong between making money and the clinical provision, then it doesn't matter whether it's in the NHS or outside the NHS, we will be a bit disdainful'*. This indicates that quality control standards inherent in clinical values, can offset some of the problems with partnership working. Even though Abdul said that being part of a group was irrelevant to his organisation's quality standards, the group environment does offer a benchmarking opportunity. This, together with the willingness and desire to strive for excellent clinical care, contributes to improved internal quality standards and enhanced cooperation for joint governance. In this study, these factors appear to have protected clients in the local system from the feared negative consequences of AQP.

Whilst clinical values, peer scrutiny and local autonomy might drive good clinical care and compensate for perverse incentives and fragmentation from competition, the financial challenges of AQP continue to cause stress for providers and the staff working in AQP/IAPT. The PbR basis of IAPT remains an ongoing risk to quality clinical care, as Nick point out:

> *the threshold is set too low for IAPT, because it is not an official threshold, [it's] based on money, rather than based on need. And I think that has been an unwanted consequence of AQP in a lot of areas.*

The analysis of the data suggests a great willingness and ability on the part of providers and commissioners to use clinical values to focus the service on patient-centred care in the face of the numerous challenges identified in previous sections. However, there are some core issues around bureaucracy and funding that remain beyond participant's control. The context and implications of these issues will now be discussed below.

4.0. DISCUSSION

> *Medicine is a social science and politics is nothing else but medicine on a large scale. Medicine as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution; the politician, the practical anthropologist, must find the means for their actual solution*
>
> (Virchow, cited by Ashton, 2006)

With an understanding of the multilayered complexity of policy and the nexus of practices in the implementation of AQP/IAPT, the research aimed to explore how commissioners and managers implemented AQP in IAPT, and their experiences of the strands of policy that shaped the services. The results of this exploration are then reviewed from a Counselling Psychology perspective, with a view to potentially developing a Counselling Psychology oriented discourse on leadership and politics. My intention is to erode the formal divisions between clinical practice and political practices that shape mental health services, to promote service design that better addresses society's increasing mental health problems. This revives Virchow's socio-political vision of medicine, as summarised by McNeely: 'The politician and the physician, if not one and the same, at least had the responsibility to co-operate in applying political salves to societal wounds' (2002, p.5).

This research is a useful addition to the study by Griffiths et al. (2013) because it investigates AQP in IAPT, interviews the same participant groups and covers several geographical areas. However, apart from the temporal difference between their study and the current study (early stage AQP vs. more recent experiences), many of the participants in the Griffiths et al. study had decided to pull out from service delivery, and therefore may not provide data to explore working *with* policy, rather than escaping it. The researchers point to this as a limitation of their study. The design of the current study addresses this limitation. It therefore offers additional perspectives on AQP/IAPT – positive, negative or neutral – that explore in greater depth the complexities of the policy impacts on PCPT.

After reflecting on the possibilities for new models of care, I discuss how the policy layers of AQP impact service effectiveness at the micro, meso and macro levels. I then discuss how these findings might be used to inform a socio-political leadership discourse for Counselling Psychology, and then offer suggestions for corresponding additions to the Counselling Psychology curriculum. The discussion ends with reflections on limitations of this study and further suggested research, followed by a final reflexive statement.

4.1. New models of care for effective services

The Dalton review calls for new care models and 'organisational forms' that use flexible delivery methods, including more joint working and local autonomy rather than top-down directives, to translate 'ideas into reality' from the Five Year Forward View (DoH, 2014, p.4). The FYFVMH states that 'new models of care' are needed to meet the increasing prevalence of CMHDs. Although AQP may not be popular in PCPT, it can be seen as an experiment in new organisational forms. As such, the experiences of participants in attempting to deliver quality person-centred care within tight financial constraints and partnership working are of potential benefit in the developing policy landscape of STPs and money-saving measures. This may usefully inform the future implementation of PCPT in the call for new models of care.

When considering what we learn from the AQP policy for the design of these 'new models of care', it must be remembered that 'new' is not the key word. Rather, we might aspire to *more effective* models of care that meet the needs of clients, and are sustainable for organisations and the staff who deliver therapies. These may be models that are not entirely new in form, but might involve new ways of interacting with policy – rather than simply new ways of working, which are implied in documents published by the British Psychological Society (BPS et al., 2007). In this context, it is worth quoting Foster and Murphy's invitation to counsellors at length, because to some extent it paraphrases the themes appearing in participant's responses in the current study on entering the quasi-market of AQP in IAPT (2005, p.4):

> *Individually, as a counsellor, you may prefer to stay out of the tussle for power and resources between various interested and competing parties. You may want to remain unaffected by such matters – you may be frightened of entering the fray. But if you enter the jungle you need to learn and live and survive with the other animals! In a*

> *new environment, where resources are limited, adaptation is necessary for survival and evolution. But you also need to be able to preserve your species identity because you have something different and unique to offer. One of the most interesting and delicate tensions around working as a counselling therapist in the NHS is that between fitting in, being useful and being different.*

Even though Foster and Murphy refer to individual practice counsellors in the NHS, themes in this passage – such as: ‘competing parties’; ‘tussle for power’; limited resources; learning and surviving with other providers; adaptation; evolution; identity; and difference – also apply to the experience of AQP/IAPT. In the current study however, rather than rival providers being the animals that create the challenges, it is the policy landscape of choice; competition; PbR; governance standards; and top-down power dynamics, that become the animals in the jungle. ‘Fitting in, being useful and being different’ reflects the challenges of finding ways to deliver effective services in a way that preserves ethical commitments – and challenge unethical compromises – whilst surviving in the jungle. In other words: efforts to address the splitting of ethical actions identified in the introduction.

As AQP overlays new variables onto the existing IAPT landscape and NHS context, the metaphors of cats, elephants, alligators and a fictional TV series *The Sopranos* summarise the challenges and opportunities arising from the AQP policy for participants in their efforts to address the increasing prevalence of CMHDs, now and into the future. Priya points out that ‘*it’s not uncommon for major planks of government health policy to pull in entirely opposite directions’*: AQP is an example of this, where participants attempt to deliver effective services in a field of practices that are impacted by different planks of policy – which include the existing New Public Management principles in IAPT, STPs, and the various NHS strategy documents such as the Five Year Forward View, in addition to the AQP policy itself. The policy strands found in AQP that might influence the future design of the new models of care are explored in further detail below.

4.2. The effects of AQP policy on Service Delivery

> *the question is whether 'patient choice' through the means of competition under the AQP policy is a reality that benefits the care and engagement of patients through improvement in the delivery of psychological therapies*
>
> (Griffiths et al., 2013, p.8)

In the citation above, Griffiths et al. redefine any potential contribution or learning from AQP in terms of any improvement in real-world service effectiveness. Service effectiveness is significantly impacted by the ongoing reorganisation of NHS and IAPT services due to policy changes. Therefore, AQP must be evaluated in relation to the wider range of real-world effects on services, not in relation to a narrow reading of service effectiveness.

Below therefore, given the complexity of assessing real-world effectiveness, I discuss the findings as they relate to the interaction of AQP policy strategies (defined here as: choice; competition; PbR; governance standards; and top-down power dynamics), and the impacts of this interaction across the micro context of clinical treatments, the meso operational context and the macro context of joint working. As Griffiths et al. (2013) point out, IAPT and AQP represent multiple layers of intersecting policy which cannot be evaluated in isolation. Therefore, the sections below are not intended to map neatly from the themes in my results, and are not mutually exclusive of each other. Instead, I will discuss how experiences of policy layers, and the resulting impacts on different aspects of service effectiveness, are interlinked across a complex field of clinical and political practices.

4.2.1. Effects of the policy on quality patient-centred care (the micro service context)

This section, discusses how participants balanced different aspects of AQP policy with a central concern for delivering effective and ethical patient-centred therapies. This is relevant beyond AQP because PCPT services will increasingly be expected to offer quality client care under challenging conditions of reorganisation and austerity, and within government directives of personalisation and choice.

Effects of choice on patient-centred care.

Participant's beliefs that the variety of providers in AQP was good for patient choice in this study contrasts somewhat to the perception of participants in the study by Griffiths et al. (2013). However, the results show that the reasons for how and why choice is desirable, are complex. A study in audiology (Accent, 2015; Monitor; 2015) reports slight differences in patient experience between AQP and non-AQP sites, and confirmed findings from this study that choice was valued for different reasons that include: location; convenience; and the perceived quality and reliability of the provider (often associated with NHS providers). However, choice – as an end in itself – was not particularly desired or recognised by patients. Similarly, a study of IAPT services demonstrated little patient expectation of choice, but some clients specifically questioned if the range of therapy offered limited quality (Hamilton et al., 2011, p.31). This echoes commissioner Paul, who believes that generally clients '*don't know they have got a choice'*, and Mark who thought that clients just want to be seen as quickly and conveniently as possible.

While improved access and choice of services were valued by all participants, it was not the main feature associated with quality and effectiveness. There are numerous references in the data to dedication and passion that evidence participant's commitment to provide a service that is responsive to client's needs, not just their ability to choose from a range of providers *per se*. Griffiths et al. define patient choice in AQP as 'a choice between providers in a market structure leading to improvement in the patient experience' (2013, p.36). This implies that choice must be from a range of *quality* and trusted providers in order to improve effectiveness. As outlined in the introduction, improvement in patient experience is a product of wide-ranging impacts on service effectiveness. Because the multiple pressures on providers threaten the quality of patient care, the policy rhetoric that 'giving people more choice and control is key to putting them at the heart of the NHS' (DoH, 2010c, foreword), therefore belies the need for a choice of *quality* services.

The policy impetus toward the quasi-market model may therefore risk 'crowding out' some of the core features of the clinical relationship when patients behave and are treated as customers in a market place (Sandel, cited by Owens, 2015, p.27). Owens argues that the personalisation agenda of the NHS that 'choice should become a defining feature of the service' (Darzi, cited by Owens, 2015, p.23), erodes the intimacy of the doctor-patient relationship – what Fotaki defines as an erosion of trust in the clinical relationship (2014).

Given the existing challenges to relational depth for psychologists in NHS settings (Morris, cited by Cooper, 2013), and the importance of relational depth to therapy outcomes, the crowding out of clinical trust with the policy rhetoric of choice, may not positively affect the effectiveness of treatments; as Priya said, '*it is not a traditional market',* reflecting the reservations of several participants about the logic of choice in PCPT.

Like Owens (2015), Mol raises question about the relational nature of patient care – drawing a distinction between the 'logic of choice' embedded in the rhetoric of NPM, and the 'logic of care', which traditionally underpins health and social care work (2008). Mol argues that the reality of giving and receiving care practices is multilayered, uncertain and complex but that 'the logic of choice simplifies the relation between means and ends' (2008, p.47). The logic of choice behind the ethos of an AQP/IAPT service sees clients as '"discriminating customers"' (Gabe et al., 2015, p.625), being able to pick a standardised and manualised therapy off the shelf and 'shop around' between providers. However, choice in PCPT does not automatically lead to improved outcomes or improved care because, as Bridget noted, choosing a wheelchair '*is very different from if someone is in psychological distress'.*

Greener (2009) explores the extensive use of the word 'choice' in policy rhetoric in the NHS since 1944, and finds strong association with 'responsiveness' to patient's needs. Here, we might find a view of the patient-clinician relationship closer to Mol's logic of care, when 'care provision becomes a process of negotiation between doctor and patient' (Greener, 2009, p.321), and where patients choose to be cared for and trust the care professionals to take control over care practices. Furthermore, the ways that choice is interpreted by clinicians are different to the rhetoric of choice espoused in policy (Peckham et al., 2012). This reflects many participant's views of clients who might just want to be looked after or to speak to someone, more than to exert choice of evidence-based therapies.

Effects of governance standards and top-down control on patient-centred care: the fantasy of *The Sopranos.*

The lack of responsivity to the client's needs in the rhetoric of choice was also seen to be inherent in IAPT's one-size-fits-all approach by several participants, notably Liz's perception of client's fantasies about *The Sopranos.* This echoes Lees' suggestion that the rhetoric around IAPT's '"revolution"' is in itself a fantasy, due to its false promises (2016, p.2). The findings here regarding AQP policy concur with the debates presented in the introduction concerning top-down control in IAPT, and suggests that what patient-centred care means to policy makers, might not be the same for clinical leaders. For example, is the focus on recovery targets designed for client benefit, or does it impede recovery, as Mollon argues (2009), and does the personalisation agenda truly represent the most important aspect of care, as Owens (2015) questions?

The broad governance standards (training, supervision etc.) and improved access of IAPT were valued by most participants and represents the 'culture of therapists', as Rachael describes: '*trying to give the best quality of care to the highest number of people at the same time'*. However, the ability to deliver these IAPT standards under AQP was not easy for multiple reasons: overly rigid guidelines; lack of funding for service governance; activity centred around chasing targets that were sometimes perceived as meaningless; and perverse incentives. As Griffiths et al. (2013) suggest, the wider range of providers in AQP from outside an NHS or IAPT background, raises questions about IAPT's effectiveness – such as the meaningfulness of outcome measures and the choice of therapies available. The top-down features of AQP policy therefore interact with the existing debates around IAPT governance.

There is evidence in this study that rigid guidelines reduce the real-world choice of therapy, but this may not be openly acknowledged by IAPT in the absence of the foreground provided by variety of providers in AQP. In offering choice as a Care Quality Commission (CQC) marker of an 'effective' service, the IAPT manual references Layard and Clark's book *Thrive* (2014) in stating that IAPT offers:

> *the right therapy: A choice of evidence-based, NICE-recommended therapies based on accurate problem descriptors. For depression, the choice of therapies extends to beyond CBT approaches to include interpersonal therapy, brief psychodynamic therapy, couple therapy, and counselling for depression* (National Collaborating Centre for Mental Health, 2019, p.64).

However, this does not accurately reflect Layard and Clark's book, which devotes less than half a page to counselling for depression as an effective treatment, and instead demonstrate a clear epistemological allegiance towards EBPP. This promise of choice is further undermined by an underfunding of IAPT training in non-CBT therapy modalities (BACP, 2017; Barkham et al., 2017; NHS England & Health Education England, 2016**)**. The mismatch of rhetoric and reality – the elephants in the room – was questioned by several participants, and caused discomfort for some. For example, Liz feared that it made the service less rigorous and ‘*leaves us at some point possibly vulnerable’* to top-down criticism of governance standards, even though local commissioners might understand that these governance requirements may be impossible to meet without adequate service funding.

These pressures highlight the need for pragmatism, flex and efficiency. Whilst not new criticisms of IAPT, the wastefulness and pressures of top-down governance are particularly apparent in AQP; where competition is intended to be based upon quality, but where strict governance measures cannot be delivered within the tariff. For example, Paul remarked that NICE restricts innovation. Commissioners Priya and Sophie both reflect on how IAPT may not be the best model to offer patient-centred care, and many participants suggested that the recovery measures used in IAPT do not reflect real-world improvement in client functioning. Both Nick and Abdul used the IAPT database (as a form of practice-based evidence) to point out that counselling is a cost-effective alternative to CBT for depression, even though its effectiveness is not endorsed by the NICE guidelines for more severe depression. This reflects the growing body of research that demonstrates the effectiveness of counselling (see for example, Pybis et al., 2017).

The frustration with top-down pressures that are disconnected from practice leads to local adaptations and trust in clinical judgment. All commissioners, except Sophie, felt the need to challenge NHS England about the pressure and assumptions around targets, and were frustrated by a lack of two-way compromise (although, Sophie felt that NHS England were supportive). Participants appear to be using parallel practices (local flexibility and awareness of top-down governance) to pragmatically apply their own definitions of quality, whilst fulfilling the requirements of top-down bureaucracy, rather than fully accepting the top-down definition of quality – especially when it is unattainable in an underfunded and complex local system. Commissioners incorporate other ways of assessing clinical effectiveness, assess providers locally on their own knowledge of local outcomes and processes, and trust the expertise of local clinical judgement. This is fortunate since McCafferty and colleagues (2012) argue that excessive performance management from commissioners can damage working relationships, and this in turn will negatively impact service effectiveness. Instead, we find that participants were using the kind of ‘soft intelligence’ to measure local effectiveness, similar to that identified by Martin et al. (2015).

The current study appears to confirm the suggestion from Griffiths et al. (2013) that the increased variety of organisational cultures has challenged the existing policies and procedures, in favour of creative practice-led adaptations of the IAPT model. However, this study did not assess the degree of flexibility in non-AQP IAPT implementations, and therefore it is not certain that the flexibility of the IAPT model found here is a consequence of AQP, rather than a consequence of other factors – such as local personalities, clinical values and being ‘*stubborn*’ (Emma). Nevertheless, the diversity, dynamism and problem solving evident in this study of those participants who succeeded in delivering and innovating in AQP (unlike those who dropped out in the Griffiths et al. study from 2013), might go some way to address the dampening of creativity from the rigid protocols in IAPT reported by Gilburt et al. (2014). The freedom found in AQP may thus promote the patient-centred flexibility recommended for IAPT by Hamilton et al. (2011). However, this responsivity is impacted by financial pressures within the AQP model, as discussed below.

Effects of PbR, low tariffs and competition on patient-centred care.

Low tariffs and the fact that the payment model is linked to outcomes in AQP, bring additional negative impacts on the quality of patient care, according to participants. Whilst intended to reward services for working hard to help clients to recover, PbR may create unintended perverse incentives such as gaming, suboptimal doses and cherry-picking. The priorities behind the ‘results’ that organisations are paid for may not therefore be driven primarily by quality, but instead by how easily or quickly that income can be earned. Although the use of PbR has been presented as inevitable and common sense in the FYFVMH, the ethics of PbR in mental health services is questioned (Wang, 2016). It is worth reflecting on the real-world effectiveness of PbR in the delivery of mental health services, bearing in mind recent – and not so recent – criticisms of the government’s insistence that PbR in probation services increases quality and effectiveness as an example (House of Commons Home Affairs Section, 2013; Napo, 2019): the reality behind the rhetoric is that PbR has not worked in this sector.

One potential negative consequence of PbR is a lack of honesty in presenting data – known as ‘gaming’ the data (Clark, 2017). It is specifically warned against in a previous IAPT manual (University of York, 2017, p.35) but interestingly, it is not mentioned in the current version (National Collaborating Centre for Mental Health, 2019). Some participants, such as Peter, believed that the pressures of AQP, to avoid looking bad compared to other providers or being penalised by NHS England, made dishonesty and gaming more likely in AQP. Whilst there was some perception from managers in this study of private providers being driven by profits, the main reason perceived to cause perverse incentives was survival, given that there are no profits to be made from AQP/IAPT according to some participants. Other participants commented that the profession was driven by clinical values, and this offered protection against fears about profit motives, along with the peer scrutiny between providers working within the system.

The issue of cherry-picking appeared as a disproportional burden on NHS providers because IAPT, in combination with AQP, does not offer spare resource or capacity to treat more complex patients who are less likely to recover in the maximum number of sessions. There are expectations (both from within and outside the NHS) that NHS providers will take on clients that may fall between the cracks between primary and secondary services, but these clients are less likely to bring in PbR for recovery and are more likely to stretch service resources. AQP in IAPT might encourage suboptimal doses because a client may be discharged early if clinical outcomes are in recovery with the assumption that they have received a full course of treatment – which might be only two sessions, including assessment (National Collaborating Centre for Mental Health, 2019, p.35). This incentive does not encourage the best quality or most effective patient-centred treatment.

Once again, it is not possible to say that perverse incentives are solely a consequence of AQP because this is an existing problem in non-AQP IAPT services due to a fear of punitive top-down scrutiny (Court et al., 2017). However, the effects of PbR in this study – as an experiment in the use of PbR as a zero-hour payment model in IAPT – are particularly relevant to the ongoing national rollout of PbR in IAPT, and its potential implementation. The very tight finances of AQP, in combination with PbR and competition, appears to have increased the ‘pressure to be able to perform effectiveness rather than actually be effective’ (Watts, 2016, p.94), simply in order to survive. In addition to the restrictions placed upon providers by IAPT’s one-size-fits-all model, AQP therefore represents a potential conflict between clinical values in patient-centred care, and organisational survival due to a PbR model in a competitive marketplace of providers.

Watson and Bohart explore the possibilities for person-centred values in the context of managed care, and claim that therapy can be ‘“humanized”’ by a creative collaboration between clients and clinicians that ‘creates the life and meaning in procedures’ in managed care settings (2015, p.596). However, a more recent study – which might be representative of more contemporary contexts – identifies ‘Crossing discourses’ of non-IAPT and IAPT discourses, for non-IAPT therapists working within IAPT services, that change the focus of the therapeutic relationship towards the organisational ‘top-down’ requirements (Altson et al., 2015, p.7) rather than creating a creative space for therapeutic collaboration. The focus on productivity to increase revenue in cash-strapped AQP/IAPT services introduces yet more crossing discourses that change the focus away from client-centred values.

The IAPT therapist is increasingly being reduced to ‘a cog in an industrialised process’ according to Clarke (cited by Marzouk, 2019). In AQP, additional institutional discourses of PbR, choice and competition might decrease the logic of care, and increase the perception of the ‘disembodied therapist’ already identified in IAPT. On the other hand, the increased reliance on clinical values to deliver more pragmatic local definitions of quality, might increase the logic of care.

Some of the criticisms of AQP/IAPT (Dalal, 2018a; Griffiths et al., 2013) do not appear to take into account the ‘culture of therapists’ evident in AQP services, that might protect PCPT from the negative effects of top-down directives and marketisation on the logic of care. Despite this dedication to person-centred principles, we have seen how the commitment of commissioners, managers and therapists to the micro service level is in constant negotiation with a wider range of factors. The next section therefore goes on to discuss the impacts of policy on the meso level operational context.

4.2.2. Effects of the policy on operational practices (the meso service context)

The policy changes in AQP that impact meso level operational issues are relevant beyond AQP because IAPT services will increasingly need to operate in a context of austerity, using PbR payment models, and meet existing governance requirements in the NHS. This section looks beyond the micro level therapeutic relationship to further examine the extent of ‘disembodiment’ of PCPT service operations in AQP/IAPT.

Focusing the threat to person-centred care onto the therapeutic encounter is problematic, because it may act to mask the top-down policy drivers of these challenges. Rather than focusing the disembodiment onto the therapist, the struggle for therapists and providers operating in AQP/IAPT might better be described as ‘Disembodied Professionalism’ (Hirvonen, 2014). Hirvonen found that care professionals undergoing organisational change adopted a new type of professional identity to rationalise the conflicts of working within a culture of ‘medico-managerial management’ (2014). Although this study was outside the UK, it addressed the same NPM principles of managing healthcare that are widely prevalent and present in AQP/IAPT. It might be a leap too far to describe the IAPT model itself – with its focus on targets and standardisation – as disembodied; however, the continuing pressures from current policy discussed earlier raise the important question of how to re-embody the logic of care. Like Owens and Mol (just owens in bibliography) (2015; 2008), Hirvonen suggests that an alternative focus on ‘the embodied, situational and social nature of care practices’ can support workers to manage the conflicts (2014, p.577).

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Despite conflicting discourses and top-down restrictions, participants suggest that therapy in AQP can be ‘humanized’ – to use Watson and Bohart’s terminology (2015, p.596) – by using clinical values, a logic of care, and practice-based evidence. However, the ability for therapists to stay human and maintain relational depth is impacted by stress on staff and the stability of the workforce – which was a strong concern for some participants. Other operational challenges came from top-down directives, although some interviewees (for example, commissioners Peter and Sophie) felt supported by NHS England. Many participants also reported service opportunities from choice and competition in AQP.

Effects of PbR, governance standards and top-down pressures on the workforce: managing the elephants in the room.

Sustainable staffing is a key concern since the core service involves delivering quality patient-centred therapies. However, managers and commissioners were aware that the measurement and audit focus of AQP/IAPT created stresses for staff. This may be in addition to the existing morale issues in IAPT reported by Rao et al. (2016) from targets, burnout, increasing complexity of cases, and lack of time to deliver good therapy. Due to the very nature of the work, many front line mental health staff are at ‘risk of being flooded by intense and unmanageable anxiety’ (Bowden et al., 2015, p.490). These real-world pressures on staff are discussed at length in the online publication *Surviving Work: A survival guide* by Cotton (2016).

However, many participants also reported opportunities from choice and competition in AQP – such as the bargaining power and autonomy of staff moving between providers. This might bring opportunities for ‘flexible working’ as required by the FYFV. However, the instability of the financial modelling of AQP may not enable ‘“de-risking” service change’ (NHS England, 2017b, p.58) and promote this flexible working, and – more importantly – provide the psychological safety for its workforce (Newman et al., 2017).

Perceptions of staff working conditions in this study varied – which perhaps also reflects the variation in employment practices, with some providers offering both permanent contracts and self employment or bank working: commissioner Mark felt that a ‘*zero-hour mentality*’ was unethical in the NHS and Liz valued the ‘socialist’ approach to looking after staff in the NHS; whereas Abdul and commissioner Priya felt that some therapists preferred a more self-employed way of working. Despite their best efforts, the stresses of organisational survival in AQP may also mean that manager’s stress reaches staff: the ‘*contagion’* of anxiety that Trisha describes. If this happens, there are risks not only to organisational survival but also to the clinical quality of the service.

Stability in the workforce is important because a high turnover rate is often associated with poorer quality of care (NHS England, 2017b). With the IAPT model being used as a base to expand in areas such as Long Term Conditions and Serious Mental Illness, and the further rollout of PbR, it is important that the complexities of workforce wellbeing are better understood to ensure sustainable staffing. The IAPT Workforce census – which is intended to inform changes in the IAPT workforce to meet future demand – identifies a high rate of movement in IAPT trained staff, but has little data about the net impact of staffing capacity as a result (NHS England & Health Education England, 2016, p.15). *The mental health workforce plan* similarly sets out the need to increase the numbers of staff to meet the increased demand (NHS England, 2017b). However, both documents are based on provider reports, and detailed information for non-NHS providers is lacking (NHS England & Health Education England, 2016, p.6; p.13 & p.27) – especially statistics relating to 'any willing provider' (Addicott et al., 2015). Therefore, it is difficult to accurately assess how stress or workplace pressures might be impacting the stability of the workforce in AQP/IAPT, and to what degree any perceived advantages for staff outweigh the stresses evidenced in this study.

The FYFVMH (Mental Health Taskforce, 2016), acknowledges the problems of staff wellbeing identified in *NSP/BPS Staff Wellbeing Charter* (The New Savoy Partnership, 2015), as well as the need for clarity and support for commissioners. Alongside sustainable staffing levels, the FYFVMH implementation document recognises the importance of 'improving wellbeing, morale, retention and career development of the people who deliver services to improve stability' in IAPT services (NHS England, 2016, p.17). However, there is an absence of strategies to sustainably address these issues or any specific interventions to reduce this stress beyond as health checks, stress management and mindfulness.

The mental health workforce plan says that, as an employer, the NHS 'should be an exemplar in creating a mentally healthy workplace: reducing stress and improving wellbeing' (NHS England, 2017b, p.23), and NHS Employers (2018) offer advice for NHS organisations to strengthen and support their workforce, via the NHS Health and Wellbeing Framework (NHS Employers, 2019). However, whilst governance processes appear to be rigorously adopted by NHS England (although, this remains arguable), the rigorous application of wellbeing directives for IAPT staff on non-NHS employment contracts working for the increasing range of non-NHS providers, is lacking. Repeated attempts by myself to clarify this issue with NHS Employers were met with either no reply, or a standardised reply stating that there is no obligation for NHS Employers to respond to anyone other than 'employers and HR professionals in the NHS in England' (personal email communication). Despite clinical and ethical values being applied to staff wellbeing by participants in the current study – as Trisha says: '*there is no point us going out delivering wellbeing...if we don't do it ourselves'* – there was some perception of other AQP providers not offering appropriate support or training for staff, as a cost cutting exercise.

The workforce plan recognises that retaining staff may be more complex than simply helping staff manage stress:

> *...so local providers and commissioners will need to understand the different variables at play, and take targeted action to ensure they have enough staff with the right skills in the right place when those who access mental health services need them* (NHS England, 2017b, p.19).

What this 'targeted action' might look like, and how the identified staffing problems can properly be addressed, is not specified however. *The King's Fund* examines workforce pressures within 'a system of care' for mental health, and suggests that organisational issues, such as service transformation, have consequential impacts on staffing levels and morale (Gilburt, 2015, p.3). It is evident that the policy context that impacts these issues can become disconnected from the logic of care in PCPT and become normalised in the practices and discourses of IAPT (Peacock-Brennan, 2016) to a point where clinicians become 'government agents' (Guilfoyle, 2019, p.117). In AQP, where commissioners are more closely involved with providers as they spin the plates (as Paul describes) and exert local autonomy to measure standards, there is an increased awareness of the importance of the therapist as a relational being, delivering relational therapy: as Mark highlighted, when he said '*we are not buying widgets'*. The more complex and demanding the service, the more staff need operational support to manage and reduce stress. The quality of supportive relationships within this system in PCPT is therefore important to counteract the problems of the 'disembodied' and 'portable' therapist in IAPT, outlined in the introduction. The increased diversity and scrutiny within the AQP system may mean that the operational problems in delivery and their impacts on service quality are more exposed – but importantly, also shared – and therefore, less easy to disconnect from the logic of care.

More generally, these pressures on IAPT services – whether AQP or not – will increasingly mount as new targets are set and funding cut, and as more changes are imposed on already struggling services.

As well as stress on staff, it must not be forgotten that the tight financial margins and pressures from NHS England targets also caused stresses for most managers and commissioners in this study (for example: exhaustion for Peter; having *'kittens from the stress'* for Liz; and needing to '*bang your head on their desk'* for Priya). Some participants spoke of the importance of relationships with colleagues as a response to this stress. As much as staff wellbeing is important to humanise the therapy relationship, it is also important to recognise the humanness of leaders. Ghin highlights the 'idealization of leader corporeality' (2018, p.94) that tends to disavow the human limitations of leaders, and suggests that the presupposition of wellness in leaders marginalises the existence of inherent illness experiences in the healthcare system (which includes the possibility of patients not recovering, and staff not coping with job pressures).

Thus, the elephants in the room for Rachael may represent the government's denial of the pressure of meeting targets whilst trying to take care of staff. The disavowal of the impossible traps of IAPT (Rizq, 2012b) and AQP, and the recruitment of therapy into a neoliberal pursuit of happiness and individuality (Layard, 2005; Pilgrim, 2008; Verhaeghe & Hedley-Prôle, 2014) are examples of political logics creating the professional discourses that then become normalised into care practices (Glynos et al., 2015). This is seen by Timmins as a cynical and strategic move by government (2017b). Speed and Gabe (2013) argue that the resulting ‘new professionalism’ weakens public trust in healthcare professionals, and distances the government from their responsibility for healthcare.

The impact of these political logics – what Turner et al. term ‘incursions of public policy’ (2015, p.612) – on provider identity, and whether or not they are seen as ethical and acceptable, depends on the perspectives of the stakeholders, and on their experience and confidence in adapting to new policy directives. It is interesting to note that of the ten providers in the study by Griffiths et al. (2013), just four went on to deliver under AQP and found the landscape of AQP fraught with challenges arising from the complex effects of the policy. The perspectives offered in the Griffiths et al. study of the engagement with the AQP policy may differ therefore with the current study, where participants had been delivering for some time. Here, we find a more nuanced picture, where some had changed their mindset and professional roles, and some were building on previous experience of more competitive ways of commissioning. In contrast to Hanley et al. (2017, p..176) who found a theme of ‘caring clinicians and uncaring managers’ relating to managers who enact the top-down rules of performance management (that might also equate to Hirvonen’s ‘medico-management’ and ‘disembodied professionalism’, 2014) – the current study evidenced a logic of care in manager’s sense of their role. The current study did not interview staff however, so it cannot directly comment upon the perceptions or experiences of staff. Nevertheless, there is much evidence that managers and commissioners were genuinely concerned about: clients; staff wellbeing; maintaining good working relationships in implementing top-down directives; and acknowledging the elephants in the room. This certainly speaks of managers being connected to the needs and challenges for staff, and does not demonstrate a dominant narrative of disembodied professionalism – perhaps because the relationships found in the local AQP/IAPT system enable 'the embodied, situational and social nature of care practices' that Hirvonen advocates (2014, p.577).

Effects of choice and competition: avoiding the alligators.

The tight tariffs were seen to reduce quality. However, driven by survival and by logics of care (the ethical commitment to provide equity and access via IAPT), most managers have changed their sense of professionalism by managing services in a more business-like way, becoming flexible and '*lean*' to manage the low tariffs (Nick). Not to adapt to this new '*operational mindset'* (Abdul), would have meant being unable to fulfil their clinical values of providing quality and ethical care. Quicke (2000, p.299) suggests that this changing sense of professionalism is a product of 'new times' that imbue the managerial persona with a sense of agency, dynamism and purpose, but in reality hides the coercion of top-down 'disciplinary' powers that make ethical and collaborative management impossible. This somewhat echoes Lees' suggestion of the fantasy of IAPT's neat outward image (2016). For instance, NHS trusts are expected to adapt to quasi-market conditions; however, they are seen in this study as failing to modernise and being resistant to competition with non-NHS organisations, and needing a '*kick up the bum'* (Mark). There is little acknowledgement of the complexity of resolving the burden of NHS bureaucracy, which at the same time proffers the 'socialist' values (Liz) and stability that makes it an ethical employer, and also enables NHS providers to address the problem of cherry-picking for example.

Despite the business adaptations by participants, the extremely tight margins in the competitive market place of AQP negatively impact the quality of therapy in several ways. Trisha's alligator analogy described how survival concerns can override the focus on quality patient-centred care. This was echoed by an interviewee in the study by Griffiths et al., explaining: 'we were forced to cut the service spec "cloth" to meet the tariff' (2013, p.23). Although the government claimed that competition in AQP would be based on quality rather than price, the required governance standards as defined by NHS and IAPT are very costly to deliver; Griffiths et al. (2013) suggested that risk-averse providers would not be able to deliver therapy under AQP due to low tariffs. Therefore, high quality provision may be potentially lost due to the instability created by the inadequately funded competitive model of AQP (Jones & Mays, 2013) and being in the '*too tricky box'* (Paul). Once again, there is a contradiction between the need for stability – seen by some participants to be provided by the backup and governance of NHS trusts – and the need for efficiency, which is easier for smaller, leaner organisations, but who may not have the resources for adequate service provision. This tension exists beyond AQP in a climate of austerity where providers are expected to compete for contracts, but also expected to ensure sustainable, quality and effective services.

Where participants did decide to implement via AQP, they made pragmatic compromises to manage the elephants and alligators – the ethical and practical conflicts – of the micro (clinical) and meso (operational) levels of operations. Chorpita and Daleiden (2018) highlight that the ability to know what *not* to implement impacts the effectiveness of the service. This allows stakeholders across all parts of the system to have a dynamic responsibility. So, in contrast to the top-down paternalistic assumption that choice is right for the client, an acknowledgement of the limits to service quality as a result of choice, reflects Mol’s idea of being honest about the inherent imperfection of care services – whilst also offering care and responsiveness to clients (2008). Perhaps then, the promotion of congruent relational depth – rather than fidelity to the model or protocol – is ‘good enough’ for quality care (perhaps reminiscent of Winnicott’s good enough parent?), and might be more cost-effective to deliver. Kendall and Frank’s notion of ‘flexibility within fidelity’ (2018) and trusting the clinical judgment of the experts to do their job (Paul), might return to a truer meaning of EBPP as ‘good clinical decision-making’ (Henton, 2012, p.13) and allow the quality to come from clinicians in a local system – not from rigid policy ideals that dictate how choice should be delivered.

These local adaptations are reminiscent of Lipsky's street level bureaucracy (1980), where front line staff are not seen as passive recipients of top-down policy, but instead respond to conflicts and challenges to their professional and ethical values in delivering care by pragmatic adjustments on the ground. Reay and Hinings (2009, p.632) suggest that individuals operating ‘“under the radar”’ can change top-down discourses, even though Mark believes that the NHS will never change from the bottom-up. The findings from this study suggest that street level bureaucracy in AQP – buoyed by the culture of autonomy with multiple competing providers – challenges IAPT’s one-size-fits-all definitions of quality and may offer flexibility for providers and commissioners, whilst also retains person-centred quality. Some perverse incentives might therefore be seen as ways that stakeholders might ‘beat the system’ in order to continue to deliver diverse person-centred care within limited resource.

Despite evidence here of the power of clinical leaders to adapt to operational pressures, how they address the wider drivers of limited resourcing and the pressures on operational viability beyond their own organisation is the topic of the next section.

4.2.3. Effects of the policy on partnership working (the macro service context)

AQP increases the diversity of providers. However, they are working as part of a single IAPT provision in their local area. This section discusses how AQP impacts the joint working between providers in this politically laden service context. This is relevant beyond AQP because IAPT services will increasingly be delivered within the integration agenda of the new landscape of STPs.

Effects of governance standards and top-down power dynamics on partnership working: AQP as a plurality of governances.

Thus far, the discussion has shown how participants have tried to preserve their core professional ethics about caring for the client, whilst adapting to a market ideology and managing top-down governance requirements. Skelcher and Smith (2015) suggest that, non-profit organisations have transformed themselves in order to deliver services as a result of NPM principles, and describe this as a process of ‘hybridization’ – which lies between the opposing governance structures of ‘markets’ (diversity) and ‘hierarchy’ (consistency). We might therefore see the adaptations to competition seen by the participants in this study as the development of professional discourses relating to markets (what Sophie calls the ‘*mixed economy’*) and the adaptations to top-down power and governance requirements as those discourses relating to hierarchy. We have already seen how participants negotiate these discourses, guided by their sense of professionalism and ethics, in order to deliver effective services. However, because commissioners and providers are also working as a single joint IAPT service, the findings demonstrate interactions between each participant’s own negotiated quality standards (hybridised, individual governances), within a single, top-down system of governance (NHS/IAPT), which is also designed for safe and effective treatments for patients.

Clearly, there are significant differences between how managers and commissioners relate to these two categories of governance structures (markets and hierarchy) identified by Skelcher and Smith (2015): managers will be more impacted by markets for organisational survival, but commissioners – as officers of the NHS, in Paul's words – might be more impacted by hierarchy and top-down mandates. Whilst both sets of participants demonstrated discourses relating to each of these structures, they *both* have – to some extent – become hybrids in their operational mindsets between different sets of discourses relating to the challenges of AQP (delivering quality though choice).

However, there is also a sense in which this local AQP/IAPT system becomes a hybrid – moving away from a block contract model, where one preferred provider is commississioned to match the service specification as described in the tender (whether this translates into practice, or not); this system then reinforces the existing norms and governance (hierarchy). Priya points out that even with other non-AQP commissioning models, a lead provider can be commissioned to accommodate a hybridity of the system – such as a framework agreement within a block contract where the lead provider is contracted to recruit multiple local partners. With AQP however, the power is more evenly distributed because each provider has been authorised as equally qualified providers by the top-down hierarchy; the variety of approaches mean that there are multiple norms, and multiple interpretations of quality care – a ***plurality of governances*** – such as the use of the IAPT database by Nick and Abdul to challenge the norms of NICE. Therefore, we see in the current study, non-NHS organisations who deliver as part of an IAPT system within a pre existing set of norms, are like cats who have herded together (Mark) and changed the direction of IAPT's norms. The interaction of contrasting policy directives in AQP/IAPT has offered more flexibility than standard IAPT services, and therefore increased local autonomy to some extent, in relation to hierarchical governance systems. This somewhat contradicts Mark's belief that the NHS cannot change from the bottom up but echoes findings by Osipovič et al. (2016) that a certain stability in the hybrid system can be offered by these local adaptations to the regulative and normative top-down rules.

As well as the use of pragmatism and trust in clinical judgement by commissioners to make local adaptations, every provider is benchmarking themselves against each other to demonstrate their clinical effectiveness, as Abdul noted. In this case, it is less the competition element that creates improvement, but the plurality of governances, that creates a practice-based, clinically-driven, local definition of quality. Using overall service effectiveness as the aim of the whole IAPT system, commissioners are mindful of monitoring performance and getting the best value for money – but also understanding the need for organisational stability and sustainability in achieving service effectiveness. This challenges the top-down political logics being imposed by AQP/IAPT and does not demonstrate disembodied professionalism. Peer scrutiny is also a resource of the hybrid IAPT system, to monitor and ensure clinical effectiveness because there would be '*disdain*' for providers who were putting profits before clinical values (Rachael). Commissioners become crucial mediators – although they might be experienced as punitive scrutineers by some – to ensure that profits or money-savings do not become a key motivator, even though some participants such as Trisha and Peter believed that profit motives were a danger.

The hybrid IAPT system – and its plurality of governances – could therefore be seen as a backup local governance strategy, existing in addition to the clinical values and the logic of care embedded in the therapy profession. This might reduce the need for top-down, one-size-fits-all IAPT/NICE governance as the dominant hierarchical marker of quality. Models that are based on EBPP, such as IAPT, are seen by Leichsenring et al. to reduce choice and the integration of therapy cultures because 'plurality is the future of psychotherapy, not a CBT-centered "one fits all" monoculture' (2018, p.5; see also Marziller & Hall, 2009). The local autonomy of AQP/IAPT might reduce the stress in the system on staff from top-down medico-management discourses, and facilitate the kind of clinician and client-led, integrated vision of PCPT proposed by Foster and Murphy in 2005. The joint IAPT system in AQP/IAPT offers a plurality of governances – rather than providers as cogs in a market-driven wheel – that enable clinical leaders to develop local definitions of quality. The evidence from this study points to the willingness and respect between providers – who are guided by different sets of discourses and governances, some of which are created by the hybrid system itself – to work together with the patient's needs in mind.

Effects of choice, PbR and competition on partnership working.

As the findings demonstrate however, there is a thin line between diversity that improves quality – '*herding such a lovely diverse bunch of cats'* as Mark puts it – and fragmentation, that reduces it. Whilst the pragmatism and flex in the local system eases some of the pressures of top-down governance, at the same time, participants identified challenges from fragmentation. Competition was cited as the main cause of mistrust and the perceived silo mentality reduced ease of joint working and communications. The threat of survival, together with the reluctance of rival providers to share knowledge (Westra et al., 2017), means that innovation for patients can be limited in competitive healthcare markets. Reay and Hinings (2009) describe this as ‘Competing Institutional Logics’, which might be part of the crossing professional discourses (Altson et al., 2015, p.7) identified earlier.

Reay and Hinings propose that organisational change can create a ‘hybrid version of two previous logics’ (2009, p.632) which can help actors to resolve such professional conflicts. In this study, whilst the plurality of governances helps to address conflicts with top-down pressure that are shared by participants, we also find that participants find strategies to address the problems of governance differences between providers (the problems of fragmentation). There is some evidence that the shared superordinate goals of survival (Gaertner et al., 2000; Sherif, 1958) occur in AQP/IAPT, and might reduce participant’s perceptions of difference between them (between providers, and between providers and commissioners). The shared ‘*camaraderie*’ (Liz) and relational support between clinical leaders, acknowledges the stress and pressure of the messy complexity of AQP – rather than the institutional denial that Ghin observes (2018). Perhaps the relational skills of therapists helps to better manage intrapersonal, interpersonal and interorganisational discord – such as the experience of ‘*warfare*’ (Liz) arising from competition in AQP/IAPT, compared to other types of services (Bovey & Hede, 2001). In the IAPT system, there is also a shared identity of clinical values and respect for rivals – the ‘*culture of therapists’* (Rachael) that offers a sense of collaboration and trust.

The ‘*mucking in together*’ (Liz) and collaborative working between competitive partners in healthcare has been described as ‘coopetition’ by Westra et al. (2017) – although it is acknowledged that the concept is poorly understood (Bouncken et al., 2015). Westra et al. (2017) suggest that competition between providers benefits clients through innovation and dynamism, as Rachael said: bringing *‘something new to the mix’*. However, it works best when providers are not in direct competition with each other (i.e. in different geographical locations); in the absence of competition, cooperation between providers usually reinforces existing practices, and inhibits change. This might explain the perception of resistance to change in the NHS, because the financial back up for the NHS providers may reduce receptivity to new ideas because there is less survival imperative to drive change – although in this study the NHS providers appeared to welcome new innovations. However, the direct competition for clients (and income) resulted in a lack of sharing, and the perception of a non-level playing field by some – although collaboration was reported by Rachael where a rival provider was unable to meet waiting list targets. Whilst there is considerable evidence of providers and commissioners learning and sharing strategies amongst themselves, the analysis of Westra et al. (2017) would suggest that, whilst there are benefits for patients from competition as we have seen in this study, the directly competitive element of AQP impedes the best innovations and joint governance for clients. Learning for IAPT in the context of partnership working in STPs might then indicate that adequate resourcing *and* individuation for providers would enhance the sense of trust and promote the sharing of innovations within the system.

Both commissioners and providers can be seen to hold a certain degree of autonomy as street level bureaucrats who have some power to shift the institutional norms (Osipovič et al., 2016) of IAPT, and top-down governance structures. This study has shown that commissioners and providers – as clinical leaders – share similar ethical and clinical values in their concern for patient-centred care and staff wellbeing, and generally identify as being under the '*same gun'* (Rachel) of top-down directives (NHS, IAPT and government). However, commissioners and providers are differentially impacted by the policy layers of AQP: commissioners might have a role as enforcers of rigid top-down governance directives, and managers are most concerned with their role to ensure organisational survival in a context of tight finances. This study did not find the same negativity of provider's views of commissioners as Griffiths et al. (2013), although the study did not specifically set out to investigate this topic; negativity may exist if investigated further. The difference may perhaps be due to the early stage of AQP and the limited number of participants who proceeded with AQP in the study by Griffiths et al. (2013). The current study's exploration of the pragmatic and practical experiences of the commissioner-provider relationship in the ongoing implementation of joint provision in AQP/IAPT, offers useful insight into the possibilities for the coopetition of multiple providers in future PCPT systems.

The ethical conflicts for commissioners of enforcing top-down policies and being part of the system where pressure is experienced was met with pragmatism and determination, and was guided by a personal sense of care for patients and colleagues. Mark recognised the need to protect providers from the pressures from NHS England, and Emma used stubbornness to challenge the top-down governance. Osipovič et al. found a similar 'cooperative service development mode' amongst commissioners and providers who were trying to survive individually whilst maintaining effective service provision in the face of competitive policies (2016, p.835). According to Osipovič et al., commissioners see AQP as a coercive and inflexible policy, but they also recognise the fluid nature of the policy landscape (2016). Osipovič et al. found similar problems with power gradients and mistrust as reported by Trisha and Peter in the current research, and similar perceptions that cooperative ways of working are better than rigid top-down rules. However, they also reported perceptions that clear top-down guidance promotes effectiveness in the local system because providers are more likely to trust commissioners who are transparent about enacting their responsibility to enforce top-down policies, rather than hopes or confusion from mixed messages. The current study did not fully align with the findings of Osipovič et al. (2016) because there was less appreciation in the current study for top-down guidance, and more preference for flexibility within AQP. This difference may be partly due to the nature of practices and sense of autonomy present in the PCPT services studied here, in contrast to the acute and community mental health services studied in the study by Osipovič et al. (2016).

It is perhaps more the top-down power gradients concerning NPM policy effects, such as management and measurement, rather than AQP itself, which become burdensome in the implementation of AQP/IAPT. Hood et al. (2000) make an interesting point that the government's rhetoric about accountability and choice does not apply to choice for providers of who regulates them (e.g. NHS Improvement). The lack of commitment to clinician's voices and autonomy in decision-making processes is also perhaps evident in the terminology used in the FYFVMH and implementation plan regarding co-production. The omission of clinicians in the implementation plan following the FYFVMH's call for co-production of services with key stakeholders reinforces the top-down power gradient. The dissemination of clinical values in these documents is therefore subtly, but significantly, eroded through – what I identify here as – ***political practices***, which become normalised to the point where clinicians do not see possibility for change (Peacock-Brennan, 2016). This marginalisation of the clinician's voice in policy will be addressed in the following sections.

The above discussion revealing the multiple and wide-ranging effects of the different policy strands of AQP/IAPT on patient-centred care, highlights the importance of making conscious those practices that are focused on real-world service effectiveness. We have seen that the clinical leaders interviewed in this study found a middle ground to challenge the normalised political practices, that may otherwise impede quality patient-centred care. A Counselling Psychology informed lens to make more conscious the processes and skills that can be used to address the splitting of ethical actions is therefore explored below.

4.3. Implications for Counselling Psychology: a new policy discourse?

Mackenbach (2009), drawing on Virchow, suggests that clinicians can position themselves on a '"ladder of political activism"' to address the impacts of politics on public health. Bond (2018, p.181) suggests that policy makers also need to engage with clinical leaders, to ensure adequate funding, to offer accountability and consider the real-world contexts of policy dissemination and implementation – rather than maintain an idealised version of policy effects. An idealised implementation of policy that is disconnected from the logic of care, is perhaps why IAPT has been subject to criticisms of idealisation and fantasy, and generated resentment from those trying to implement the IAPT model – and why the implementation of AQP/IAPT has been challenging.

However, as discussed in the introduction, engaging with policy makers and taking socio-political action to address the challenges of service implementation in this policy context is not easy. This section is therefore intended to initiate a discourse that might give form to the 'ladder' of socio-political action for clinicians, with a Counselling Psychology insight into the real-world challenges identified in the previous sections. In other words, and to reiterate my core argument: an expanded skill set relating to the implementation of policy is a social justice concern for Counselling Psychology, because it can maximise the effectiveness of services (and therefore best serve clients and therapists).

At the beginning of the discussion, Foster and Murphy suggested that: 'One of the most interesting and delicate tensions around working as a counselling therapist in the NHS is that between fitting in, being useful and being different' (2005, p.4). This section looks at how CoPs – as clinical leaders (but not necessarily working in a managerial or commissioner role) – might contribute to the development of new models of care by fitting in, being useful and being different. This involves reflecting on: the CoP skills that are already well suited to the new models of care evolving in the NHS; how CoP skills might address some of the problems identified in this study; and how CoP might be able to challenge existing practices. It might also need to challenge its own practices in order to survive in the jungle along with the cats, elephants and alligators; as Willig suggests: '"practice" is not about putting something we know into practice, but about creating something new' (1999, p.40). This involves engaging with the policy narratives outlined throughout this study, to contribute to a discourse on socio-political action that is currently underdeveloped in CoP.

4.3.1. Socio-political action at the micro level

Embodied intersubjectivity in Primary Care Psychological Therapy services.

> *Counselling psychology holds a humanistic value base that goes beyond the traditional understanding of human nature and development as passive and linear and views human beings and their experience as inherently dynamic, embodied, and relational in nature* (BPS, 2018b, p.5).

The disembodied professionalism evident in IAPT, and exacerbated in AQP by the logic of choice, might be addressed by the relational values embedded in the ethos of Counselling Psychology – similar to what Rizq calls: 'the emotional contract between patient and therapist' (2012, p.21). This forms the core of CoP training, described by the BPS as 'the pivotal role of intersubjective experience and collaborative formulation…emphasising the joint creation of meaning within the therapeutic alliance' (BPS, 2017, p.4). One of the CoP competences listed by the BPS is to: 'be able to critically evaluate the primary philosophical paradigms that inform psychological theory and the understanding of the subjectivity and intersubjectivity of human experience' (BPS, 2018b, p.32) – also appearing almost identically in the HCPC standards of proficiency for Counselling Psychologists (2015, p.15). This then raises a question about what intersubjectivity means in CoP. Furthermore, how this can relate to a discourse that might challenge a landscape of service delivery that increasingly favours the logic of choice, and one which is is still impacted by NPM principles?

The concept of intersubjectivity varies across disciplines. Coelho and Figueiredo (2003) propose four 'Intersubjective Matrices' that represent different dimensions of how otherness is experienced in therapy relationships. Gillespie and Cornish (2010) extend the concept of intersubjectivity beyond one-to-one relationships to intra-group and inter-group relationships, and propose a ‘dialogical method of analysis’ to conceptualise how an individual’s sense of self interacts with the individual and group identities of others. This widens the idea of intersubjectivity beyond the therapeutic encounter and can perhaps elucidate, for example, the notion of disembodied professionalism. Thus, the complex intersections of discourses (within the nexus of practice) that create the subjectivities and intersubjectivities of – and between – clients, therapists, managers, commissioners and beyond, can impact the quality of the intersubjectivity of therapeutic relationships at the core of a PCPT service.

In order to address disembodied professionalism, the CoP notion of intersubjectivity might need to expand to consider how policy impacts the therapeutic relationship. This may better enable the types of ‘embodied care practices’ (Hirvonen, 2014, p.585) that might enact the logic of care in PCPT and see clients choosing treatments as ‘embodied selves’ (Gabe et al., 2015). We certainly see a range of efforts by participants in this study to challenge disembodied professionalism; such as relational support, street level bureaucracy, and focus on clinical values. Gallagher and Payne argue that clinical reasoning in therapy (as with other clinical settings) requires ‘an ongoing embodied, embedded and intersubjective process embodiment’ (2015, p.68) which enables an interactive ‘“participatory sense making”’ (De Jaegher & Di Paolo, cited by Gallagher & Payne, 2015, p.72). Used consciously then, this approach may make more explicit the impacts of policy on therapy process and outcomes, and could be applied to contexts beyond one-to-one intersubjectivity (Gillespie & Cornish, 2010); for instance the benefits of relational support between participants and the humanising of therapy may filter through the system to the micro level, just as the *‘contagion’* of the anxiety is feared by Trisha to impact therapist’s wellbeing. Furthermore, for CoP to contribute usefully towards genuinely person-centred service design and to challenge unhelpful discourses, it is important to understand how these embodied relationships and identities develop and are communicated in language, as explored, for example, by Zlatev et al. (2016).

Embodiment is conceived of here as ‘phenomenological and ecological’ (Fuchs & Schlimme, 2009, p.570), following Merleau-Ponty’s concept of lived experience (1962). Embodiment is also seen to promote an ‘embodied enactive’ understanding of human agents in a complex and dynamic environment (Salvatore et al., 2015, p.2). This view considers people as agents who are connected through feelings, thinking, needs and intentions; it aligns with the notion of actors and practices within complex responsive systems, as set out in the introduction.

An embodied, intersubjective reading of the logic of care involves ‘caring for insiderness’ (Todres et al., 2014), where the relationship with another’s inner experience requires a truly person-centred sensibility. However, this may become lost in a monitored, cash-strapped, one-size-fits-all AQP/IAPT service that causes stress for staff. Todres et al. go on to describe insiderness as the: ‘“soft underbelly” that often lies hidden in the shadows. It is both the place that hides our vulnerabilities and therefore often the place that is neglected in our discourses’ (2014, p.9), echoing Rizq’s suggestion of disavowal and perversion of care in IAPT (2012a; 2012b; 2014). The added fantasy – or ‘perversion’ – of the logic of choice in AQP and other policy pressures, challenges CoP’s ability to stay connected to their own vulnerabilities, and that of clients and colleagues not only at the micro level, but also the meso and macro levels in the system of care. An awareness of embodied intersubjectivity is a socio-political action that can help identify the nature of the splitting of ethical actions and its impact upon therapy, to help foreground the importance of authentic person-centred practice. However, mounting external pressures make caring for insiderness harder, and reduce protection from the crowding out of clinical trust. The protection of these clinical values beyond the micro level is explored further below.

4.3.2. Socio-political action at the meso level

New professionalism and embodied organisations in PCPT.

In response to the increasing external pressures, a contrasting conception of ‘outsideness’ might perhaps offer critical distance and a grounding response that allows space to resolve some of the conflicts from the splitting of ethical actions (Pollard, 2011). When participants rely on each other for moral support to manage the ‘*nonsense*’ of top-down directives (Liz and Trisha), they are perhaps distancing themselves from the pressures, rather than ‘splitting off’ as Hanley et al. suggest (2017). Pollard uses Bakhtin's ideas around the ethics of intersubjectivity and interdependency in relation to the professional boundaries and responsibilities of the therapy professions (2011). It might be true to say that the clear delineation of IAPT as a therapy service already distances and disembodies the therapist; however, Pollard describes therapists’ ability to adapt to changing conditions and their strong internal compasses towards managing conflicts as: ‘powerful centrefugal [*sic*] forces...tending towards diversity and plurality of theory and practice’ (2011, p.5). This may explain some of the differences in the impact of AQP in IAPT compared to other AQP services, such as the use of street level bureaucracy to ameliorate ethical and practical conflicts with top-down governance.

Pollard cites Emerson in the suggestion of reaching outward to make meaning from challenge: '"*how do I get outside of my life – with its pain, indignity, missed opportunity, crimped perspective – so as to shape it into something I can live with, that is, shape it as I might shape an artistic creation?"'* (2011, p.10). With the ability to connect with protective discourses and with each other, participants held their ground to increase agency for themselves and for their clients, rather than feel like helpless victims of external change ('a cog in an industrialised process', Clarke, cited by Marzouk, 2019) and pressure from policy 'incursions' (Turner at al., 2015, p.612). Pollard describes this skillset as 'embodied dialogical subjectivity' (2011, p.7). The ability to find meaning within discord fits with the identification of a 'maverick/outsider repertoire' in Counselling Psychology, building on 'an exciting heritage consisting of independent free-thinkers' (Moore & Rae, 2009, p.384), and with the requirements for professional artistry required by the BPS (2018b, p.36). In this way, CoPs might use their embodied intersubjectivity to connect with their own and other's needs, but also be open to new solutions by connecting creatively with the different professional discourses of colleagues and policy makers. This will be increasingly important with mounting financial pressures, partnership working and changing top-down ideologies.

The importance of the embodied enactment of social justice is highlighted by Tapson (2016). In contrast to Speed and Gabe's pessimistic view of 'new professionalism' (2013), Tapson explores 'new professionalism' as part of a necessary balancing of different mythologies and narratives held by the range of stakeholders in the system – be they partnership organisations/providers, commissioners or indeed policy makers. The business mindset referred to by many participants is a necessity in delivering cost-effectiveness, and is part of their ethical commitment to accessible, quality therapy. New professionalism also involves negotiating power dynamics within the system and, as this study has shown, power can be claimed in different ways: for instance, local autonomy as an example of street level bureaucracy.

As changes in the management of the NHS break down barriers between commissioners and providers – or perhaps even reverse the purchaser-provider split that introduced NPM principles to healthcare, as Brennan suggests (2019) – new professionalism may offer opportunities for socio-political action at the meso level. Currently it seems that STPs are working without legislation, but it seems that the competition aspect of the HSCA 2012 policy reforms is being re-evaluated – which *may* give local leaders more autonomy. However, whilst this top-down control may potentially ease the operational aspects of PCPT (which is in no way guaranteed), Verhaeghe and Hedley-Prôle warn that the stealth of market-based neoliberalism may be replacing the control and command of NPM (2014). This, they argue, normalises the principles that create individualism – which in turn creates suffering and increases the demand for therapy services; they consequently call for awareness and resistance to the political forces creating this normalisation. In becoming better at new professionalism to make services more effective, clinical leaders may normalise the service context of austerity and lack of resource, and unwittingly play the role of 'government agents', that Guilfoyle warns against (2019, p.117).

Tapson's study (2016) points to the importance of practitioners being able to internally rationalise the organisational – and I would also argue here, the political – impacts upon professional identity. Therefore, I propose that the lacuna in CoP discourse regarding political and operational skills is part of the 'rhetoric-action' gap for CoP in social justice commitments identified by Cutts (2013b, p.150). Understanding how professional identities and mythologies are constructed might help to rationalise the power – or lack of power – beyond street level bureaucracy, and better identify the opportunities for change at the 'high level' identified by the BABCP in the introduction (2014), for instance. To address the complex challenges to a therapist's sense of professionalism, Adamson and Johansson (2016) have proposed an 'embodied and embedded intersectionality framework' which acknowledges different types of service priorities and conflicts. For example, this might help explain the participant's relative positivity about their changing professionalism, and their new business mindset that enables clients to access a wider range of meaningful and cost-effective therapies.

Viewing policy discourses concerning PbR and EBPP as inevitable however, risks the ossification of PCPT into IAPT's image – and the associated limits for effectiveness such as perverse incentives, meaningless outcome measures and staff stress. As we have seen in this study, there is a tension between Tapson's vision of new professionalism (2016) and the policy discourses creating the pressures on services. Martin et al. attribute this tension to: 'a fundamental ontological difference between local knowledge (narrative, explanatory, and particular) and managerial knowledge (quantitative, predictive, and generalising)' (2015, p.20). It is therefore important for clinical leaders to challenge 'the principle legitimating discourse' of scientific-technical rationality and move towards a more 'communicative rationality' (Habermas, 2010, p.177) – where the relational becomes a given in the process of negotiation, throughout the system. Martin at al. (2015, p.20) describe such orientations as 'soft intelligence', which incorporates both social and cognitive skills to allow for a more nuanced evaluation of service effectiveness. This becomes especially important when other policy discourses such as choice and competition crowd out the logic of care. This challenge to the policy norms constitutes a socio-political action which not only embodies the therapeutic relationship, but also embodies leaders and organisational identity. In this study, providers and commissioners are already embodied in local relationships to generate support and validation of their feelings of stress and frustration. However, the lack of an embodied policy discourse was revealed by participant's perceptions of the top-down forces of policy that do not trust the experience of clinical leaders and do not enable the embodiment of the organisational practices (e.g. staff wellbeing and practice-based evidence). There is therefore, a disconnect in the nexus of practices between clinical voices and policy voices that exacerbates the challenges for the logic of care – as demonstrated by the marginalisation of clinicians in the co-production of services by policy directives.

The barriers facing clinical leaders who wish to challenge top-down discourses to incorporate a more embodied understanding of services, are considerable. For example, Walker et al. encountered institutional resistance to their attempts to disrupt 'hegemonic practices' in a public consultation exercise (2018, p.770). When clinical leaders attempt to incorporate data – for instance, about the staff stress described in the *NSP/BPS Staff Wellbeing Charter* (The New Savoy Partnership, 2015) – into the evaluation of real-world service effectiveness, the resulting conflict with top-down performance targets might evoke similar resistance from commissioners and/or NHS England. Playing political football and attempting fancy footwork using disruptive practices may result in being sent off the pitch or being brought down in the penalty box (losing employment or being bullied, etc.), and is therefore perceived as risky for clinicians, as highlighted by Thompson (2007) and Dalal (2018c).

Nevertheless, with an awareness of the opportunities for ethical practice with an embodied, intersubjective new professionalism, and CoP's ability to take an outsider viewpoint as well as tolerate institutional resistance, a conception of the 'embodied organization' might place clients and staff more at the centre of PCPT services (Küpers, 2016). It may provide a softening of the perception of the overpowering influence of IAPT on PCPT – which might be seen by some as an example of the 'disintegrating and monstrous, hyper-worlds' visualised by Küpers (2016, p.1436).

Embodied practices are especially important in caring professions, such as the framework for a 'lifeworld approach' to patient care, suggested by Galvin and Todres (2013). This approach gives practical and theoretical form to 'humanising' concepts in healthcare systems that, as the authors point out, mean more than a simplistic reading of patient-led care – perhaps evident in the perception of the empty government rhetoric around choice in this study. It offers a more thorough understanding of the limitations behind the suggestions for '"humanizing"' therapy by Watson and Bohart (2015, p.596), such as the assumptions that might have become normalised in a disembodied IAPT. As highlighted already, embodiment must be enacted and embedded at all levels of service implementation, as Adamson and Johansson suggest: 'What becomes crucial in the composition of professionalism is an *embodied* "knowing" of the other that engenders trust and a sense of professional credibility' [authors' emphasis] (2016, p.2218). Professional credibility might mean that clinical leaders must face, head-on, some difficult dilemmas in service implementation to make more explicit the blockages to embodied intersubjective leadership practice.

Operational skills as socio-political action.

Blair reflects on the challenges for CoPs working as scientist-practitioners within real-world healthcare settings (2010) and recognises, like Cutts (2013b) and Thompson (2007), that even though CoPs might be aware of socio-political tensions and challenges to professionalism, the real-world practicalities for working psychologists might inhibit new responses for real-world practice problems. Blair proposes 'embodied' team working (2010) as one way to develop CoP's identity in relation to science and practice in real-world contexts. The informal close alliances found in this study might be an example of the need for human connections in the management of care systems. Creating more formal resource and a safe space for these connections, such as reflective practice, might be an important part of challenging disembodied practices, as Steen suggests (2015, p.226).

Other researchers and fields in psychology are developing insights to manage the complex field of practices that impact service effectiveness (Schoenwald, 2018). For example, implementation science – defined as ‘the systematic uptake of proven clinical treatments, practices, organisational, and management interventions into routine practice’ (Implementation Science, cited by Allanson et al., 2017, p.1) – has been applied to IAPT services (Steen, 2015). May and Finch (2009) propose the use of ‘Normalization Process Theory’ (NPT) to understand and influence the ways that practices become embedded in complex systems. Developing a better understanding of these processes could, for instance, assist CoPs to describe and ‘normalise’ to policy makers, the fundamental importance of the logic of care in embodied therapy services – and to challenge the normalisation of practices that do not promote embodied subjectivity.

When considering the challenge of complexity, it may be helpful to view the emerging organisational forms through the lens of organisational change models that can accommodate the dynamic and multifaceted nature of the change process (for example: Balogun & Hope, 2008; Dawson, 1994; Lewin, 1960; Senior, 2002). Bamford and Forrester identify the ‘”emergent approach”’ to organisational change (2003, p.547) that emphasises the dynamic and complex nature of change – in opposition to a planned model of change that assumes predictable change processes – and instead suggest that organisational change is driven from the bottom up, rather than top-down. Todnem points out however, that there is much debate about the usefulness of emergent models of change, and calls for a more ‘pragmatic framework for change management’ based on empirical studies to respond to the varying facets of different change processes (2005, p.378). A pragmatic framework would have to reflect the wide range of adjustments and impacts from all parts of the system, as demonstrated by this study.

In terms of operational skills, Chorpita and Daleiden (2018, p.2) offer a practical model for addressing the multiple processes and expectations of leaders; they see this as an ethical imperative for ‘*how best to transform systems to ensure quality, ultimately yielding the best possible outcomes for stakeholders in the system’* [authors’ italics] – which equates to the striving for effective real-world services, outlined in the introduction. This puts patient-centred ethics at the core of each decision. Their ‘coordinated strategic action’ (CSA) model is an example of a practical, flexible and pragmatic model of care, that goes some way to addressing the complex challenges at the meso level, revealed in this study.

The adjustments in operational processes and professional identities can be considered as socio-political action, if it prioritises embodied intersubjectivity. In the new integrated models of care however, skills relating to the macro level of partnership working and political practices are also needed to deliver effective real-world services.

4.3.3. Socio-political action at the macro level

Provider pluralism and co-production in PCPT.

The mutual respect between providers evidenced in this study promotes what Quicke terms the ‘collaborative culture of organizational learning’ (2000, p.299). Pluralism, that is driven by clinical values and respect for multiple professionalisms, is a particular strength of CoP (Cooper & McLeod, 2011). This may offer opportunities – as this study has shown – for multiple providers across the system to improve effectiveness through coopetition, as Skelcher and Smith suggest: ‘We view hybridization as a process in which plural logics and thus actor identities are in play within an organization, leading to a number of possible organizational outcomes’ (2015, p.434). The plurality and eclecticism of CoP may be helpful in a world of competing professionalisms and practices, to mitigate some of the negative effects of competition between providers which have been exacerbated by fears resulting from low tariffs and PbR. An ability to use an evidence-base from a wide range of sources, with people at its core, re-embodies a disembodied IAPT for clients *and* clinicians, both of whom necessitate an ethical consideration that – it could be argued – overrides the requirements of the ‘*nonsense*’ of the statistics required by IAPT’s database (Liz).

However, a study on the ‘politics of mental health policy’ by Turner et al. highlights the ‘single-issue mythologies’ (2015, p.599) of different professions that contribute to the fragmentation of services in a complex and evolving nexus of practice. As well as the problems of silo mentality raised by participants, these mythologies include the ‘incursions of public policy and policymakers into clinical autonomy’ (Turner et al., 2015, p.612), echoing the mistrust of top-down policy in this study – such as the questions about the effectiveness of NICE and IAPT’s directives. For instance, the ‘master political logic’ of integrated care is seen by Glynos et al. (2015, p.46) to embed taken-for-granted fantasies about the need for choice in AQP and ‘provider-blind provision’. They argue that norms about the benefits of provider pluralism are marginalised: choice and competition may have increased diversity of provision, but the pluralism of provision has not been given top-down guidance or support – and this leads to fragmentation and dysregulation of the healthcare system (the problems with silo mentality, identified in this study). This reflects the illusion of the choice of quality providers in AQP as suggested by Griffiths et al. (2013), due to low margins pricing the higher quality providers out of the market. Despite Glynos and colleagues' pessimistic view of the marginalisation of provider pluralism, there are some similarities of their proposed model of provider pluralism with how participants here have worked together in AQP as: 'a broad ecology of providers...actively monitored and maintained to avoid the dominance of specific providers or types of providers' (2015, p.63).

It is possible that street level bureaucracy – from the professional and ethical values used by participants within the AQP model – drives *coopetition* with a plurality of governances (that provide a logic of care), rather than market values driving *competition,* with its fantasy of a choice of quality providers. This may go some way to address the lack of top-down understanding of the importance of provider pluralism (as highlighted by Glynos et al., 2015), diversity of professions, and trust in the governance offered by clinical and ethical professional values (evident in pre-IAPT models) in the new integrated systems (Barkham & Margison, 2007).

However, the extent to which the plurality of governances can improve the local health system is limited by policy positions that perpetuate the perception and experience of a lack of top-down responsivity to clinical values, as evident in this study. Walker et al. challenge existing approaches to public consultation and describe the lack of top-down responsivity as 'organisational hypocrisy if such tools and procedures are more enabling of practices which enact restrictions on stakeholder voice' (2018, p.762). If we view clinicians as stakeholders in the design of future services, then addressing the problems of power hierarchy (in the marginalisation of clinician's voices in co-production, for example) needs more than a model of provider pluralism. This requires embodied practice and co-production with the elusive 'high level' decision makers that the BABCP highlight (2014). If clinician's voices are to contribute to creating new models of care – what Singh et al. visualise as a 'responsive, integrated, and outward-looking healthcare systems' (McCannon & Berwick, referenced by Singh et al., 2017, p.1133) – clinical leaders must overcome the barriers of the bureaucratic nature of policy. Singh et al. make the following recommendation:

> *We suggest that those involved in envisioning and implementing co-creation initiatives pay close attention to significant questions of equity, power, and justice and to the fundamental challenge of securing a common vision of the aims of and agendas for health care systems* (2017, p.1132).

Therefore, the outward-facing sensibility of CoP – and other caring professions – needs to expand, to enable solutions for ethical splitting via socio-political actions across the micro, meso *and* macro levels; it must include the nexus of political practices to become, as Kuhlmann describes: 'the notion of professionalism as embodied practice that is based on shared cultural values and embedded in societies' institutions' (2006, p.608). Whilst CoP's relational focus lends itself to embodied practices, this form of professionalism might also draw on forms of 'emancipatory activism' found in Critical Community Psychology that incorporate: 'theory and practice of bottom-up emancipatory efforts to tackle health inequalities and other social injustices' (Cornish et al., 2018, p.526). As well as advocating for clients' rights, this approach can equally apply to communities of clinicians who are subject to similar inequalities in relation to top-down power dynamics. Cornish et al. identify the relational focus of Community Psychology as especially relevant in order to challenge the current 'environment of neoliberal individualism and intolerance' (2018, p.526). If this is the case, then Counselling Psychology may also use an outwardly extended relational focus – such as Pollard's concept of 'embodied dialogical subjectivity' (2011, p.7) – to tackle the politics of power in the design of services, that adversely impact the lives of both clinicians and clients (Cornish et al., 2018, p.526).

I equate here the notion of co-creation presented above by Singh that enables socio-political action with the terms 'co-production' and 'co-design', which are frequently used to denote the contributions from stakeholders to the design of public services. Counselling Psychology has a related notion of 'co-construction', but it is somewhat focused on an understanding of the micro level client-therapist processes (BPS, 2018b, p.5). The BPS Qualification in Counselling Psychology (QCoP) curriculum suggests that co-construction should be used to contribute to a 'holistic understanding of clients' predicaments' (BPS, 2018b, p.32). Neither this curriculum, nor the HCPC practitioner standards (2015), refer to policy or politics as a contributing factor to the 'clients' predicaments'. Nevertheless, a closer reading of the position of the apostrophe in *clients'* – with a collective framing of multiple clients sharing one set of predicaments – could include the wider political and systemic causes of distress beyond the intersubjective context of the therapy room. An explicit linking of the micro context *and* macro political context is needed to facilitate co-construction of meaning, and then to collaboratively generate possible solutions to the ‘predicaments’ (predicaments themselves that are created from circumstances that extend beyond the individualistic conception of psychological problems).

Challenging the rhetoric-action gap?

The commitment to addressing the systemic causes of austerity and challenging the hidden agendas of neoliberalism highlighted by many (such as: Dalal, 2018a; Rizq, 2014; Watts, 2016) are existing and important social justice discourses for CoP, and are important in order to prevent the naturalisation of policy effects in clinical discourse. However, this is a wider political debate and one which does not change the ‘now’ of the problem: the day-to-day pressures on services, outlined in the introduction. In this case, clinical leaders must try to deliver the best care to as many people though the development of ethical professionalism; embodied intersubjectivity; operational skills; street level bureaucracy; and the plurality of governances, outlined above as socio-political actions. In the introduction, Winter (née Cutts) highlights ethics as a guide to enact social justice (2015), and as one way to address the same author’s earlier identification of a ‘rhetoric-action gap’ in Counselling Psychology’s commitment to act upon their social justice values (Cutts, 2013b, p.150). As Crethar et al. suggest, there are many aspects to social justice (2008): therefore, increasing access to effective client-centred services by engaging with political practices, may be another important social justice principle (and socio-political action) guided by clinical ethics.

Lloyd and Pollard call for politics to be explicitly recognised as a ‘macro’ effect of society on client’s processes. While they refer to the ethos of Cognitive Analytic Therapy (CAT), their commitment to clinical and ethical values is relevant to all therapy modalities. They relate the politics of psychotherapy to practical and real-world clinical issues, where prescriptive models of care place ‘a straightjacket on freedom of expression for both client and therapist’ (2018, p.4) and restrict authentic patient-centred care. This highlights the pervasive impact of top-down policy on PCPT, such as the rigid governance of IAPT. Therefore, it is important that CoP engages with these macro policy impacts as part of socio-political action.

Understanding political logic: theory development of political practices as socio-political action.

> *the government's emphasis upon health inequalities is widely supported but conceptual and empirical evidence suggests that wider policy and organisational issues pose serious barriers to policy implementation* (Exworthy et al., 2002, p.93).

The term 'logics' has appeared throughout this discussion: the logic of care (Mol, 2008); political logics (Glynos et al., 2015); institutional logics (Reay & Hinings, 2009; Skelcher & Smith, 2015); and so on. The discourse between professionalisms happens within a complex nexus of practice and can frequently be unacknowledged or marginalised, but it *does* have form and logic attached to it. Embodying the political however, means avoiding the 'high-flown rhetoric' of intellectualised political arguments that may not relate to the practical challenges facing NHS mental health services now, and into the future (Lloyd & Pollard, 2018, p.15). It involves messy and imperfect trials and tribulations; embodied leaders need reflexivity and support to engage with this process authentically. CoP's philosophical and pluralistic approach might therefore lend itself to recognising and engaging with the different 'logics' that contribute to the system – to make clearer sense of the political football game that clinical leaders find themselves playing. Becoming more aware of how the logic of care, at the heart of CoP's relational values, interacts with other logics is important if CoPs are to enact the pragmatic socio-political actions needed at the operational *and* system levels of implementing PCPT.

Glynos et al. analyse the policy rhetoric surrounding the integration agenda at the heart of STPs, and relate it to the principle of 'social logic' (2015, p.47). Like Deleuze et al. (2013) they use the concept of 'nodes' to explain how different parts of the system become defined and operate: for example, the different nodes of governance; provision; distribution; and delivery in health and social care, determine how different aspects of services emerge. The themes identified in this study illustrate the varied policy effects on services at different nodes – not necessarily the same nodes defined by Glynos et al. (2015), however. Their model offers a framework for how political agendas – and their alternatives – arise and interact. For instance, in the case of the integration agenda, the 'political logics of marginalisation' sideline certain kinds of debate and produce a 'master political logic' which creates norms suggesting that choice and competition are inevitable and necessary (Glynos et al., 2015, p.63). They make special note of the absence in the debate of 'an alternative norm organised around *provider pluralism'* (2015, p.63). As demands on services increase and resources dwindle, these potential alternatives – where discourses meet to create new norms for health systems and new models of care – deserve further consideration. Counselling Psychologists are well placed to guide these norms using clinical values, embodied intersubjectivity, professional artistry, and pluralism. AQP, for instance, might therefore offer opportunities beyond the master political logic of choice and competition, if guided by the socio-political actions identified above.

It is important therefore to acknowledge and understand the policy landscape in healthcare systems as a messy, ever-changing – and at times surprising – interaction of many moving parts. As well as the agendas behind policy, Kingdon (2014) highlights the alternatives that are ever-present and paints a picture of government policy as more arbitrary than one might imagine. For example, Walker et al. realised that the emerging landscape of STPs offers new forms of collective democracy, despite the existence of top-down bureaucracy; they observe that: ‘margins and opportunities exist that allow room for manoeuvre toward the construction and implementation of alternative engagement practices’ (2018, p.763). In the current example of AQP, we can perhaps see a glimpse of Deleuze and Guattari’s ideas (Deleuze et al., 2013), allowing for unexpected and unanticipated opportunities that may then be used to counteract the top-down coercion/powerlessness perceived by the many critics of the policy effects on PCPT.

By developing a theory of political logic and political practices, this discussion has extended the proposals by Winter to address the rhetoric-action gap (2015) and has given practical form to the suggestions by Lloyd and Pollard (2018); Bond (2018); and others. This might then enable Counselling Psychologists, and other clinical leaders, to enact socio-political action within the nexus of practices in PCPT, and other mental health services which are affected by policy. Based upon the findings from this study, some practical suggestions for training are offered in the following sections, to address the lacuna concerning policy and operational skills in Counselling Psychology discourse. These suggestions may of course be applied beyond the field of Counselling Psychology; the current suggestions are set in the context of the existing CoP discourses, because they may already lend themselves to socio-political action.

4.4. A skillset for socio-political action: the example of the Counselling Psychology curriculum

> *In its concern with philosophy, counselling psychology embraces a pluralistic and interdisciplinary attitude which overlaps with other applied psychologies, counselling, psychotherapy, psychiatry, and the political and economic systems that sustain them*
>
> (BPS, 2019b, p.6)

With an understanding of the importance of political logic, how can the curriculum for Counselling Psychology training be improved to better equip trainees to enact socio-political action at the micro, meso and macro levels? In line with BPS directives (BPS, 2018a), the call to action for CoP trainers suggested here constitutes a socio-political action in itself; this is because it will enable a change in practices that may have positive impacts on the effectiveness, efficiency, ethics and enduring nature of services. This is intended to address, in part, the rhetoric-action gap in Counselling Psychology's social justice commitment identified by Cutts (2013b). Below therefore, I outline some suggestions for potential additions to the Counselling Psychology curriculum, that build upon some already helpful existing CoP discourses. These suggestions may equally be adopted by other applied psychologies and disciplines.

A brief scan of the course specifications of the available Counselling Psychology doctorate courses in the UK understandably place a focus on the therapeutic relationship and reflexivity. References to learning outcomes relating to politics typically cite the aims that are stated in the latest BPS *Standards for the accreditation of Doctoral programmes in counselling psychology* to: 'appreciate the significance of wider social, cultural, spiritual, political, and economic domains within which counselling psychology operates' (BPS, 2019b, p.11). Only a minority of accredited courses explicitly highlight skills connected to leadership and operational contexts (for example, audit and evaluation skills taught at both Teeside and London Metropolitan University), but in general there is a paucity of training around management and leadership skills (Gale, 2016, p.567). In contrast, a cursory glance at the aims of just a few Clinical Psychology doctorate courses, places organisational and managerial skills clearly in their course descriptions.

At this point, it should be noted that not all Counselling Psychologists qualify via doctoral courses; the independent route to qualification – Qualification in Counselling Psychology (QCoP) – is overseen by the BPS and follows the same broad philosophical framework as accredited university courses (BPS, 2018b). The suggestions here however, are intended primarily for formal doctorate courses in Counselling Psychology.

Most CoP courses contain professional development modules. These usually encourage the application of theoretical content to therapy practice in professional contexts (placements, etc.). It is in year three (or the latter part of the course for part-time courses) when most courses introduce reflection concerned with the professional contexts themselves. For example, third year modules such as: *Professional roles and* relationships (Teeside); *Supervising, Consulting and Leading in Counselling Psychology* (City of London); and *Clinical Practice and Workshops: Systemic, Contextual and Professional Issues* (Wolverhampton). Although Roehampton has a module entitled *Inclusion, Ethics and Social Justice,* which is incorporated across first and second year teaching, it mainly appears to focus on inclusive clinical practice in an unequal social world, rather than critiquing the ethics concerning power structures surrounding services.

It is also interesting to note the placing of each course within a wide range of academic schools – for example: School of Arts and Social Sciences (City of London); Institute of Human Sciences (Wolverhampton); School of Social Sciences, Humanities and Law (Teeside); School of Environment, Education and Development (Manchester); and the School of Health and Social Sciences (University of the West of England). This perhaps reflects differing approaches to conceptualising therapy delivery outside of a traditional medical model, that may be consistent with CoP's maverick identity (Moore & Rae, 2009). However, the variation perhaps also reveals an inconsistency in CoP's discourse relating to organisational structures within established health systems – which is an oversight, given that many Counselling Psychology trainees will go on to work in statutory settings (as well as private organisations). The problems with neglecting the impacts on service effectiveness at the meso and macro levels have been highlighted by this study.

Counselling Psychology could improve the degree to which it can address its lacuna in relation to these subject areas by borrowing from other applied psychologies such as the pragmatic leadership focus of Clinical Psychology courses, and the politically challenging focus of Community Psychology. Therefore, I detail below a possible approach to the curriculum that might be adopted by courses to equip CoPs with a more robust skillset that will help them to enact socio-political action at these levels, and thus ultimately facilitate contexts for more effective and more ethical relational practice.

The content outlined in the following three sections could constitute three 5 credit modules to be spread over three years (15 credits in total) to be entitled *Political and operational contexts*, or it could be included as a specific component within the professional practice modules. For each section, I refer to the specific HCPC *Standards of proficiency – Practitioner psychologists* (2015) and BPS curricula that relate to this important subject area (2019b; 2019c).

4.4.1. Curriculum content for socio-political skills at the micro level

First year trainees will probably have some experience of one-to-one therapeutic work, but they may not have a critical awareness of the effects of the organisational or political contexts on the therapeutic relationship. The ideas of Paulo Freire (2018) around critical pedagogy can be introduced at an early stage to embed a more politically aware sense of self as a therapist – a critical consciousness – to embed social justice into the concept of embodied intersubjectivity. This means that a logic of care, for both client and therapist, must challenge disembodied professionalism in mental health services. At the micro level, this includes recognising staff stress and burnout, as well as any crowding out of clinical values in treatment protocols. The ideas of Mol (2008), Owens (2015), and other documented critiques of IAPT, might contribute to a discourse for socio-political action at this micro level. Such a discourse in year one is designed to help trainees enhance their appreciation of the external pressures on intersubjectivity and help them build internal resources, an example of ‘caring for insiderness’ (Todres et al., 2014). Using critical pedagogy, and in the same way that they might understand the concept of projective identification with clients, they could also use the ideas of disavowal by Rizq (202b) to understand the processes whereby organisations might project ‘badness’ into therapists. This might enable them to better identify and connect with their own ‘“soft underbelly”…hidden in the shadows’ – in the words of Todres et al. (2014, p.9). Therapists can then formulate strategies to shield themselves and clients from any negative effects.

Learning formats might include lectures and process groups where trainees can share experiences – of burnout in IAPT for example – identifying signs; impacts on clients and colleagues; and the importance of governance processes that incorporate care for staff. Possible topics might cover: the therapeutic relationship within a system of care; ethical dilemmas; measuring stress and distress; the importance of supervision and good line management; peer support; and the use of ethical frameworks to support sustainable and effective services. Assessment could be by reflective essay on the topic of reflexive experiences of real-world service effects.

This taught component of the course covers several points included in the HCPC *Standards of proficiency – Practitioner psychologists* (2015). For Counselling Psychologists only, this includes: '[to] be able to critically reflect on the use of self in the therapeutic process' (HCPC, 2015, p.12). Other areas for all psychologists include: legal and ethical boundaries; understanding organisational contexts; autonomous professional judgement; working in partnership with stakeholders; evaluating practice for service improvement; and ensuring safe practice (2015, p.7; p.8; p.11; p.12; p.13; p.28).

The BPS curriculum for Counselling Psychology stresses the importance of the therapeutic relationship '*to promote the wellbeing of individuals by focusing on their subjective experience as it unfolds in their interaction with the physical, social, cultural, and spiritual dimensions in living'* (BPS, 2019b, p.6). The key differences between CoP and Clinical Psychology (CP) can be seen in the equivalent CP curriculum, which stresses core skills in treatment and team working *'relevant to working across a very wide range of health and social care programmes and presentations'* (BPS, 2019c, p.8). This difference highlights a lack of an outward and service-facing focus in CoP's engagement with effects on the therapeutic relationship, as Moloney observes (2000), in contrast to a more dialogical approach to understanding the nature of intersubjectivity (Gillespie & Cornish, 2010).

Developing a critical understanding of intersubjectivity and the ability to address problems impacting the therapeutic relationship is a socio-political action at the micro level because it can enhance the quality of care. However, this study has highlighted the limits to micro level changes in a complex nexus of practices. Therefore, the next curriculum component goes on to invite trainees to consider leadership skills at operational levels.

4.4.2. Curriculum content for socio-political skills at the meso level

By their second year, trainees will have developed more confidence in managing client and organisational dynamics. Courses can now extend the idea of leadership from embodied intersubjectivity at the micro level towards embodied organisations, using ideas such as Pollard’s ‘embodied dialogical subjectivity’ (2011, p.7); Küpers’ notion of the ‘embodied organization’ (2016, p.1436); and Tapson’s ‘new professionalism’ (2016). A consideration of the barriers to embodied organisations might reference Ghin’s notion of the ‘sick body’ and how embodied leadership might be hard to achieve in healthcare systems (2018). Nevertheless, there is a nascent body of helpful literature that looks at the question: ‘“What works for whom?”’ (Wiltsey Stirman & Comer, 2018, p.2) in the implementation and delivery of services, such as the ‘coordinated strategic action’ (CSA) model of Chorpita and Daleiden (2018) and studies of implementation science (May & Finch, 2009; Steen, 2015). A critical appreciation of ways to challenge disembodied practices might be enhanced by Pollard’s notion of ‘outsiderness’ (2011), which builds on CoP’s maverick identity to address the messy reality of operational pressures. These approaches offer practical solutions to the operational problems that create ethical splitting.

The content might offer a more in-depth examination of the ways in which different modalities of therapy might understand the systemic context of a service – be it organisational or political – and how this impacts the client’s experience of therapy. Psychodynamic theory speaks of the dynamic processes of projection and defences within the system, for instance the ‘organization-in-the-mind’ (Armstrong, French & Obholzer, 2005), and organisational melancholia and states of abjection arising from political ideologies (Rizq, 2012b). Person centred traditions might examine, for instance, the ‘environments person-centred therapy itself inhabits’ (Tudor & Worrall, 2006, p.11); factors that affect how well a therapy can be ‘humnaized’ in the context of external directives (Watson & Bohart, 2015); and the impact of organisational culture on the supervisory relationship (Copeland, 2013). Cognitive Behavioural Therapy traditions also address the impact of systemic forces on the therapeutic alliance (Armstrong & Freeston, 2006) and effects of organisational variables on outcomes in IAPT (Clark et al., 2018).

Group discussion and process groups might explore how trainees might demonstrate leadership in their day-to-day roles, and embed ethical decision-making and clinical values whilst also considering manager perspectives – how to balance top-down service demands. A critical exploration of different models of supervision might further support therapists and equip them to present the case for ethical values at a managerial level. Assessment might be via presentation or written examination on ways of addressing different problems or audit requirements in services.

When looking at the HCPC standards for practitioner psychologists, there are several references to operational skills: the roles of psychologists in respect to evaluation and audit; working in different organisational contexts with different stakeholders; adapting to organisational change; and the promotion of services for example (HCPC, 2015, p.12; p.13; p.20; p.24).

There are some interesting divergences between the different standards for clinical and Counselling Psychologists. As expected, the emphasis for Counselling Psychologists utilises the philosophical perspectives about the therapeutic relationship, and the use of self and professional 'artistry' (DcoP, 2017, p.1). But the lack of specificity about *what* CoPs do, compared to Clinical Psychologists makes interesting reading. It reads as if the critical reflective characteristics of CoP should be used primarily in the therapeutic relationship, but there is less reference to using CoP characteristics in challenging the operational context outside of the relationship with the client or with the therapist's own processes. For example, in the section relating to the application of knowledge to inform practice (HCPC, 2015, p.20), the CoP only standard: '*[to] be able to formulate service users' concerns within the chosen therapeutic models'* (HCPC, 2015, p.24), contrasts with a more outward-facing Clinical Psychology only standard: '*[to] be able to assess social context and organisational characteristics'* (HCPC, 2015, p.22). The difference in emphasis is subtle, but it appears to present CoP as less operationally oriented than Clinical Psychology.

This can be further observed in comparing the BPS curricula for Counselling and Clinical Psychology (BPS, 2019b; 2019c), where the level of detail given to the broad aims of CP courses explicitly emphasise the importance of leadership roles and consultancy. This can be perhaps best observed in the differences between specific learning outcomes relating to the comparable areas of leadership and consultancy. In the CP curriculum, there are two separate categories (section 8 & 9) covering leadership and consultancy: *Communication and teaching*; and *Organisational and systemic influence and leadership* (BPS, 2019c, p.20). This equates to a single section in the CoP curriculum entitled: *Communication, influencing, teaching, and leadership skills* (BPS, 2019b, p.18). Additionally, references to *leadership*, *consultation* and *stakeholders* appear significantly more frequently throughout the CP curriculum document.

The argument presented in this thesis points to the value of the embodied, intersubjective nature of the Counselling Psychologist as clinical leader. Whilst the professional logbooks for both curricula list *consultancy* as examples of required non-therapy experiences (BPS, 2019b, p.39; BPS, 2019c, p.55) it is clear that Clinical Psychologists are encouraged to engage more in the operational aspects of service provision. Whether or not this is because they are more embedded in statutory services due to the nature of the funding for these courses is not fully clear. However, with Counselling Psychologists increasingly working in services such as IAPT and other mental health services, it is important that CoPs use their creative, relational and reflexive skills to contribute to the development of the new models of care outlined earlier in this study, with the ultimate aim of improving the real-world effectiveness of services and reducing the impact of poor mental health on society.

The adjustments in operational processes and professional identities can be considered as socio-political action if they prioritise embodied intersubjectivity. However, as this study has suggested, skills relating to the macro level in a complex healthcare system are also needed to deliver effective real-world services in the new integrated models of care. Suggestions for curriculum additions to promote these skills are outlined below.

4.4.3. Curriculum content for socio-political skills at the macro level

> *Research straddling the boundaries between academic inquiry and political activism speaks to the many issues that are prevalent in the changing HE sector as well as NHS privatisation, health commissioning and public sector cuts* (Walker et al., 2018, p.759)

As Walker et al. suggest above, real-world service contexts call for a pragmatic and active engagement by psychologists, as scientist-practitioners. Bearing in mind Rizq's political commentary on neoliberalism and IAPT (2012a; 2012b; 2014) and the importance of real-world service effectiveness to enact social justice, reflexive perspectives on the political context of services might extend Freire's critical consciousness (2018) to introduce an element of political activism. Year 3 therefore examines the top-down determinants of service design and explores the multiple causes of the 'clients' predicaments' acknowledged in the BPS curriculum (2018b, p.32). It might use ideas from Critical Community Psychology and use post-structural perspectives to challenge political practices through: 'analysis and understanding of discourse, access to understandings, challenging the "rules" and what is taken for granted' (Kagan et al., 2020, p.121). These ideas would need to engage in a common-sense way with the barriers of toxic managerialism and top-down bureaucracy that have been identified in this study.

In the new integrated services – which increasingly will incorporate a wide range of non-statutory providers – clinical leaders need an understanding of the 'single-issue mythologies' (Turner et al., 2015, p.599) that get in the way of provider pluralism and co-production, as this study has demonstrated. Ideas such as Habermas' *Communicative Action* (2012), might offer a space to re-embody the lifeworld of the healthcare system away from the single-issue mythology of neoliberal policy narratives. According to Jovchelovitch, this is a 'theory of rationality and language based on dialogue and **intersubjectivity** rather than monologue of a solitary individual detached from others' [author's emphasis] (2011, p.130). An example of how this theory might be applied to pressing real-world problems is *Surviving Work: A survival guide* (http://survivingwork.org/wp-content/uploads/2016/09/Survival-Guide-2016.pdf), which validates the experience of the government-denied realities of stress in the care professions and offers practical ways to make sense of the context of work. The guide emphasises the importance of embodied leadership and organisations in a coercive policy context, to offer a ‘relational model of solidarity where we can make the best of a bad lot without fear of victimisation’ (Cotton, 2016, p.73).

In order to effectively challenge the rhetoric-action gap identified by Cutts (2013b), CoP trainees – the clinical leaders of the future – can consciously use a framework, such as Communicative Action, to identify and engage with political practices and be in a better position to influence the new models of care. For example, trainees might learn from the real-world case study by Walker et al. (2018) about how political logic might be translated into socio-political action. Walker et al. used ‘statactivism’ – a concept coined by Bruno and colleagues (2014) – to challenge the co-opting of statistics by top-down bureaucratic power structures after the HSCA 2012 to re-frame the representation of patient experience in an NHS service, in a way that diverged from the standard ways of data gathering and dissemination by CCGs. In the conscious use of similar and less conformist forms of data gathering and dissemination (such as the ‘soft intelligence’ explored by Martin et al., 2015), new knowledge about real-world service effectiveness comes to the fore.

Learning in this part of the curriculum might utilise experiences of the trainee’s own work contexts in process groups, with a critical appraisal of the ideological and political assumptions behind service design. Assessment might be by presentation of taking a case for system change to parliament or a local CCG, for example.

As has been observed previously, there is little direction from the BPS – in either the clinical or counselling curricula – to prepare trainees for any form of political activism, despite its call for training to improve skills that will promote a greater influence on policy development (BPS, 2018a, p.4). Neither is there reference to policy or politics in the HCPC standards, for either clinical or Counselling Psychologists, beyond skills around: consultation; leadership; and service and delivery changes (HCPC, 2015, p.13; p.23; p.24). Additional HCPC standards for Clinical Psychologists only include: ‘*understand social approaches such as those informed by community, critical and social constructivist perspectives*’ and ‘*understand change and transition processes at the individual, group and organisational level’* (HCPC, 2015, p.15). Similarly, the BPS standards for Clinical Psychologists cover knowledge of: *‘national strategies and policy initiatives’*; management in statutory settings; principles of organisational governance; local and national service frameworks; and whistleblowing procedures (BPS, 2019c, p.7; p.19; p.22). In subtle contrast perhaps, any references of policy and politics in the BPS Counselling Psychology standards revolve around a rather woolly understanding of the effects of politics relating to: service context; social context; socio-political impacts upon inclusion; statutory and legal frameworks; and organisational power dynamics (BPS, 2019b, p.6; p.11; p.16; p.18).

Whilst there is debate about how far real-world skills can be learnt in university (Feltham, 2010), Cornish et al. call for a ‘bold and combative scholar-activism’ (2018, p.526) to enable the translation of social justice values into socio-political action (*emancipatory activism*, in their words). Whilst the findings from this study speak to the very real challenges around enacting socio-political action in real-world settings, the curriculum additions proposed here collectively represent part of a real-world toolkit of socio-political actions for trainees to invigorate the social justice agenda within Counselling Psychology.

4.5. Limitations and suggestions for further research

It has been acknowledged that this study was ambitious in its scope and attempted to investigate complex and transdisciplinary subject areas. Consequently, this section identifies some of its limitations, and possible further research.

Different implementations studied in this thesis bring local variation in participant’s experiences: for instance, there are differences between working in partnership with two providers vs. fifteen providers, or working under a gateway provider system vs. managing the full care pathway. This complicates an already complex policy context. Therefore, this study did not aim to provide an exact blueprint of responses to specific policy directives, but instead aimed to represent a selection of factors influencing participant’s experiences. A more detailed study would be helpful to link responses to implementation type, and examine how commissioner data and provider data interact. This would offer more detailed knowledge of decision-making during implementation, similar to Steen’s research (2015), and others who use implementation science.

This study did not interview patients or clinicians, and so the reports of staff stress and client hoop-jumping for instance, cannot be triangulated using the current data. My own experience as a clinician and hearing client's experiences, gives me some confirmation of participant's reports – although I am mindful of my own researcher bias. Researcher bias was also managed using triangulation within the supervision team and at progression points to assist with the interpretation and analysis of the data.

Since non-AQP sites were not studied, it is not fully possible to state that the effects and processes observed in this study are due to AQP, or to separate out which aspects are due to IAPT and which are due to AQP, or identify which aspects are a consequence of other factors. However, existing research suggests that the issue of complexity applies to different IAPT sites: as Delgadillo et al. (2018) and Clark et al. (2018) suggest, the wide variation in service-level effects contribute in complex ways to overall real-world effectiveness, and so we might assume that AQP is one of several factors impacting services. In an attempt to track policy effects, this study specified the components of AQP (choice; competition; PbR; governance standards; and top-down power dynamics) to make it easier to map specific responses to specific aspects of policy. Many participants had experience of non-AQP IAPT sites however, so they *were* in a position to identify differences in AQP and non-AQP policy effects. Future research might be progressed by using alternative methods of analysis – such as Grounded Theory or Interpretative Phenomenological Analysis – to yield more detailed information about the nature and range of decision-making processes. It is hoped that this study offers a broad view that can be applied to other policy contexts and other mental health applications. Therefore, it would be appropriate to conduct service-specific case studies to understand more about which aspects of policy interact with particular implementation experiences.

Since there is little existing CoP discourse regarding implementation and no CoPs were specifically interviewed in this study, evidence to inform a CoP discourse was sought in this study from those clinical leaders who have implemented services. It is assumed that there is enough crossover of CoP identity with these commissioners and managers, so that insights demonstrated in this study are transferable to CoPs who might work in a similar operational role. However, it might be that CoPs are indeed already operating as socio-political actors in these contexts, but this possibility was not explored in this study. More research would investigate this further, such as research by Cutts (2013b).

The suggestions offered here for additions to the CoP curriculum have not been formally researched with programme leaders of nationwide CoP courses. Consultation and discussion groups (at the DCoP annual conference, for instance) might create new ideas about formally introducing the concept of socio-political action, with the suggestions in the previous section acting as a starting point for discussion. However, the ideas presented here *have* been informed by informal discussions and involvement in groups such as *Psychologists for Social Change*, with a curiosity about what CoP might add to an already active interest in socio-political action by Community and Clinical Psychologists throughout England and the devolved nations. Consultation with such groups – and others outside the discipline of psychology – might ensure that the CoP curriculum does not needlessly duplicate existing training courses, but instead complements them.

4.6. Final reflexive statement

I acknowledge that there may be lack of depth or omissions at times because of the study’s wide scope, but I have made every effort to ensure that this study is as rigorous and as relevant to contemporary contexts as possible, using regular summaries to guide the reader. Because this is an under researched topic, I hoped to invite the reader to stay open to making new connections, in the spirit of the rhizome.

However much my self-identified ‘octopus mind’ caused me many moments of paralysis in this research, my strengths around working with complexity enabled me to feel secure in the process of abduction – a process of logical inference proposed by C.S. Peirce, where a number of possible explanations might all be valid. This is an important skill, needed to generate new theory and respond to complex data, and to acknowledge that ‘all that one can achieve, using the procedure [of verification], is an intersubjectively constructed and shared “truth"’ (Reichertz, 2007, p.222). In addition, my prior interests in all matters policy and operational, helped me to ensure ‘adequacy in relevant disciplines’ to be able to navigate this wide-ranging and complicated research project with some degree of confidence without the need to work with a researcher from another discipline (Repko & Szostak, 2017, p.146).

After attending a qualitative research psychology conference, I considered using autoethnographic data to account for my positionality. However, whist clearly being good academic practice to account for researcher bias, the keynote speech warned against being too honest about the shortcomings of one’s own vantage point. I rejected the idea of a first person account of AQP in IAPT for my own employment security, and that of my participants and their confidentiality.

I have experienced strong emotions at times as a therapist and supervisor in reaction to negative effects that I attribute to AQP and IAPT, and wider political impacts on my employment context and beyond. My experience has been greatly affected by my reading of NHS documents and my perception of a mismatch between the espoused intentions of policy and the end effects of policy on clients, staff and sustainable services. I have sought support from my clinical supervisor, colleagues and academic supervision team with professional stresses so that I could remain as objective as possible about the processes I was experiencing in order to avoid bias in my reading of participant's responses. I am conscious of the literature around IAPT, especially in the CoP field which is at times – in my opinion – hostile to IAPT, so I remained alert to make my own judgements based on the data rather than seek to reinforce existing views. At a workshop on social justice at the DCoP conference in 2014, I remember arguing for pragmatism with a therapist who only wanted to criticise IAPT for not allowing enough sessions. As a recipient of NHS counselling and psychology at a time before IAPT, I offered a personal viewpoint of the negatives of long wait times prior to IAPT, plus a pragmatic view on the realism of limited funding for therapy on the NHS. As an example of my reflexivity, an early folder on my computer was entitled 'IAPT bashing'.

Given my awareness of and attempts to address possible researcher bias, I hope that the personal viewpoints and experiences described here, enhance the process and the outcomes of this study.

5.0. CONCLUSION

> *Engaging in dialogical research and practice necessitates that practitioners are open to themselves changing and coming to new understandings, achieved through communication in safe social spaces, and to the 'reinvention' of approaches appropriate to that particular context*
>
> (Vaughan, 2011, pp.65-66)

As Vaughan suggests, the ability to question the self and to engage with others who are also questioning themselves, offers fertile ground for the understanding and resolution of problems – and this is highly relevant to these times of change and challenge in the design and implementation of mental health services. Vaughan also draws on Freire to describe the dangers of the 'outsider-change agent' position (2011, p.62), where a lack of genuinely reflexive engagement in the change process may hinder the ability to address the deep political power structures that produce and re-produce repression. Nevertheless, even in the face of the blockages posed by external power structures and internal bias, Vaughan suggests that genuine and reflexive communication *can* produce the conditions for socio-political action. In other words, using the embodied commitment of 'caring for insiderness' (Todres et al., 2014) and a pragmatic – but equally committed – notion of 'outsiderness' (Pollard, 2011), clinical leaders may be able to resolve ethical splitting by drawing on clinical values and robust boundaries with power structures. These ideas echo the core philosophy of intersubjectivity in Counselling Psychology, as well as its maverick repertoire and reflexivity. With an openness to change, Counselling Psychology may adopt some of the ideas presented in this thesis, to become better equipped to engage with the ***political practices*** that have been explored in this study.

The ultimate aim of this study was to offer a better understanding of the complex field of these political practices in healthcare services in order to better address ethical splitting, which might then improve service effectiveness in the new models of care. The case being investigated here is AQP/IAPT, but the findings are deliberately framed in order to be generalisable so that they may be applied in different healthcare settings. In doing so, the contribution here also hopes to address a gap in CoP discourse regarding policy that can address the rhetoric-action gap in CoP's social justice commitment identified by Cutts (2013b). This concluding summary will outline how the policy strategies of AQP have interacted with some of the existing problems of real-world effectiveness connected to the IAPT model, in a complex health system. Building on the responses of the clinical leaders in this study, it will highlight any helpful practices and nodes of opportunity – seen through a CoP lens – that may be applied to future services.

The first three themes in the data represent areas of operational challenge for the participants in this study. Some of these challenges will become more relevant to service delivery in the new models of care. The final theme broadly speaks to the clinical values which permeate the decision-making in response to the different kinds of operational challenges. The ethical splitting can therefore be identified (and be anticipated in future implementations) as a conflict between the clinical concerns about the impacts upon clients, and the pragmatic decisions involving service pressures at the micro, meso and macro service levels. Below, I capture these challenges in relation to the AQP policy strategies found to impact clinical leaders in this study (defined here as: choice; competition; PbR; governance standards; and top-down power dynamics) together with the possible solutions proposed in this thesis.

Choice.

Mol (2008) highlights the logic of care as a guiding principle to override choice as the priority of clinicians. Choice is valued by clinical leaders because it is considered that collaborative treatment which embodies autonomy for clients offers 'responsiveness' to patient's needs (Greener, 2009). However, the policy rhetoric of choice and the personalisation agenda – the ever-present product of NPM political logics – crowds out the central clinical values that offer quality care for the client. Choice must therefore be a *real* choice (and *not* a fantasy of the *Sopranos*, as Liz identifies) if it is to engender authentic and embodied care at the micro service level. At the meso level, the concept of choice in AQP is closely aligned with competition (intended to be based on quality, not price); the need for organisational survival has driven providers to offer something distinctive, innovative and efficient in order to increase numbers of clients, and therefore ensure financial stability. The variety of providers in AQP at the macro level expands the choice in a positive way, because providers are generally motivated by clinical values and – if they can survive in AQP – can increase the range of treatments and contexts, perhaps more so than a single provider who may be less motivated to extend their service in already demanding service contexts.

To address the ethical splitting around the logic of choice, clinical leaders can develop a conscious and unapologetic logic of care, and a genuine regard for embodied intersubjectivity in the therapeutic relationship. These clinical and patient-centred values speak strongly for the incorporation of embodied organisations (Küpers, 2016) into the new models of care, to ensure ethical practice and genuine real-world effectiveness; at the same time, new professionalism (Tapson, 2016) can be used to adapt to the quasi-markets that are designed to promote choice within effective services. This might mean gathering soft data (Martin et al., 2015) about meaningful measures of quality and effectiveness. It may also mean setting clear professional and ethical boundaries in the face of the multiple challenges and pressures from different parts of the system – including those political logics that do not prioritise the logic of care over the logic of choice. The policy strategy of choice in AQP/IAPT therefore, may *not* present excessive challenge if clinical leaders can prioritise clinical values over government rhetoric. This may not be as easy (or indeed, as important) in other types of NHS services however; for example, patient care where the relationship with the patient is not as central to the treatment being offered – such as the wheelchair services pointed out by Bridget.

Competition.

The competition element of AQP – which also relates to wider retendering processes – forces rival providers to benchmark their services and improve innovation. This more business-like mindset is seen as positive, because it prompts services at the meso level to become more efficient and reduce waste. Whilst the larger NHS organisations are seen to be less able to respond in this way, the concept of marketing to clients (because providers are competing for clients) can be helpful when there are genuine efforts to improve the quality of care for the client. The risk might be – especially in the wider context of private services tendering for large contracts – where marketing to commissioners to win a bid might hide a lack of genuine commitment to care practices, which may only become apparent once the contract is won. There is a need to monitor and evaluate these new services to ensure that an improvement in effectiveness actually materialises before existing services are dismantled and therefore unable to be part of the mixed economy of healthcare envisaged by Sophie. The scrutiny embedded within AQP/IAPT kept providers constantly striving for good outcomes. However, there is a fine line between healthy competition and the kind of competition that creates stress, especially with the low tariffs in AQP/IAPT; and there are limits to the degree of innovation possible if services are not resourced adequately.

A second aspect of competition arises at the macro level in AQP/IAPT where services are in competition but must operate in partnership and are coordinated by commissioners (described by Mark as '*herding cats'*). The resulting fragmentation of operations and existing silo cultures cause problems and tensions in the local system; this can waste resources and impede quality of care. However, 'coopetition' (Westra et al., 2017) amongst providers – when adequately resourced – represents a healthy combination of competition and cooperation that works best when providers are not in direct competition with each other. In AQP/IAPT (and therefore likely in other integrated mental health and care services), there is a high level of clinical commitment by commissioners and providers to patient care which reduces the negative effects of competition, and promotes coopetition via good working relationships and *Communicative Action* (Habermas, 2012), despite the lack of resources.

Governance standards.

Clinical leaders value consistent governance standards, and see these as central in offering a quality service. However, this study has shown that the hybrid system arising from the competitive model of AQP/IAPT results in a ***plurality of governances*** at the macro level. Whilst introducing fragmentation and incoherency, the individual organisational governances are underpinned by clinical values, that can promote the logic of care *and* effective services. This pragmatic approach to care, challenges the current one-size-fits-all rhetoric of IAPT – as a manifestation of the top-down management aspect of NPM – which is seen as unhelpful, especially when resources are limited and cannot offer what is promised in real-world services.

Furthermore, the local quasi-market system offers fertile ground for organisations to learn from each other as they compete as part of a joint service. Commissioners and providers found the equivalent of *communities of practice* (Wenger, 1998) – a situated learning environment where they learn from each other and can extend their practices to help manage the conflicting demands of delivering quality care in challenging circumstances (described by Liz as '*mucking in together'*). This community also provided moral support that supported clinical leaders to agree on which governance priorities and clinical values were foregrounded.

Street level bureaucracy and clinical values are trusted in mental health professions to deliver reliable care. The IAPT database represents practice based psychological practice that can be used to challenge the established reliance on NICE and its CBT focus (see Barkham et al., 2017) – which is costly to implement and might result in wastage. Therefore AQP/IAPT has shown that established governance standards can be challenged, whilst still offering real-world effectiveness and quality patient-centred care.

Payment by Results.

The issue of money however, is highly problematic in a complex policy landscape. The helpful adaptations described above can only go so far without adequate resourcing, because otherwise, there will be a '*race to the bottom*' as Nick warned, with a reduced diversity of quality care. Because the tariffs are so low in AQP/IAPT, their survival fears mean that providers cannot focus on quality care because they are dealing with the '*alligators'*, in Trisha's analogy. This weakens the claim that AQP is a model that competes on quality, not price. It also increases the risk of perverse incentives and cherry picking, for example, and consequently increases the burden on NHS of treating the more complex clients who are less likely to reach recovery in a limited number of sessions (and thus, are not cost effective in the AQP/IAPT model). Financial competitiveness is helpful to stimulate a business mindset, but when payment is linked to targets and outcomes, it also creates stress and conflicts for staff and managers.

The problems associated with financial resourcing are closely allied to political power in statutory services because of top-down funding decisions. Not only do smaller organisations expend more energy on survival, they may also not have the confidence to challenge top-down power because it is 'he who pays the piper' (Craig et al., cited by Taylor, 2001, p.101).

Top-down power.

We have seen that some commissioners are seen as allies for providers, but both commissioners and providers are generally wary about being viewed as not towing the government line, whether they agree with it or not: as Abdul observes, NHS England is considered to be the government's mouthpiece.

Because the clinical governance standards of IAPT and NICE are a product of top-down power structures, the ability to challenge sometimes wasteful governance standards, is hampered by the perceived power hierarchy and the instruments used by top-down power structures to keep the status quo (as seen in the study by Walker et al., 2018). The *'elephants in the room'* described by Rachael represent the conflict for clinical leaders between meeting governance standards in line with clinical values and meeting other targets that are sometimes seen as arbitrary (such as the statistical *'nonsense'* observed by Liz, and the '*whimsical'* NHS targets that frustrated Mark). This kind of governance consequently becomes disconnected from the logic of care. The target focus of IAPT is a good example of this, because it causes stress for staff and may not contribute to quality patient-centred care if it encourages gaming and perverse incentives to avoid punitive measures from NHS England. The fanfare surrounding IAPT's success and its strong branding makes it hard for any critique to be genuinely heard and considered. The elephants in the room from top-down pressures echo with concerns about the possibility for organisational change and authentic openness, following the recommendations in the Francis report (Thorlby et al., 2014), and are therefore of key importance in the quality of patient care.

The frustrations of clinical leaders with top-down power structures and the perceived inability to change wasteful and retrograde directives, equates to Buber's 'monologue disguised as a dialogue' (Buber cited by Górzna, 2014, p.50) – the monologue of impossible targets disguised as dialogue of the (empty) political rhetoric offering co-production with clinicians. Mark believed that bottom up change was not possible, and yet we see in this study how clinical leaders have exercised internal autonomy and joint problem-solving strategies (to some degree) to promote patient-centred care and to co-produce local systems in AQP/IAPT.

The perception from Trisha that the government *'doesn't give a damn'* and Atkinson's assertion of the government's 'contempt' for mental health (2014, pp.18-19) may not be wholly accurate. However, policy appears to promote competition and mistrust over cooperation and shared clinical teamwork, and to marginalise clinical voices in co-production. It is arguably designed to get more quality for less money, without considering the human cost on staff or clients. The elephants in the room and the alligators do not enable effective or sustainable care systems, but instead hinder them.

Incorporating more critical engagement with leadership within healthcare systems and their interface with policy could help to counter the dangers of the normalisation of practices that are not client-centred (Peacock-Brennan, 2016). It may also reduce perceptions of the powerlessness against top-down forces of policy and ‘institutionalization’ (May & Finch, 2009, p.536) that threaten a practitioner's sense of agency and contribute to the disembodied professionalism and disenchantment that we have seen in IAPT, and other forms of top-down policy practices in PCPT in the NHS (Ham, 2014). Therefore, effective new models of care that can meet the increasing demand for PCPT require additional skills from clinical leaders that can address the disconnect with top-down power structures and that can prioritise ethical and patient-centred service design. It may also involve engagement with alternative ways of challenging established top-down practices (see for instance, Cotton, 2016).

However, many top-down problems at the macro level lie beyond the power horizon (Smail, 2005, p.32). As organisations become larger in the new models of care (as the only ones able to compete in the landscape of STPs), the moderating forces on the political logics of marginalisation are likely to reduce further (Glynos et al., 2015, p.63). It remains important then not to give up, in the face of a perceived *Leviathan*. The community and solidarity described by Vaughan (2011) becomes a place of safety, to connect with the power of a joint clinical voice that may then be able to influence the top-down decision-making process that becomes canonised in NHS documents and pervading political rhetoric.

The role for Counselling Psychology in future models of care.

Driven by the logic of care as the core guiding principle, it may be possible for Counselling Psychology to engage in purposeful socio-political action in leadership roles. This may mean playing with the other side of the political football team to create opportunities, similar to Clark and Layard’s partnership in the conception of IAPT (Evans, 2013). However, unlike Clark and Layard, CoPs might argue pragmatically for the cost-savings from more flexible practice-based epistemologies and draw attention to the negative real-world effects of top-down pressures and cost-savings on responsive, integrated patient-centred care. David Clark teamed up with Lord Richard Layard (programme director of the Centre for Economic Performance at the London School of Economics), who already had the language of economics and was well versed in political logics. Therefore, to create similar opportunities in policy identified by Kingdon (2014), this study has demonstrated that Counselling

Psychology, and allied health professions, require a better understanding of the complexity and fluidity of political logics.

Any Qualified Provider has shown that policy can be flexible and offer opportunities within a complex healthcare system. It has also shown the dangers of commissioning practices based on payment by results, and the challenges and benefits of partnership working. As Sustainability and Transformations Partnerships (STPs) expand, it is important that the benefits of provider pluralism are not marginalised in favour of cost-savings and or large providers who may not offer service responsivity. The agendas and alternatives for STPs offer an interesting example of the process of policy implementation, where we find the HSCA 2012 being pushed to its limits, shifting agendas away from quasi-market systems towards efficiencies and patient-centred care.

The recent Covoid-19 situation has demonstrated that governments can choose to use science in whichever way serves their purpose. It perhaps vividly demonstrates the different languages that politics and clinical practice speak. It also serves to demonstrate the ways in which policy and practices can rapidly change, as Kingdon suggests (2014) – presenting the the ***nodes of opportunities*** as I have proposed here – and described by Taylor as: ‘the windows and cracks that appear when political systems change’ (2001, p.104). AQP/IAPT offered such nodes of opportunity for smaller providers to contribute to a plurality of governances and to create a space for clinical values and local autonomy. However, due to its challenges, AQP is unlikely to play any significant part in the new models of care for mental health. Nevertheless, the insights and understanding gained from this study about policy effects, might equip clinical leaders to recognise and improve their negotiation with the top-down policy strategies that can impact the real-world effectiveness of services.

As an example of the awareness needed by clinical leaders at a service level, an anecdotal snapshot of the realities of the complex layers of policy that impact practice on the ground can be seen in the Public Accounts committee minutes (2017). Set against the ‘unprecedented efficiency gains’ required of the NHS in the white paper that preceded the HSCA 2012, (DoH, 2010a, p.5), Department of Health directives concerning STPs display a failure in the government's rhetoric to acknowledge the impossibility of achieving savings *and* the high standards of quality expected by the NHS: Anne Marie Morris is direct in saying *‘I think the other bogey in the room, if I can put it like that, is money’* (Public Accounts committee, 2017, q.128). Later, Simon Stevens (Chief Executive, NHS England) – equally direct – points out that the government cannot have more for less, and chooses the same expression of cutting the cloth as an interviewee in the study by Griffiths et al. (2013): *'we have to cut our cloth accordingly, and it will involve some trade-offs'* (Public Accounts committee, 2017, q.141). This shows that these discussions are being held at the high level described by the BABCP but as yet, clinical leaders do not seem to have a significant voice in these discussions. Furthermore, whilst Simon Stevens appears to offer a candid and direct levelling to government rhetoric, Whitehall may yet push to take back some of the autonomous power given to NHS England (Smyth, 2020). This example serves to show how important it is that clinical leaders contribute to these high-level decision-making processes, if clinical values are to be put at the forefront of the design of the new models of care.

The missing discourse regarding politics in CoP has been identified here as an omission for its socio-political action commitments and, therefore, misaligned with its relational ethos. When we view this with an interdisciplinary lens, we might therefore identify 'conflicts between insights' (Repko, 2017, p.244). The suggestions for CoP curriculum development offered here is intended to improve CoP's understanding of how socio-political action can be enacted through leadership skills, and to address gaps in the training for Counselling Psychologists (Mallinckrodt et al., 2014) that might reduce conflict. Perhaps by embracing Fine's notion of 'critical bifocality' – through expanding CoP's remit to more fully understand and relate to the gritty complexity of service delivery – we might better enact socio-political actions and address the rhetoric-action gap highlighted by Cutts (2013b), as Fine energetically advocates (2016, p.363):

> *With a sense of critical optimism, by interrogating and filling in the linkages that bond global to local, history to present, and elites and quasi-elites to marginalized communities, we might begin to understand the circuits of dispossession, but also the circuits of solidarity that need to be connected in the march toward social justice.*

Counselling Psychologists need an understanding of the complex socio-political landscape, that requires practical and pragmatic approaches to change. Learning from the real-world socio-political actions of the participants in this study, can begin to fill in some of the gaps in Counselling Psychology discourse. With a real-world language of client-centred ethics, and an understanding of how the 'other' side plays political football, clinical leaders might better hold policy-makers to account for creating unsustainable and unethical systems of care in times of increasing pressure on Primary Care Psychological Therapy services, described by Rees as ‘an emerging reality of resource-constrained, large-scale and Payment by Results-based contracting’ (2013, p.45). I argue therefore, that deciphering the political landscape and holding policy makers to account constitutes a powerful and practical social justice commitment for Counselling Psychology.

However, the importance of safe social (and professional) spaces for enabling critical dialogue, as highlighted by Vaughan (2011), cannot be underestimated in the context of the current study. The ideas communicated in this thesis ultimately aim to help create safer social spaces within mental health services to focus on the improvement of real-world and meaningful service effectiveness. However, a powerful and robust discourse to support socio-political action for Counselling Psychologists to create these safe clinical spaces, also needs safe social space at the macro level from which to challenge the power structures that place clinicians on the political football pitch. AQP, and its policy correlates, is a manifestation of these power structures (and itself one of the political footballs that participants are grappling with). The skills highlighted here may enable a better technical understanding and engagement with policy. However, Counselling Psychologists also need to find a common voice alongside other applied psychologies and care professions, to create the ‘*circuits of solidarity’* (Fine, 2016, p.363) that might help us to hold the middle ground when attempting to challenge the power dynamics that may lie beyond the power horizon. In this way, we might better resolve the ethical splitting that arises from the complex policy effects on real-world services.

6.0. REFERENCES

Accent. (2015). *How Choice is Working in NHS Adult Hearing Services in England Report February 2015.* Retrieved 31-01-2016 from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/409186/Findings_-_how_choice_is_working_in_adult_hearing_services.pdf

Adamson, M., & Johansson, M. (2016). Compositions of professionalism in counselling work: An embodied and embedded intersectionality framework. *Human Relations, 69,* 12, pp.2201-2223.

Addicott, R., Maguire, D., Honeyman, M. & Jabbal, J. (2015). Workforce planning in the NHS. The King's Fund. Retrieved 17-05-19 from: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Workforce-planning-NHS-Kings-Fund-Apr-15.pdf

Alderwick, H. et al. (2018). Can accountable care organisations really improve the English NHS? Lessons from the United States. *BMJ, 360*, pp. k921.

Allanson, E.R., Tunçalp, Ö., Vogel, J.P. et al. (2017). Implementation of effective practices in health facilities: a systematic review of cluster randomised trials. *BMJ Global Health, 2,* no. 2, pp.e000266.

Altson, C., Loewenthal, D., Gaitanidis, A. & Thomas, R. (2015). What are the perceived implications, if any, for non-IAPT therapists working in an IAPT service, *British Journal of Guidance & Counselling*, *43*:4, 383-396, DOI: 10.1080/03069885.2014.962485

APA [American Psychological Association]. (1995). *American Psychological Association Task Force on Psychological Intervention Guidelines, Template for Developing Guidelines: Interventions for Mental Disorders and Psychosocial Aspects of Physical Disorders,* American Psychological Association, Washington, DC, USA, 1995.

APA [American Psychological Association]. (2006). Evidence-Based Practice in Psychology: APA Presidential Task Force on Evidence-Based Practice. *American Psychologist, 61,* 4 pp.271-285. Retrieved 12-02-19 from: https://www.apa.org/pubs/journals/features/evidence-based-statement.pdf

Appleby, J., Harrison, T., Hawkins, L. & Dixon, A. (2012). *Payment by Results How can payment systems help to deliver better care?* The King’s Fund. Retrieved 16-06-18 from: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/payment-by-results-the-kings-fund-nov-2012.pdf

Argyris, C. & Schön, D. A. (2003). *Theory in practice: Increasing professional effectiveness*. San Francisco, Calif: Jossey-Bass.

Armstrong, D., French, R., & Obholzer, A. (2005). Organization in the mind: Psychoanalysis, group relations, and organizational consultancy: occasional papers 1989-2003. London: Karnac.

Armstrong, P. and Freeston, M.(2006). Conceptualising and formulating cognitive therapy supervision. In N. Tarrier (Ed.), Case Formulation in Cognitive Behaviour Therapy. London: Routledge.

Ashton, J.R. (2006). Virchow misquoted, part-quoted, and the real McCoy. *Journal of Epidemiology and Community Health, 60*, no. 8, pp.671.

Athanasiades, C. (2009). Issues from Practice The changing nature of health care: Implication for counselling psychologists and service users. *DCoP Newsletter*, *1*, No. 1, November 2009.

Atkinson, P. (2014). Lies Damned Lies, and IAPT. *Statistics. Self & Society*, *42*, pp.18-19.

Bachelor, A., Laverdière, O., Gamache, D. & Bordeleau, V. (2007). Clients' collaboration in therapy: Self-perceptions and relationships with client psychological functioning, interpersonal relations, and motivation. *Psychotherapy (chicago, Ill.), 44,* 2, pp.175-92.

BACP [British Association of Counselling and Psychotherapy]. (2017). Not so, NICE! *Therapy Today*, July 2017: *28,* Issue 6. Retrieved 03-02-19 from: https://www.bacp.co.uk/bacp-journals/therapy-today/2017/july-2017/not-so-nice/

Baker, C. (2018). *Mental health statistics for England: prevalence, services and funding*. House of Commons Library Briefing paper, no.6988, 25 April 2018. Retrieved 11-11-18 from: https://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN06988#fullreport

Baker, T. (2014). *To AQP or not to AQP?* Unpublished Research project and poster presentation at DCoP conference, London, 2014 (see appendix 17).

Balogun, J., & Hope, H. V. (2008). *Exploring strategic change*. Harlow, England: FT Prentice Hall Financial Times.

Bamford, D. R. and Forrester, P. L. (2003). Managing planned and emergent change within an operations management environment. *International Journal of Operations & Production Management*, *23*, 5.

Bammer, G. (2013). The Relationship of Integrative Applied Research and I2S to Multidisciplinarity and Transdisciplinarity. In: Bammer, G. (2013). *Disciplining interdisciplinarity : Integration and implementation sciences for researching complex real-world problems*. Canberra: ANU E Press. Stable URL: https://www.jstor.org/stable/j.ctt2jbkj5.37

Banister, P., Burman, E., Parker, I. et al. (1994). *Qualitative methods in psychology: A research guide*. Buckingham: Open University Press.

Barker, C., Pistrang, N., & Elliott, R. (1994). *Research methods in clinical and counselling psychology*. Chichester: Wiley.

Barkham, M., & Margison, F. (2007). Practice-based evidence as a complement to evidence-based practice: from dichotomy to chiasmus. In: C. Freeman, & M. Power (eds.), *Handbook of evidence-based psychotherapies: A guide for research and practice*. (pp.443-476). Chichester, United Kingdom: Wiley.

Barkham, M., & Mellor-Clark, J. (2003). Bridging Evidence-Based Practice and Practice-Based Evidence: Developing a Rigorous and Relevant Knowledge for the Psychological Therapies. *Clinical Psychology and Psychotherapy, 10,* pp.319-327.

Barkham, M., Moller, N. P. & Pybis, J. (2017). How should we evaluate research on counselling and the treatment of depression? A case study on how the National Institute for Health and Care Excellence's draft 2018 guideline for depression considered what counts as best evidence. *Counselling and Psychotherapy Research, 17,* 4.

Bartlett, L. & Vavrus, F. (2017). Comparative Case Studies: An Innovative Approach. *Nordic Journal of Comparative and International Education (NJCIE), 1*, no. 1.

Beck, A. T. & Waltman, S. (2015). Commentary on “The effects of cognitive behavioral therapy as an anti-depresive treatment is falling: A meta-analysis”. *Cognitive Therapy Newsletter, 15/16*, 2, p.9.

Bennett, S. (2014). *Getting Serious About Personalisation in the NHS*. London: Think Local Act Personal.

Binder, P., Holgersen, H. & Nielsen, G.H. (2010). What is a "good outcome" in psychotherapy? A qualitative exploration of former patients' point of view. *Psychotherapy Research, 20*, no. 3, pp.285.

Binnie, J. (2015). Do you want therapy with that? A critical account of working within IAPT. *Mental Health Review Journal, 20,* 2, pp.79-83.

Blair, L. (2009). Issues from Practice Psychotherapy and the economic context: Some reflections for practice *DCoP Newsletter, 1,* No. 1, November 2009.

Blair, L. (2010). Theoretical Article: Trainee Prize Award Winner A critical review of the scientist practitioner model for counselling psychology *Counselling Psychology Review*, *25,* No. 4, December 2010.

Blendon, R.J. & Steelfisher, G.K. (2009). Commentary: understanding the underlying politics of health care policy decision making. *Health services research, 44*, no. 4, pp.1137-1143.

Bohart, A.C., Elliott, R., Greenberg, L.S. & Watson, J.C. (2002). Empathy. In J.C. Norcross (Ed.), *Psychotherapy relationships that work* (pp.89-108). Oxford: Oxford University Press.

Bond, G.R. (2018). Evidence-based policy strategies: A typology. *Clinical Psychology: Science and Practice, 25,* no. 4, pp. e12267-n/a.

Bouncken, R.B., Gast, J., Kraus, S. & Bogers, M. (2015). Coopetition: a systematic review, synthesis, and future research directions. *Review of Managerial Science, 9,* no. 3, pp.577-601.

Bovaird, T. & Davies, R. (2011). Outcome-Based Service Commissioning and Delivery: Does it make a Difference?. Chapter in: Groeneveld, S. & Van De Walle, S. (eds.). *New Steering Concepts in Public Management (Research in Public Policy Analysis and Management, 21.*. Emerald Group Publishing Limited, pp.93-114.

Bovey, W., & Hede, A. (2001). Resistance to organisational change: the role of defence mechanisms. *Journal of Managerial Psychology. 16*, pp.534-548.

Bowden, G. E., Smith, J. C. E., Parker, P. A., & Boxall, M. J. C. (2015). Working on the Edge: Stresses and Rewards of Work in a Front-line Mental Health Service. *Clinical Psychology & Psychotherapy*, *22*, 6, pp.488-501.

Bower, P., and Gilbody, S. (2005). Stepped care in psychological therapies: access, effectiveness and efficiency: Narrative literature review. *The British Journal of Psychiatry, 186,* 1, pp.11-17.

BPS [British Psychological Society], Care Services Improvement Partnership, & National Institute for Mental Health in England. (2007). *New ways of working for applied psychologists in health and social care: Organising, managers and leading psychological services*. Leicester: British Psychological Society.

BPS [British Psychological Society]. (2017). *BPS Qualification in Counselling Psychology Handbook.* Qualifications Office The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester, https://www1.bps.org.uk/system/files/Public%20files/QCoP%20Candidate%20Handbook%20Jan%202017.pdf

BPS [British Psychological Society]. (2018a). *Briefing paper: The future of training in applied psychology*. Retrieved 06-02-19 from: https://www.bps.org.uk/news-and-policy/briefing-paper-future-training-applied-psychology

BPS [British Psychological Society]. (2018b). *Qualification in Counselling Psychology Candidate handbook*. April 2018. Leicester: British Psychological Society.

BPS [British Psychological Society]. (2018c). *Style Guide for authors and editors* September 2018 The British Psychological Society. Leicester: British Psychological Society.

BPS [British Psychological Society]. (2019a). *NHS Long Term Plan shows promise on mental health and acknowledges workforce challenge.* [BPS news article]. Retrieved 07-01-19 from: https://www.bps.org.uk/.../nhs-long-term-plan-shows-promise-mental-health-and-acknowledges-workforce-challenge

BPS [British Psychological Society]. (2019b). *Standards for the accreditation of Doctoral programmes in counselling psychology*. January 2019. Leicester: British Psychological Society. Retrieved 27-03-19 from: https://www.bps.org.uk/sites/www.bps.org.uk/files/Accreditation/Counselling%20Accreditation%20Handbook%202019.pdf

BPS [British Psychological Society]. (2019c). *Standards for the accreditation of Doctoral programmes in clinical psychology.* January 2019. Leicester: British Psychological Society. Retrieved 27-03-19 from: https://www.bps.org.uk/sites/www.bps.org.uk/files/Accreditation/Clinical%20Accreditation%20Handbook%202019.pdf

Bradbury-Jones, C., Breckenridge, J., Clark, M. T., et al. (2017). The state of qualitative research in health and social science literature: a focused mapping review and synthesis, *International Journal of Social Research Methodology, 20*, 6, pp.627-645.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* no. 2, pp.77-101.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners.* London: SAGE.

Brennan, S. (2019). NHS England and Improvement seek full merger 28 February 2019. Retrieved 13-03-19 from: https://www.hsj.co.uk/policy-and-regulation/nhs-england-and-improvement-seek-full-merger/7024536.article

British Association for Behavioural and Cognitive Psychotherapies [BABCP]. (2014). Bullying culture in the NHS mental health services putting vulnerable patients at risk. Issued: 25th September 2014. BABCP Board. Retrieved 12-11-18 from: https://www.babcp.com/About/Press/Bullying-Culture-in-NHS-Mental-Health-Services-Putting-Vulnerable-Patients-at-Risk.aspx

British Medical Association [BMA]. (2018a). Health and Social Care Act. [Webpage]. Retrieved 02-02-19 from: https://www.bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/nhs-structures-and-integration/hsca

British Medical Association [BMA]. (2018b). *Lost in transit? Funding for mental health services in England*. Retrieved 25-11-18 from: https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/mental-health/funding-mental-health-services

Bruno, I., Didier, E. & Vitale, T. (2014). Statactivism: forms of action between disclosure and affirmation. *Partecipazione e conflitto - PArticipation and COnflict, 7,* no. 2, pp.198-220.

Brunsson, N. (2009). Constructing Organizations: The Example of Public Sector Reform. Chapter in: *Reform as Routine Organizational Change and Stability in the Modern World.* Oxford: Oxford University Press.

Callan, S. & Fry, B. (2012). *Completing the Revolution: Commissioning Effective Talking Therapies.* London: The Centre for Social Justice. Retrieved 31-01-16 from: http://www.centreforsocialjustice.org.uk/UserStorage/pdf/Pdf%20reports/TalkingTherapiesPaper.pdf

Callan, S. (2013). Response to presentations at One-day conference: Social Justice Philanthropy Implications for Practice and Policy. Friday 1 March 2013. National Council for Voluntary Organisations. Retrieved 21-02-19 from: https://www.kent.ac.uk/sspssr/philanthropy/esrc/Samantha%20Callan%20-%20Response.pdf

Callard, F. & Fitzgerald, D. (2015). *Rethinking Interdisciplinarity across the Social Sciences and Neurosciences*. London: Palgrave Macmillan UK.

Care Quality Commission [CQC]. (2018). New approaches to funding, commissioning and regulation needed to meet people’s health and care needs. [Webpage]. 3 July 2018. Retrieved 28-12-18 from: https://www.cqc.org.uk/news/releases/new-approaches-funding-commissioning-regulation-needed-meet-people%E2%80%99s-health-care-needs

Charlton B. G. (2000). The new management of scientific knowledge: a change in direction with profound implications. In: Miles, A., Hampton, J.R. & Hurwitz, B. (eds.). (2000). *NICE, CHI and the NHS reforms: enabling excellence or imposing control?* Aesculapius Medical Press: London. pp.13-32.

Charmaz, K. (2000). Grounded Theory: Objectivist and Constructivist Methods. In: Norman K. Denzin & Yvonna S. Lincoln (Eds.), *Handbook of Qualitative Research*, 2nd edition (pp.509-535). Thousand Oaks, Ca: Sage.

Checkland, K. et al. (2012). Commissioning in the english national health service: What's the problem?. *Journal of Social Policy, 41*, no. 3, pp.533-550.

Chorpita, B.F. & Daleiden, E.L. (2018). Coordinated strategic action: Aspiring to wisdom in mental health service systems. *Clinical Psychology: Science and Practice, 25,* no. 4, pp.e12264-n/a.

Clarke, A., Taylor-Phillips, S., Mills, P. et al. (2013). Evidence-based commissioning in the English NHS: Who uses which sources of evidence? A survey 2010/2011. *Bmj Open*, *3*, no. 5: e002714.

Clark, D. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: The IAPT experience. *International Review of Psychiatry, 23,* no. 4, pp.318-327.

Clark, D. (2017). Improving Access to Psychological Therapies (IAPT) Manual [Powerpoint presentation]. Retrieved 03-02-19 from: https://www.nwppn.nhs.uk/attachments/article/648/David_Clark_2017.pdf

Clark, D. (2018a). A guide to Improving Access to Psychological Therapies services. [Webpage]. 5 June 2018. Retrieved 25-11-18 from: https://www.england.nhs.uk/blog/a-guide-to-improving-access-to-psychological-therapies-services/

Clark, D. (2018b). Realizing the Mass Public Benefit of Evidence-Based Psychological Therapies: The IAPT Program. 19 January 2018. .*Annual Review of Clinical Psychology, 14,* 1.

Clark, D. M., Canvin, L., Green, J. et al. (2018). Transparency about the outcomes of mental health services (IAPT approach): an analysis of public data. *The Lancet, 391*, 10121, pp.679-686.

Clark, D.M., Layard, R., Smithies, R. et al. (2009). Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy, 47*, no. 11, pp.910-920.

Coelho, N. E., & Figueiredo, L. C. (2003). Patterns of Intersubjectivity in the Constitution of Subjectivity: Dimensions of Otherness. *Culture and Psychology, 9,* pp.193-208.

Common, R. (2004). Organisational learning in a political environment: improving policy-making in UK government. *Policy Studies, 25,* pp.35-49.

Cooke, A. & Watts, J. (2016). *We're not surprised half our psychologist colleagues are depressed: Psychological therapists are feeling the strain of time limits and targets, with many suffering from the very problems that they treat patients for.* [News article]. 17 Feb 2016. The Guardian Newspaper. Retrieved 03-05-18 from: https://www.theguardian.com/healthcare-network/2016/feb/17/were-not-surprised-half-our-psychologist-colleagues-are-depressed

Cooper, M. (2013). Experiencing relational depth in therapy: What we know so far. In: *Relational Depth*. Palgrave McMillan, pp.62-76. ISBN 9780230279391. Retrieved 04-01-19 from: https://strathprints.strath.ac.uk/42197/2/2012_RD_research_review_2012_09_05.pdf

Cooper, M. & McLeod, J. (2011). *Pluralistic counselling and psychotherapy*. Los Angeles: Sage.

Copeland, S. (2013). *Counselling Supervision in Organisations: Professional and Ethical Dilemmas Explored*. Florence: Taylor and Francis.

Cornish, F., Campbell, C. & Montenegro, C. (2018). Activism in changing times: reinvigorating community psychology – introduction to the special thematic section. *Journal of Social and Political Psychology*, *6*, 2. pp. 526-542.

Costello, P.J.M. (2003). *Action research.* Continuum, London.

Cotton, E. (2016). *Surviving Work: A survival guide*. [Online publication]. Retrieved 14-05-20 from: http://survivingwork.org/wp-content/uploads/2016/09/Survival-Guide-2016.pdf

Cotton, E. (2017). *Surviving Work in Healthcare: Helpful stuff for people on the frontline.* Abingdon: Routledge.

Court, A.J., Cooke, A. & Scrivener, A. (2017). They're NICE and Neat, but Are They Useful? A Grounded Theory of Clinical Psychologists' Beliefs About and Use of NICE Guidelines. *Clinical Psychology & Psychotherapy, 24,* no. 4, pp.899-910.

Crethar, H. C., Rivera, E. T., & Nash, S. (2008). In search of common threads: Linking multicultural, feminist, and social justice counseling paradigms. *Journal of Counseling and Development, 86*, 269-278. doi:10.1002/j.1556-6678.2008.tb00509.x

Cromby, J. (2006). Fundamental questions for psychology. *Clinical Psychology Forum*, *162,* pp. 9-12.

Crown Commercial Service. (2019). About Crown Commercial Service (CCS). [Webpage]. Retrieved 02-02-19 from: https://www.crowncommercial.gov.uk/about-ccs/

Cuijpers, P., Smit, P., Bohlmeijer, E. et al. (2010). Efficacy of cognitive-behavioural therapy and other psychological treatments for adult depression: meta-analytic study of publication bias. *British Journal of Psychiatry 196*, pp.173-8.

Cukrowicz, K.C. et al. (2011). Improved treatment outcome associated with the shift to empirically supported treatments in an outpatient clinic is maintained over a ten-year period. *Professional Psychology: Research and Practice*, *42,* pp.145-152.

Curry, N. & King's Fund (London, England). (2008). *Practice-based commissioning: Reinvigorate, replace or abandon?* London: King's Fund.

Cutts, L.A. (2013a). Considering a Social Justice Agenda for Counselling Psychology in the United Kingdom. *Counselling Psychology Review, 28,* 2, pp.8-16.

Cutts, L. A. (2013b). *Social Justice in UK Counselling Psychology: Exploring the perspectives' of members of the profession who have a high interest in and commitment to social justice.* A thesis submitted to the University of Manchester for the degree of Doctorate in Counselling Psychology (DCounsPsych) in the Faculty of Humanities. Retrieved 23-03-17 from: https://www.research.manchester.ac.uk/portal/files/54542630/FULL_TEXT.PDF

Dalal, F. (2018a). *CBT: The cognitive behavioural tsunami : politics, power and the corruptions of science*. London: Routledge.

Dalal, F. (2018b). *'How Could They?' Hyper-rational Responsibility and the Ethics of Managerialism*. Video of conference presentation. 3rd Limbus Critical Psychotherapy Conference Toxic Organizations: Retrieved 03-12-18 from: https://www.youtube.com/watch?v=K6tuPUPHZ6I

Dalal, F. (2018c). *Toxic Organizations: Hyper-rationality, Managerialism and the Fetishization of Measurement.* Video of conference presentation. 3rd Limbus Critical Psychotherapy Conference Toxic Organizations: Retrieved 03-12-18 from: http://www.limbus.org.uk/toxicorganizations/Videos.html

Dalingwater, L. (2014). Post-New Public Management (NPM) and the Reconfiguration of Health Services in England. *Observatoire De La Société Britannique,* 51-64. Retrieved 03-12-18 from: https://journals.openedition.org/osb/1714?lang=en

Dan, S. & Pollitt, C. (2015). NPM Can Work: An optimistic review of the impact of New Public Management reforms in central and eastern Europe. *Public Management Review*, *17*, no. 9, pp.1305.

Davies, C. (2007). Grounding Governance in Dialogue? Discourse, Practice and the Potential for a New Public Sector Organizational Form in Britain. *Public Administration*, *85*, no. 1, 2007, pp.47-66.

David, D., Cristea, I. & Hofmann, S.G. (2018). Why Cognitive Behavioral Therapy Is the Current Gold Standard of Psychotherapy. *Frontiers in psychiatry*, *9*, pp.4.

Davidoff F, Dixon-Woods M, Leviton L, et al., (2015) Demystifying theory and its use in improvement. *BMJ Quality and Safety* 2015;*24*: pp.228-238.

Davis, J. & Tallis, R. (2013). *NHS SOS: how the NHS was betrayed - and how we can save it.* London: Oneworld.

Davis, J., Lister, J. & Wrigley, D. (2015). *NHS for Sale: Myths, Lies & Deception*. Chicago: Merlin Press.

Dawson, P. (1994). *Organizational Change: A Processual Approach*. London: Paul Chapman.

DCoP [Division of Counselling Psychology]. (2017). *Professional Practice Guidelines,* Leicester: British Psychological Society. Retrieved 03-04-18 from: http://www.bps.org.uk/sites/default/files/documents/professional_practice_guidelines_-_division_of_counselling_psychology.pdf

DCoP [Division of Counselling Psychology]. (2018). *Strategic Plan 2017-2020.* Leicester: British Psychological Society. Retrieved 12-12-18 from: https://www1.bps.org.uk/networks-and-communities/member-microsite/division-counselling-psychology

Deleuze, G., Guattari, F., & Massumi, B. (2013). *A thousand plateaus*. London: Bloomsbury.

Delgadillo, J., Saxon, D. & Barkham, M. (2018). Associations between therapists' occupational burnout and their patients' depression and anxiety treatment outcomes. *Depression and Anxiety, 35,* no. 9, pp.844-850.

Del Re, A. et al. (2012). Therapist effects in the therapeutic alliance-outcome relationship: A restricted-maximum likelihood meta-analysis. *Clinical Psychology Review, 32,* 7, pp.642-649.

Desai, M. & Hadjiosif, M. (2019). The evolution of the community psychology festival. In: C. Walker, Zlotowitz, S. & Zoli, A. (Eds.). *New ideas for new times: A handbook of innovative community and clinical psychologies* (in preparation). London: Palgrave.

de Lusignan, S., Jones, S., McCrae, N. et al. (2013). *An evaluation of a stepped-care model of psychological therapy for people with long-term conditions and medically-unexplained symptoms*. University of Surrey for IAPT. Retrieved 31-01-16 from: http://epubs.surrey.ac.uk/804165/

Division of Clinical Psychology. (2007a). *Leading Psychological Services.* Leicester: British Psychological Society.

Division of Clinical Psychology. (2007b). *Understanding 'Customer' Needs of Clinical Psychology Services.* Leicester: British Psychological Society.

Division of Clinical Psychology. (2010). *Clinical Psychology Leadership Development Framework.* Leicester: British Psychological Society.

DoH. (1997). *The new NHS: Modern, dependable*. S.l.: Department of Health. Presented to Parliament by the Secretary of State for Health by Command of Her Majesty, December 1997 Cm 3807, published by The Stationery Office: ISBN 0 10 138072 0. Retrieved 23-11-18 from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/266003/newnhs.pdf

DoH. (2003). *Choice of Hospitals. Guidance for PCTs, NHS Trusts and SHAs on offering patients choice of where they are treated.* 15 July 2003. London: Department of Health. Retrieved 23-11-18 from: http://www.nhshistory.net/choiceguidance.pdf

DoH. (2004). *Organising and Delivering Psychological Therapies*. London: Department of Health. Retrieved 23-11-18 from: https://webarchive.nationalarchives.gov.uk/20091106084435/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4086097.pdf

DoH. (2007a). *New Ways of Working for Everyone: A best practice implementation guide.* London: Department of Health. Retrieved 23-04-19 from: https://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_079106.pdf

DoH. (2007b). *New Ways of Working for Everyone Developing and sustaining a capable and flexible workforce*. London: Department of Health. Retrieved 23-04-19 from: https://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074490

DoH. (2008). *IAPT Outline Service Specification: Improving Access to Psychological Therapies Programme (IAPT).* Care Services Improvement Partnership (CSIP) and National Institute for Mental Health in England (NIMHE). Retrieved 12-04-18 from: https://www.uea.ac.uk/documents/246046/11991919/iapt-pathfinder-outline-service-specification.pdf/9fc11891-ecc5-48e4-a974-9bbc8ab0c690

DoH. (2010a). *Equity and excellence: liberating the NHS*. Cm 7881. London: Department of Health. Retrieved 05-10-18 from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf

DoH. (2010b), *Extension of Any Qualified Provider Impact assessment 14/07/2010* IA No: 2026. London: Department of Health. Retrieved 05-10-18 from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216136/dh_128461.pdf

DoH. (2010c). *Liberating the NHS: Greater choice and control - A consultation on proposal.* October 2010. London: Department of Health. Retrieved 28-02-19 from: https://webarchive.nationalarchives.gov.uk/20130105062415/http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_119651

DoH. (2011) *Operational guidance to the NHS: Extending Patient Choice of Provider - Best Practice Guidance.* London: Department of Health. Retrieved 28-02-19 from: https://www.gov.uk/government/publications/operational-guidance-to-the-nhs-extending-patient-choice-of-provider--2

DoH. (2012). *IAPT three-year report. The first million patients*. London: Department of Health. Retrieved 10-07-18 from: from: http://www.mhinnovation.net/sites/default/files/downloads/innovation/reports/Three-year-report.pdf

DoH. (2014). *Examining new options and opportunities for providers of NHS care. The Dalton review*. London: Department of Health. Retrieved 15-01-19 from:: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/384126/Dalton_Review.pdf

DoH Payment by Results Team. (2013). *Mental Health Payment by Results Guidance for 2013-14.* London: Department of Health. Retrieved 13-09-18 from: http://media.dh.gov.uk/network/357/files/2013/02/01-Mental-Health-PbR-Guidance-for-2013-14v2.pdf

Elliott, R. & Zucconi, A. (2006). Doing Research on the Effectiveness of Psychotherapy and Psychotherapy Training: A person-centered/experiential perspective / Forschung zur Effektivität von Psychotherapie und Psychotherapietraining: Eine Personzentrierte/Experienzielle Perspektive / Investigar sobre la eficacia de la psicoterapia y de la formación en psicoterapia: una perspectiva centrada en la persona/experiencial. *Person-Centered & Experiential Psychotherapies, 5*, no. 2, pp.81-100.

Ettelt, S., Mays, N. & Allen, P. (2015). Policy experiments: Investigating effectiveness or confirming direction? *Evaluation, 21*, no. 3, pp.292-307.

Evans, J. (2013). *David Clark on Improving Access for Psychological Therapy (IAPT)* [Online article] Friday, May 31, 2013. Retrieved 24-01-19 from: https://www.philosophyforlife.org/blog/david-clark-on-improving-access-for-psychological-therapy-iapt?rq=David%20Clark%20on%20Improving%20Access%20for%20Psychological%20Therapy%20

Exworthy, M., Berney, L. & Powell, M. (2002). How great expectations in Westminster may be dashed locally': the local implementation of national policy on health inequalities. *Policy & Politics, 30*, no. 1, pp.79-96.

Fairbairn, W. R. D. (1952). *Psychoanalytic studies of the personality*. London: Tavistock Publications.

Feltham, C. (2010). Are Colleges and Universities the Best Place to Train Counsellors? Chapter in: *Critical Thinking in Counselling and Psychotherapy.* Feltham, C. (2010). London: SAGE.

Fine, F. (2016). Just methods in revolting times, *Qualitative Research in Psychology, 13,* 4, pp. 347-365, DOI: 10.1080/14780887.2016.1219800

Fisher, B. (2013). *The dangers of marketisation.* [Online article]. 23 January 2013. HSJ. Retrieved 20-12-18 from: https://www.hsj.co.uk/comment/the-dangers-of-marketisation-/5053782.article

Fitzgerald, D. & Callard, F. (2015). Social Science and Neuroscience beyond Interdisciplinarity: Experimental Entanglements. *Theory, Culture & Society, 32,* 1, pp.3-32.

Flodgren, G., Eccles, M. P., Shepperd, S. et al. (2011). An overview of reviews evaluating the effectiveness of financial incentives in changing healthcare professional behaviours and patient outcomes. *The Cochrane Database of Systematic Reviews, 7.*

Foster, J., & Murphy, A. (2005). *Psychological therapies in primary care: Setting up a managed service*. London, New York: Karnac.

Fotaki, M. (2014). Can consumer choice replace trust in the National Health Service in England? Towards developing an affective psychosocial conception of trust in health care. *Sociology of Health & Illness, 36,* no. 8, pp.1276-1294.

Foucault, M. (1973). *The birth of the clinic: An archaeology of medical perception*. London: Routledge.

Frankland, A., & Walsh, Y. (2005). Counselling Psychology in the NHS. *Mental Health Review Brighton, 10,* 3, pp.31-34.

Fraser, S., & Matthews, S. A. (2008). *The Critical practitioner in social work and health care*. Milton Keynes, U.K: Open University.

Freire, P. (2018). *Pedagogy of the oppressed*. New York: Bloomsbury Academic.

Fuchs, T., & Schlimme, J. (2009). Embodiment and psychopathology: A phenomenological perspective. *Current Opinion in Psychiatry, 22*, 6, pp.570-575. doi:10.1097/YCO.0b013e3283318e5c

Fulford, K.W.M. (2008). Values-based practice: a new partner to evidence-based practice and a first for psychiatry? *Mens sana monographs, 6*, no. 1, pp.10.

Gabe, J., Harley, K. & Calnan, M. (2015). Healthcare choice: Discourses, perceptions, experiences and practices. *Current Sociology, 63*, no. 5, pp.623-635.

Gadamer, H.-G. (1996). *The enigma of health: The art of healing in a scientific age*. Cambridge: Polity Press.

Gaertner, S.L., Dovidio, J.F., Banker, B.S. et al. (2000). Reducing Intergroup Conflict: From Superordinate Goals to Decategorization, Recategorization, and Mutual Differentiation, *Group Dynamics: Theory, Research, and Practice, 4,* no. 1, pp 98-114.

Gale, N. (2016). Leading and Managing. Chapter in: Douglas et al. (2016). *Handbook of Counselling Psychology*. (4th edn.). Los Angeles: Sage.

Gallagher, S. & Payne, H. (2015). The role of embodiment and intersubjectivity in clinical reasoning. *Body, Movement and Dance in Psychotherapy, 10,* no. 1, pp 68-78.

Galvin, K.M. & Todres, L. (2013). *Caring and well-being: a lifeworld approach*. Routledge, Milton Park, Abingdon, Oxon;New York, N.Y.

Gambrill, E. & Littell, J.H. (2010). Do haphazard reviews provide sound directions for dissemination efforts?. *The American psychologist, 65*, no. 9, pp.927-927.

Geyer, R. (2013). The complexity of GP commissioning. *Clinical Governance: An International Journal, 18,* no. 1, pp.49-57.

Gherardi, S. (2008). Situated Knowledge and Situated Action: What do Practice-Based Studies Promise?. In: Barry, D. & Hans Hansen, H., (eds.). (2008). *The SAGE Handbook of New Approaches in Management and Organization.* London: SAGE Publications Ltd. Print ISBN: 9781412912181 Online ISBN: 9781849200394. Retrieved 17-03-19 from: http://dx.doi.org/10.4135/9781849200394.n89

Ghin, P. (2018). The Sick Body: Conceptualizing the Experience of Illness in Senior Leadership. In: Fotaki, M. & Pullen, A. (2018). *Diversity, Affect and Embodiment in Organizing.* Palgrave Macmillan US, Cham.

Gilburt, H. (2015). Mental health under pressure. The King's Fund. Retrieved 13-01-19 from: https://www.kingsfund.org.uk/publications/mental-health-under-pressure

Gilburt, H. et al. (2014). Service transformation Lessons from mental health. The Kings Fund, Retrieved 13-01-19 from: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/service-transformation-lessons-mental-health-4-feb-2014.pdf

Gilbert, P. (2009). Moving beyond cognitive behaviour therapy. The Psychologist. vol 22 no 5, May 2009. Retrieved 23-11-18 from: https://thepsychologist.bps.org.uk/volume-22/edition-5/moving-beyond-cognitive-behaviour-therapy

Gillespie, A. & Cornish, F. (2010). Intersubjectivity: Towards a Dialogical Analysis. *Journal for the Theory of Social Behaviour, 40*, no. 1, pp.19-46.

Giovanella, L. (2016). "Austerity" in the English National Health Service: fragmentation and commodification - examples not to follow. *Cadernos De Saúde Pública, 32*, 7.

Glover-Thomas, N. (2013). The Health and Social Care Act 2012: The emergence of equal treatment for mental health care or another false dawn? *Medical Law International*, *13*, no. 4, pp.279-297.

Glynos, J., Speed, E. & West, K. (2015). Logics of marginalisation in health and social care reform: Integration, choice, and provider-blind provision. *Critical Social Policy*, *35*, no. 1, pp.45-68.

Goldman, S., Brettle, A., & McAndrew, S. (2016). A client focused perspective of the effectiveness of Counselling for Depression (CfD). *Counselling and Psychotherapy Research, 16*, 4, pp.288-297.

Greener, I. (2009). Towards a history of choice in UK health policy. *Sociology of health & illness*, *31*, no. 3, pp.309-324.

Griffiths, S., & Steen, S. (2013a). Improving Access to Psychological Therapies (IAPT) Programme: scrutinising IAPT cost estimates to support effective commissioning. *The Journal of Psychological Therapies in Primary Care, 2*, 2, pp.142-156.

Griffiths S. & Steen S. (2013b). Improving Access to Psychological Therapies (IAPT) programme: setting key performance indicators in a more robust context: a new perspective. *The Journal of Psychological Therapies in Primary Care 2,* pp.133-141.

Griffiths, S., Foster, J., Steen, S & Pietroni, P. (2013). Mental Health's Market Experiment: Commissioning Psychological Therapies Through Any Qualified Provider. Chester: University of Chester Press. Retrieved 31-01-16 from: http://www.chester.ac.uk/cptpc/research/papers

Górzna, S. (2014). Martin Buber father of the philosophy of dialogue. *European Journal of Science and Theology, 10*, 5, pp.45-53.

Guilfoyle, M. (2019). CBT's integration into societal networks of power. In: Jackson, C. & Rizq, R. (2019). *The Industrialisation of Care: counselling, psychotherapy and the impact of IAPT*. Monmouth: PCCS Books.

Guy, A., Loewenthal, D., Thomas, R., & Stephenson, S. (2012). Scrutinising NICE: The impact of the National Institute for Health and Clinical Excellence Guidelines on the provision of counselling and psychotherapy in primary care in the UK. *Psychodynamic Practice, 18,* 1, pp.25-50.

Gyani, A., Shafran, R., Layard, R. & Clark, D.M. (2013). Enhancing recovery rates: Lessons from year one of IAPT. *Behaviour Research and Therapy, 51*, no. 9, pp.597-606.

Habermas, J. (2010). Technical Progress and the Social Life-world. In: Hanks, C. (ed.) (2010). *Technology and values: Essential readings*. Chichester: Wiley-Blackwell.

Habermas, J. (2012). *The theory of communicative action: 2*. Boston, Mass: Beacon Press.

Hadjiosif, M. & Coyle, A. (2017). 'That boy needs therapy': Constructions of psychotherapy in popular song lyrics. *European Journal of Psychotherapy & Counselling*. *19*, 4, pp.357-377.

Ham et al. (2015). *The NHS under the coalition government Part one: NHS.* The King's Fund. Retrieved 31-01-18 from: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/the-nhs-under-the-coalition-government-part-one-nhs-reform.pdf

Ham C (2014). *Reforming the NHS from within: beyond hierarchy, inspection and markets.* London: The King's Fund. Retrieved 15-01-15 from: www.kingsfund.org.uk/publications/reforming-nhs-within

Hamilton, S., Hicks, A., Sayers, R. et al. (2011). *A user-focused evaluation of IAPT services in London. Report for Commissioning Support for London. Rethink, March 2011.* Retrieved 31-01-16 from: https://www.rethink.org/resources/a/a-user-focused-evaluation-of-iapt-services-in-london

Hanley, B., Scott, H. & Priest, H. (2017). The impact of organisational change on professionals working within a Community Mental Health Team (CMHT): a psychodynamic perspective, *Psychoanalytic Psychotherapy, 31*, 2, pp.176-194, DOI: 10.1080/02668734.2017.1315338

Hann, A., Hemming, L., Billsborough, J. et al. (2015). *A Service User Evaluation of the IAPT for SMI Demonstration Sites.* McPin Foundation and NHS England. Retrieved 31-01-16 from: http://mcpin.org/wp-content/uploads/Full-report-from-service-user-evaluation-of-IAPT-for-SMI.pdf

HCPC [Health & Care Professions Council] (2015). *Standards of proficiency – Practitioner psychologists.* Retrieved 14-03-20 from: https://www.hcpc-uk.org/globalassets/resources/standards/standards-of-proficiency---practitioner-psychologists.pdf

Heginbotham, C. (2012). *Values-based commissioning of health and social care,* Cambridge University Press, Cambridge.

Hemsley, C. (2013). An enquiry into how counselling psychology in the UK is constructed as a profession within discipline-oriented publications. *Counselling Psychology Review*, *28*, 1, pp.8-23.

Henton, I. (2012). Practice-based research and counselling psychology: A critical review and proposal. *Counselling Psychology Review British Psychological Society New Series-, 27*, 3, pp.11-28.

Hirvonen, H. (2014). From Embodied to Disembodied Professionalism? Discussing the Implications of Medico-Managerial Management in Welfare Service Work. *Social Policy & Administration, 48,* no. 5, pp.576-593.

Holbrook, J.B. (2013). What is interdisciplinary communication? Reflections on the very idea of disciplinary integration. *Synthese, 190,* no. 11, pp.1865-1879.

Holmes, B.J., Finegood, D. T., Riley, B. L. & Best, A. (2012). Systems Thinking in Dissemination and Implementation Research. In: Brownson, R., Colditz, G. & Proctor, E. (2012). *Dissemination and implementation research in health: Translating science to practice*. Oxford: Oxford University Press.

Hood, C. (1991). A Public Management for all Seasons? *Public Administration*, 69, 1, pp.3-19.

Hood, C., O. James and C. Scott. (2000). Regulation of Government: Has it Increased, is it Increasing, Should it be Diminished?, *Public Administration, 78,* 2, pp.283-304.

Hounslow and Richmond Community Health Care NHS Trust. (2013). *Musculoskeletal Service Patient Experience Audit Report July - September 2013.* Hounslow and Richmond Community Health Care NHS Trust. Retrieved 31-02-18 from: http://www.hrch.nhs.uk/our-services/information-for-gps/aqp-msk-patient-audit-july-september-2013/

Howard, S. (2012). The portable therapist: The challenges for therapists working in primary care settings. *Psychodynamic Practice, 18,* no. 1, pp.93-104.

Howard, R. (2018). Working as a Counselling Psychologist. In: Galbraith, V. (2018). *Counselling psychology*, pp.233-247 Oxon: Routledge.

House of Commons Home Affairs Section. (2013). *Introducing "Payment by Results" in Offender. Rehabilitation and other reforms.* Standard Note: SN/HA/6665. Last updated: 24 October 2013. Retrieved 25-10-18 from http://researchbriefings.files.parliament.uk/documents/SN06665/SN06665.pdf

House of Commons Public Administration Select Committee. (2014). *Whose accountable? Relationships between Government and arm's-length bodies.* House of Commons. Retrieved 24-10-18 from: http://www.publications.parliament.uk/pa/cm201415/cmselect/cmpubadm/110/110.pdf.

House, R. (2016). Alternatives to Managed Care in Research and Practice. In: Lees, J. (2016). *The future of psychological therapy: From managed care to transformational practice*. Hove, East Sussex: Routledge. pp.146-165.

HSCIC [Health and Social Care Information Centre, now NHS Digital]. (2015). *Mental Health Problems*. Report by Sally Bridges. Retrieved 02-12-18 from: http://healthsurvey.hscic.gov.uk/media/37739/HSE2014-Ch2-Mental-health-problems.pdf

Hudson, B. (2018). Citizen accountability in the 'New NHS' in England. *Critical Social Policy, 38*, no. 2, pp. 418-427.

Hunt, J. (2017). *I share Stephen Hawking's passion for the NHS. But he is wrong on our policy*. [Opinion piece]. 27 August 2017. The Guardian Newspaper. Retrieved 28-07-18 from: https://www.theguardian.com/commentisfree/2017/aug/27/stephen-hawking-nhs-wrong-policy-jeremy-hunt

Hunter, D. (2015). Role of politics in understanding complex, messy health systems. *British Medical Journal, 7999*, pp.15-17.

Hui, A., Schatzki, T.R. & Shove, E. (2017). *The nexus of practices: connections, constellations, practitioners,* 1st edn, Routledge, Taylor & Francis Group, London;New York.

Iacobucci, G. (2018). STPs: from sticky toffee puddings to just plain fudge", *BMJ (Clinical research ed.), 360*, pp.k922.

James, P. (2017). Developing Ethical Awareness Whilst Training to Be a Counselling Psychologist. In: Murphy, D. & British Psychological Society. (2017). *Counselling psychology: A textbook for study and practice*. 1st edn., Wiley-Blackwell:GB.

Johnsen, T.J. & Friborg, O. (2015). The effects of cognitive behavioral therapy as an anti-depressive treatment is falling: A meta-analysis. *Psychological Bulletin, 141*, no. 4, pp.747-768.

Johnson, J., Hall, L.H., Berzins, K. et al. (2018). Mental healthcare staff well-being and burnout: A narrative review of trends, causes, implications, and recommendations for future interventions. *International Journal of Mental Health Nursing, 27*, no. 1, pp.20-32.

Johnstone, L. (1993). Psychiatry: are we allowed to disagree? *Clinical Psychology Forum.* 56, pp.30–32.

Jones, L. & Mays, N. (2013). Early experiences of any qualified provider. *British Journal of Healthcare Management*, *19*, 5, pp.217-224.

Jordan, R. (2009). Adapt, research and survive! Taking Counselling Psychology forward into the next decade. *Counselling Psychology Review, 24,* No. 1.

Joseph, S. (2017). Introduction. In: Joseph, S. (2017). *The handbook of person-centred therapy and mental health: Theory, research and practice*. 2nd edition. Monmouth: PCCS Books.

Jovchelovitch, S. (2011). Communicative Action and the Dialogical Imagination. Chapter in: Hook D, Franks B, & Bauer M. (eds.). *The Social Psychology of Communication.* Palgrave MacMillan: Basingstoke.

Kagan, C. et al. (2020). *Critical Community Psychology: Critical Action and Social Change.* (2nd edn.). Abingdon: Routledge.

Katikireddi, S.V., Niedzwiedz, C.L. & Popham, F. (2012). Trends in population mental health before and after the 2008 recession: a repeat cross-sectional analysis of the 1991-2010 Health Surveys of England. *BMJ open*, *2*, no. 5, pp.E001790.

Keating, M. & della Porta, D. (2010). In Defence of Pluralism in the Social Sciences. *European Political Science, 9*, no. S1, pp.S111-S120.

Keefe, A. (2013). Learning From Each Other: Introducing Any Qualified Provider (AQP) Into the Talking Therapies Market in Bristol. *The Journal of Psychological Therapies in Primary Care, 2*, no. 1, pp.19-34.

Kendall, P.C. & Frank, H.E. (2018). Implementing evidence-based treatment protocols: Flexibility within fidelity. *Clinical Psychology: Science and Practice, 25*, no. 4, pp.e12271-n/a.

Khanom, J. (2015). The Unemployment Agenda in Mental Health Services: The Therapist's Perspective. Professional doctorate thesis, University of East London. Retrieved 13-12-18 from: http://roar.uel.ac.uk/4699/

King, M., Marston, L. & Bower, P. (2014). Comparison of non-directive counselling and cognitive behaviour therapy for patients presenting in general practice with an ICD-10 depressive episode: A randomized control trial. *Psychological Medicine, 44*, 9, pp.1835-1844.

King, M.F. & Bruner, G.C. (2000). Social desirability bias: A neglected aspect of validity testing. *Psychology and Marketing, 17*, no. 2, pp.79-103.

Kingdon, J. W. (2014). *Agendas, alternatives, and public policies*. Harlow: Pearson Education Limited.

Kislov, R. (2019). Engaging with theory: From theoretically informed to theoretically informative improvement research. *B M J Quality and Safety, 28*, 3, pp.177- 179.

Krachler, N. & Greer, I. (2015). When does marketisation lead to privatisation? Profit-making in English health services after the 2012 Health and Social Care Act. *Social Science & Medicine, 124*, pp. 215-223.

Kringos, D. S., Boerma, W. G. W., Hutchinson, A. et al. (2010). The breath of primary care: a systematic literature review of its core dimensions. *BMC Health Services Research, 10*, [65]. DOI: 10.1186/1472-6963-10-65.

Kuhlmann, E. (2006). Traces of Doubt and Sources of Trust: Health Professions in an Uncertain Society. *Current Sociology*, *54*, no. 4, pp.607-620.

Küpers, W. M. (2014). *Phenomenology of the embodied organization: The contribution of merleau-ponty for organizational studies and practice*. Basingstone, UK: Palgrave Macmillan.

Küpers, W. (2016). Phenomenology of embodied and artful design for creative and sustainable inter-practicing in organisations. *Journal of Cleaner Production, 135*, pp.1436-1445.

Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectical therapists. In: J. C. Norcross & M. R. Goldfried (Eds.). (1992). *Handbook of psychotherapy integration.* (pp.94-129). New York, NY, US: Basic Books.

Lambert, M.J. & Harmon, K.L. (2018). The merits of implementing routine outcome monitoring in clinical practice. *Clinical Psychology: Science and Practice, 25*, no. 4.

Lapsley, I. (2008). The NPM agenda: Back to the future. *Financial Accountability & Management*, *24*, pp.77-93.

Lavender, T. (2005). English Survey of Applied Psychologists in Health & Social Care and in the Probation & Prison Service. Leicester, UK: British Psychological Society.

Lavender, A. & Hope, R. (2007). *New Ways of Working for Applied Psychologists in Health and Social Care: The End of the Beginning: summary report.* Leicester, UK: British Psychological Society. In: *Mental Health: New Ways of Working for Everyone Developing and sustaining a capable and flexible workforce.* DoH. (2007). Department of Health. Retrieved 15-03-2019 from: https://webarchive.nationalarchives.gov.uk/+/www.../dh_074495.pdf

Layard, R. (2005). *Happiness: Lessons from a new science.* London: Penguin.

Layard, R., & Clark, D. M. (2014). *Thrive: The power of evidence-based psychological therapies*. London: Penguin. Kindle edition previewed. Retrieved 31-01-19 from: https://books.google.co.uk/books?id=tGL5AgAAQBAJ&printsec=frontcover&dq=contents+page+thrive+layard&hl=en&sa=X&ved=0ahUKEwirjaPimeHgAhWp3eAKHcKcCvIQuwUILjAA#v=onepage&q&f=false

Layard, R., Clark, D., Knapp, M. & Mayraz, G. (2007). Cost-benefit analysis of psychological therapy. *National Institute Economic Review, 202*, pp.90-98.

Leader, D. (2008). *A quick fix for the soul*. [News article]. 9 September 2008. The Guardian Newspaper. Retrieved 04-08-18 from: www.theguardina.com/science/2008/sep/09/pschologyhumanbehaviour/

Lederach, J. P. (2010). *The moral imagination: The art and soul of building peace*. Oxford: Oxford University Press.

Lees, J. (2016). *The future of psychological therapy: From managed care to transformational practice*. Hove, East Sussex: Routledge.

Le Grand, J. (1997). Knights, Knaves or Pawns? Human Behaviour and Social Policy. *Journal of Social Policy, 26*, no. 2, pp.149-169.

Leichsenring, F., Abbass, A., Hilsenroth, M. J. et al. (2018). Gold Standards," Plurality and Monocultures: The Need for Diversity in Psychotherapy. *Frontiers in Psychiatry, 9.*

Lempert, L. (2007). Asking Questions of the Data: Memo Writing in the Grounded Theory Tradition. *In:* Bryant, A., & Charmaz, K. (eds.) (2007). *The SAGE handbook of grounded theory*. Los Angeles: SAGE.

Lewin, K. (1960). *Frontiers in group dynamics: Concept, method and reality in social science : social equilibria and social change*. Indianapolis:Ind: Bobbs-Merrill, College Division.

Lewis, A.M. (2012). Organisations adjusting to change: A discussion of the impact of an Improving Access to Psychological Therapies (IAPT) service on the organisational dynamics of an existing psychological therapies department. *Counselling Psychology Review, 27,* no. 1, March 2012.

Light, D. (1995). Countervailing powers: A framework for professions in transition In: Johnson, T., Larkin, G., & Saks, M. (1995). *Health professions and the state in Europe*. London: Routledge.

Lipsky, M. (1980). *Street Level Bureaucracy: Dilemmas of the Individual in Public Services*. Russell Sage Foundation. Retrieved 20-02-19 from http://www.jstor.org/stable/10.7758/9781610447713

Little et al. (2015). *A Health Equity Audit of the Improving Access to Psychological Therapy (IAPT) services in Derbyshire*. Derbyshire County Council. Retrieved 31-01-18 from: https://observatory.derbyshire.gov.uk/IAS/Custom/Resources/HealthandWellbeing/Health_Equity_ Audits/IAPT_HEA_report_feb2015.pdf

Lloyd, J & Pollard, R. (2018). *Cognitive analytic therapy and the politics of mental health*. Abingdon: Routledge.

Long, J.W. (2002). Who's a Pragmatist: Distinguishing Epistemic Pragmatism and Contextualism. *The Journal of Speculative Philosophy, 16,* no. 1, pp.39-49.

Lovell, K., Bower, P., Gellatly, J. et al. (2017). Clinical effectiveness, cost-effectiveness and acceptability of low-intensity interventions in the management of obsessive-compulsive disorder: the Obsessive-Compulsive Treatment Efficacy randomised controlled Trial (OCTET). *Health Technology Assessment. 21*, pp.1-132.

Loughlin, M. (2014). *Debates in values-based practice: Arguments for and against.* Cambridge: Cambridge University Press.

Lubian, K., Weich, S., Stansfeld, S. et al. (eds.) (2014). Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital.

Mackenbach, J.P. (2009). Politics is nothing but medicine at a larger scale: reflections on public health's biggest idea. *Journal of Epidemiology and Community Health (1979-)*, *63,* no. 3, pp.181-184.

Madill, A., Jordan, A. & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, *91,* no. 1, pp.1-20.

Mallinckrodt, B., Miles, J.R. & Levy, J.J. (2014). The scientist-practitioner-advocate model: Addressing contemporary training needs for social justice advocacy. *Training and Education in Professional Psychology*, *8,* no. 4, pp.303-311.

Martin, G.P., McKee, L. & Dixon-Woods, M. (2015). Beyond metrics? Utilizing 'soft intelligence' for healthcare quality and safety. *Social Science & Medicine*, *142,* pp..19-26.

Marzillier, J. (2017). What does success of failure look like? John Marzillier responds to a recent conversation. Online article, 28 November 2017. Retrieved 03-02-19 from: https://thepsychologist.bps.org.uk/what-does-success-or-failure-look

Marziller, J. & Hall, J. (2009). The challenge of the Layard initiative. *The Psychologist, 22*, 5, pp.396-399.

Marzouk, P.K. (2019). *Has 'IAPT' eaten itself?*. Mental Health Today [blog article] 07 January 2019. Retrieved 13-02-19 from: https://www.mentalhealthtoday.co.uk/blog/the-inside-story-of-how-iapt-ate-itself

Mason, M., (2010). Sample Size and Saturation in PhD Studies Using Qualitative Interviews. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 11,* 3, Art. 8, http://nbn-resolving.de/urn:nbn:de:0114-fqs100387.

May, C. & Finch, T. (2009). Implementing, Embedding, and Integrating Practices: An Outline of Normalization Process Theory. *Sociology, 43,* no. 3, pp 535-554.

May, C., Finch, T., Mair, F. et al. (2007). Understanding the implementation of complex interventions in health care: the normalization process model. *BMC health services research*, *7*, no. 1, pp.148-148.

McCafferty, S. et al. (2012). Implementing World Class Commissioning Competencies. *Journal of Health Services Research & Policy, 17*, no. 1_suppl, pp.40-48.

McDaniel, J., Reuben R, Lanham, H.J. & Anderson, R.A. (2009). Implications of complex adaptive systems theory for the design of research on health care organizations. *Health care management review, 34*, no. 2, pp.191.

McDonald, K. M. et al. (2007). *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies*. Technical Review 9 (Prepared by the Stanford University-UCSF Evidence-based Practice Center under contract 290-02-0017). AHRQ Publication No. 04(07)-0051-7. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved 03-03-19 from: https://www.ncbi.nlm.nih.gov/books/NBK44015/

McGonagle, I. (2015). *Transferring new skills and knowledge to practice: A mixed methods case study of Improving Access to Psychological Therapy (IAPT) in a single English region*. PhD thesis, University of Lincoln. Retrieved 05-07-18 from: http://eprints.lincoln.ac.uk/24205/

McHugh, R. K., & Barlow, D. H. (2010). The dissemination and implementation of evidence-based psychological treatments: A review of current efforts. *American Psychologist*, *65*, 2, p.73.

McLeod, J. (2011). *Qualitative research in counselling and psychotherapy.* London: SAGE.

McManus, S., Bebbington, P., Jenkins, R., Brugha, T. (eds.). (2016). *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital.

McNeely, I. F. (2002). *"Medicine on a grand scale": Rudolf Virchow, Liberalism, and the Public Health*. London: Wellcome Trust. Retrieved 21-02-2020 from: Retrieved 20-02-2020 from: https://core.ac.uk/download/pdf/36688109.pdf

McPherson, S., Evans, C. & Richardson, P. (2009). The NICE Depression Guidelines and the recovery model: Is there an evidence base for IAPT? *Journal of Mental Health*, *18*, 5, pp.405-414.

Meltzer, H., Bebbington, P. & Brugha, T. et al. (2013). The relationship between personal debt and specific common mental disorders. *Eur J Public Health*, *23,* 1,pp.108-13.

Mental Health Foundation. (2017). *Surviving or Thriving? The state of the UK's mental health.* Report of survey findings. Retrieved 26-11-18 from: https://www.mentalhealth.org.uk/publications/surviving-or-thriving-state-uks-mental-health

Mental Health Foundation. (2016). *Fundamental Facts About Mental Health 2016.* Mental Health Foundation: London. Retrieved 02-02-19 from: https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-about-mental-health-2016.pdf

Mental Health Taskforce (2015). *The Five Year Forward View Mental Health Taskforce: public engagement findings*. Retrieved 11-07-18 from: https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2015/09/fyfv-mental-hlth-taskforce.pdf

Mental Health Taskforce. (2016). *The Five Year Forward for Mental Health.* Retrieved 11-07-18 from: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Merleau-Ponty, M. (1962). *Phenomenology of Perception*. London: Routledge.

Merrifield, N, & Mahase, E. (2018). *Revealed: How patients referred to mental health services end up back with their GP*. *Pulse* magazine, 2 November 2018. Retrieved 02-02-19 from: http://www.pulsetoday.co.uk/clinical/clinical-specialties/mental-health/revealed-how-patients-referred-to-mental-health-services-end-up-back-with-their-gp/20037700.article

Mofidi, R. & Marrow, C. (2017). The effects of the NHS reforms on quality of care. *British Journal of Healthcare Management, 23,* 3, pp.120-130.

Mol, A. (2008). *The logic of care: Health and the problem of patient choice*. London: Routledge

Mol, A., Moser, I., & Pols, J., (2010). *Care in Practice: On Tinkering in Clinics, Homes and Farms*. Care in Practice. 8. 10.14361/transcript.9783839414477. Retrieved 23-02-19 from: https://www.researchgate.net/publication/241888510_Care_in_Practice_On_Tinkering_in_Clinics_Homes_and_Farms

Moller, N. (2011). The identity of counselling psychology in Britain is parochial, rigid and irrelevant but diversity offers a solution. *Counselling Psychology Review, 26,* 2, pp.8-16.

Mollon, P. (2009). The NICE guidelines are misleading, unscientific, and potentially impede good psychological care and help. *Psychodynamic Practice, 15,* 1, pp.9-24.

Moloney, P. (2013). *The therapy industry: The irresistible rise of the talking cure, and why it doesn't work*. London: Pluto.

Moloney, P. (2000). Counselling Psychology: Are we allowed to disagree? *The Journal of Critical Psychology, Counselling and Psychotherapy.* Winter, 2000: *1*, 4, pp.209-216.

Moloney, P. (2016). Community psychology and the counselling psychologist. Chapter in: Douglas et al. (2016). *Handbook of Counselling Psychology.* (4th edn.). Los Angeles: Sage.

Monitor. (2013). *Guidance on mental health currencies and payment.* NHS England. Retrieved 31-01-16 from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/300864/Guidance_to_mental_health_currencies_and_payment.pdf

Monitor (2015). NHS adult hearing services in England: exploring how choice is working for patients. Retrieved 31-01-16 from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/409273/Adult_hearing_services_-_Monitor_s_report.pdf

Morgan, M.S. (2012). Case Studies: One Observation or Many? Justification or Discovery? *Philosophy of Science, 79,* no. 5, pp.667-677.

Moore, T. & Rae, J. (2009). “Outsiders”: How some counselling psychologists construct themselves. *Counselling Psychology Quarterly*, 22:4, pp.381-392, DOI: 10.1080/09515070903335026

Mrdjenovich, A.J. & Moore, B.A. (2004). The professional identity of counselling psychologists in health care: a review and call for research. *Counselling Psychology Quarterly, 17*, no. 1, pp.69-79.

Murphy, D. (2011). Unprecedented times in the professionalisation and state regulation of counselling and psychotherapy: The role of the higher education institute. *British Journal of Guidance & Counselling, 39,* 3, pp.227-237.

Murray, R. (2019). *The NHS long-term plan: five things you need to know.* The King’s Fund [Blog post] 08 January 2019.. Retrieved 09-02-2019 from: https://www.kingsfund.org.uk/blog/2019/01/nhs-long-term-plan

Mårtensson, P. & Lee, A.S. (2004). Dialogical Action Research at Omega Corporation. *MIS Quarterly*, *28*, no. 3, pp.507-536.

NAPO. (2019). *Capitalism’s undeliable chokehold on our lives.* [Online article] NAPO magazine. 28 February 2019. Retrieved 13-03-19 from: https://www.napomagazine.org.uk/2019/02/28/capitalisms-undeliable-chokehold-on-our-lives/

National Collaborating Centre for Mental Health. (2019). The Improving Access to Psychological Therapies Manual. Gateway reference: 08101 Version number: 2 First published: June 2018. National Collaborating Centre for Mental Health. Retrieved 23-02-19 from: https://www.england.nhs.uk/wp-content/uploads/2019/02/improving-access-to-psychological-therapies-manual.pdf

Naylor, C., Bell, A., & King's Fund. (2010). *Mental health and the productivity challenge: Improving quality and value for money.* London: The King's Fund. Retrieved 31-01-16 from: http://www.kingsfund.org.uk/sites/files/kf/Mental-health-productivity-Chris-Naylor-Andy-Bell-2-December-2010.pdf

Newman, A., Donohue, R., & Eva, N. (2017). Psychological safety: A systematic review of the literature. *Human Resource Management Review, 27*, 3, pp.521-535.

NHS. (1999). *A National Service Framework for Mental Health*. DoH: London. Retrieved 21-02-19 from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198051/National_Service_Framework_for_Mental_Health.pdf

NHS. (2014). *Five year forward view.* London: NHS England. Retrieved 08-10-18 from: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

NHS. (2019). *The NHS Long Term Plan.* Retrieved 08-02-19 from: https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

NHS Cheshire, Warrington and Wirral. (2011). *Extending Patient Choice of Any Qualified Provider - Report from Public Consultation, October 2011.* Retrieved 31-01-16 from: https://www.westcheshireccg.nhs.uk/document_uploads/you-said-we-did/AQPConsultationReportOctober2011.pdf

NHS Digital [previously Health and Social Care Information Centre]. (2013). *Improving Access to Psychological Therapies, Key Performance Indicators (IAPT KPIs) - Final Q4 2012-13* [webpage]. Retrieved 14-02-19 from: https://digital.nhs.uk/data-and-information/publications/statistical/improving-access-to-psychological-therapies-key-performance-indicators-iapt-kpis/improving-access-to-psychological-therapies-key-performance-indicators-iapt-kpis-final-q4-2012-13

NHS Digital. (2013). *Psychological Therapies, Annual Report on the use of IAPT services - England, 2013-14: This is part of Psychological Therapies, Annual Reports on the use of IAPT services Official statistics.* Retrieved 03-02-19 from: https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2012-13

NHS Digital. (2018). *Improving Access to Psychological Therapies (IAPT) Executive Summary (January 2018).* Published 25th April 2018. Retrieved 03-02-19 from: https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2013-14

NHS Digital. (2019). *Improving Access to Psychological Therapies Data Set.* [webpage]. Retrieved 14-03-19 from: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/improving-access-to-psychological-therapies-data-set

NHS Employers. (2018). *Your workforce.* [Webpage]. Retrieved 03-02-19 from: http://www.nhsemployers.org/your-workforce

NHS Employers. (2019). *NHS Health and Wellbeing Framework.* [Webpage]. Retrieved 03-02-19 from: https://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing/health-and-wellbeing-framework.

NHS England. (2013). *Changes to AQP Support for 2014-15.* NHS England Gateway Publication Number: 00837. Retrieved 03-04-15 from: http://www.england.nhs.uk/wp-content/uploads/2013/11/aqp-sup-com-serv.pdf.

NHS England. (2015). *The Future of locally-led commissioning: A Local Payment Example for IAPT.* Retrieved 03-04-17 from: https://www.newsavoypartnership.org/2015presentations/day1/stream-6-a-local-iapt-payment-example.pdf

NHS England. (2016). *Implementing the Five Year Forward View for Mental Health* (gateway ref. 05574). NHS England. Retrieved 14-05-18 from: https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

NHS England. (2017a). *Next Steps on the NHS Five Year Forward View*. Retrieved 13-02-18 from: https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/

NHS England. (2017b). *Stepping forward to 2020/21: The mental health workforce plan for England July 2017.* Retrieved 13-02-18 from: https://www.hee.nhs.uk/sites/default/files/documents/Stepping%20forward%20to%20202021%20-%20The%20mental%20health%20workforce%20plan%20for%20england.pdf

NHS England. (2018). *Commissioning for Quality and Innovation (CQUIN).* Retrieved 28-12-18 from: https://www.england.nhs.uk/wp-content/uploads/2018/04/cquin-guidance-2018-19.pdf

NHS England. (2019). *Adult Improving Access to Psychological Therapies programme.* [Webpage]. Retrieved 24-04-2019 from: https://www.england.nhs.uk/mental-health/adults/iapt/

NHS England & Health Education England. (2016). *2015 Adult IAPT Workforce Census Report.* Retrieved 18-11-18 from https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/09/adult-iapt-workforce-census-report-15.pdf

NHS England & NHS Improvement. (2016). *Linking quality and outcome measures to payment for mental health Technical guidance* [pdf]. Retrieved 24-04-2019 from: https://improvement.nhs.uk/documents/493/Linking_quality_and_outcome_measures_to_payment_for_mental_health_FINAL.pdf

NHS England & NHS Improvement. (2017). *Developing an outcomes based payment approach for IAPT services*. NHS England publication. Retrieved 23-04-18 from: https://improvement.nhs.uk/documents/661/IAPT_Payment_Guidance.pdf

NHS England & NHS Improvement. (2018). *Paying for quality and outcomes: IAPT case studies.* A joint publication by NHS England and NHS Improvement. https://www.england.nhs.uk/wp-content/uploads/2018/04/iapt-payment-casestudy.pdf

NHS Improvement. (2019a). *Clinical leadership –-a framework for action: A guide for senior leaders on developing professional diversity at board level.* Retrieved 09-01-19 from: https://improvement.nhs.uk/resources/clinical-leadership-framework-action/

NHS Improvement. (2019b). *New payment approaches for mental health services.* [Webpage] Retrieved 24-04-2019 from: https://improvement.nhs.uk/resources/new-payment-approaches/

NHS Providers. (2018). *The state of the NHS provider sector: The mental health provider challenge.* [Webpage]. Retrieved 16-11-18 from: https://nhsproviders.org/state-of-the-provider-sector-07-17/the-mental-health-provider-challenge

NHS Providers. (2019). *Briefing paper: The NHS long term plan.* [Briefing paper] 7 January 2019. Retrieved 20-02-19 from: https://nhsproviders.org/media/605845/nhs-long-term-plan-nhs-providers-on-the-day-briefing-7-january-2019.pdf

NICE [National Institute for Clinical Excellence]. (2018). *What we do.* [Webpage]. Retrieved 03-10-18 from: https://www.nice.org.uk/about/what-we-do

Nicholson, B. C., & Madson, M. B. (2015). Introduction to the special issue: Science-practice integration in counseling psychology training: Trends and models. *Counselling Psychology Quarterly, 28*, 3, pp.215-219.

Norcross, J. C. (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. New York: Oxford University Press.

O'Brien, B.C., Harris, I.B., Beckman, T.J. et al. (2014). Standards for Reporting Qualitative Research: A Synthesis of Recommendations", *Academic Medicine, 89,* no. 9, pp.1245-1251.

OED Online. (2019). *"applied, adj."*. [Web page]. Oxford English Dictionary Online entry. Oxford University Press. Retrieved 19-03-2019 from: http://www.oed.com/view/Entry/9713?redirectedFrom=applied+psychology#eid121980452

Ogrinc, G., Davies, L., Goodman, D. et al. (2015). Squire 2.0 (standards for quality improvement reporting excellence): Revised publication guidelines from a detailed consensus process. *American Journal of Critical Care, 24,* no. 6, pp.466-473.

Oliver, D. (2018). Constant structural reorganisation won't improve or transform healthcare. *BMJ,* 2018; *361. doi:* https://doi.org/10.1136/bmj.k2433

Onwuegbuzie, A.J. & Leech, N.L. (2004). Enhancing the interpretation of "significant" findings: the role of mixed methods research. *The Qualitative Report, 9,* no. 4, pp.770.

Onyett, S (2007). New Ways of Working for Applied Psychologists in Health and Social Care Working Psychologically in Teams. Leicester: British Psychological Society.

Orlans, V. & Van Scoyoc, S. (2009). *A short introduction to counselling psychology*. Los Angeles: SAGE.

Osborne, S.P. (2017). Public management research over the decades: what are we writing about? *Public Management Review, 19,* no. 2, pp.109-113.

Osipovič, D., et al. (2016). Interrogating Institutional Change: Actors' Attitudes to Competition and Cooperation in Commissioning Health Services in England. *Public Administration*, *94,* no. 3, 2016, pp.823-838.

Owens, J. (2015). Creating an impersonal NHS? Personalization, choice and the erosion of intimacy. *Health Expectations, 18,* 1, 22-31.

Oxman, A.D., Sackett, D.L., Chalmers, I., & Prescott, T.E. (2005). A surrealistic mega-analysis of redisorganization theories. *J R Soc Med*, 2005, *98*, pp.563-8.

Palinkas, L.A. (2014). Qualitative and Mixed Methods in Mental Health Services and Implementation Research. *Journal of Clinical Child & Adolescent Psychology, 43*, no. 6, pp.851-861.

Palinkas, L.A., Horwitz, S.M., Green, C.A. et al. (2015). Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research. *Administration and Policy in Mental Health and Mental Health Services Research, 42,* no. 5, pp.533-544.

Parry, G., Barkham, M., Brazier, J. et al. (2011). *An Evaluation of a New Service Model: Improving Access to Psychological Therapies Demonstration Sites 2006-2009*. London: HMSO. Retrieved 31-01-16 from: http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1610-154_V01.pdf

Patterson, T. (2017) Assessing efficacy and effectiveness in person-centred therapy. In Joseph, S. (2017). *The handbook of person-centred therapy and mental health: Theory, research and practice*. 2nd edition. Monmouth: PCCS Books

Peacock-Brennan, S. (2016). *A genealogical investigation of the conditions of possibility for the emergence of Improving Access to Psychological Therapies (IAPT) services*. University of East London Professional Doctorate Thesis.

Peckham, S., Mays, N., Hughes, D. et al. (2012). Devolution and Patient Choice: Policy Rhetoric versus Experience in Practice. *Social Policy & Administration*, *46*, no. 2, pp.199-218.

Petrosyan, Y., Sahakyan, Y., Barnsley, J. M. et al. (2017). Quality indicators for care of depression in primary care settings: a systematic review. *Systematic Reviews*, *6*, 1, pp.1-14.

Phillippi, J. & Lauderdale, J. (2018). A Guide to Field Notes for Qualitative Research: Context and Conversation, *Qualitative Health Research, 28*, no. 3, pp.381-388.

Pilgrim, D. (2008). Reading 'Happiness': CBT and the Layard thesis, *European Journal of Psychotherapy and Counselling, 10,* 3, pp.247-260. DOI: 10.1080/13642530802337967.

Pitchforth, J., Fahy, K., Ford, T. et al. (2018). Mental health and well-being trends among children and young people in the UK, 1995-2014: analysis of repeated cross-sectional national health surveys, *Psychological medicine*, *2018*, pp.1-11.

Plsek, P. & Greenhalgh, T. (2001). Complexity science: The challenge of complexity in health care. *British Medical Journal.* 2001, *323*, 7313, pp.625-628.

Pollard, R. (2011). Ethics in practice: a critical appreciation of Mikhail Bakhtin's concept of "outsideness" in relation to responsibility and the creation of meaning in psychotherapy. *American journal of psychotherapy, 65,* no. 1, pp.1.

Pollock, A.M. & Roderick, P. (2018). Why we should be concerned about accountable care organisations in England's NHS. *BMJ (Clinical research ed.), 360*, pp.k343.

Proctor, E.K. et al. (2009). Implementation Research in Mental Health Services: an Emerging Science with Conceptual, Methodological, and Training challenges. *Administration and Policy in Mental Health and Mental Health Services Research, 36,* no.1, pp.24-34.

Pryce, Helen, et al. (2016). A Qualitative Investigation of Decision Making during Help-Seeking for Adult Hearing Loss. *International Journal of Audiology*, *55,* no.11, 2016, pp.658-665.

Public Accounts Committee. (2017). *Public Accounts Committee Oral evidence: Integrated Health and Social Care,* House of Commons. HC 959. Monday 27 February 2017. Retrieved 07-06-18 from: http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/public-accounts-committee/integrated-health-and-social-care/oral/48009.pdf

Public Health England. (2019a). Common Mental Health Disorders - Prevalence. (GP patient survey data). Online webpage. Retrieved 28-11-18 from: https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/data#page/0/gid/8000026/pat/46/par/E39000046/ati/154/are/E38000010/iid/90647/age/168/sex/4

Public Health England. (2019b). Public Health Profiles. Online webpage. Retrieved 28-02-19 from: https://fingertips.phe.org.uk/search/iapt#page/11/gid/1/pat/46/par/E39000046/ati/154/are/E38000010

Pugh, D. & Coyle, A. (2000). The construction of counselling psychology in Britain: a discourse analysis of counselling psychology texts. *Counselling Psychology Quarterly, 13,* 1, pp.85-98.

Pybis, J., Saxon, D., Hill, A., & Barkham, M. (2017). The comparative effectiveness and efficiency of cognitive behaviour therapy and generic counselling in the treatment of depression: evidence from the 2nd UK National Audit of psychological therapies. *Bmc Psychiatry, 17,* no.1, pp.1-13.

Pym, H., (2014). *The very public NHS privatisation debate*. BBC news article. 31 July, 2014. Retrieved 31-01-16 from: http://www.bbc.co.uk/news/health-28581878

Quality and Outcomes Framework [QOF]. (2017). *Quality and Outcomes Framework Prevalence, Achievements and Exceptions Report, England, 2016-2017.* Published 26 October 2017. Retrieved 23-11-18 from: https://files.digital.nhs.uk/publication/c/r/qof-1617-rep.pdf

QualityWatch. (2018). *Improving Access to Psychological Therapies (IAPT) programme: We explore how well people can access the IAPT programme*. Indicator Last updated: 09/10/2018. Retrieved 15-12-18 from: https://www.nuffieldtrust.org.uk/resource/improving-access-to-psychological-therapies-iapt-programme

Quicke, J. (2000). A new professionalism for a collaborative culture of organizational learning in contemporary society. *Educational Management Administration & Leadership, 28,* 3, pp.299-315.

Radhakrishnan, M., Hammond, G., Jones P. B. et al. (2013). Cost of Improving Access to Psychological Therapies (IAPT) programme: an analysis of cost of session, treatment and recovery in selected Primary Care Trusts in the East of England region. *Behaviour Research and Therapy*, *51*, pp.37-45. Retrieved 16-04-17 from: www.sciencedirect.com/science/article/pii/S0005796712001556

Rao, A.S., Bhutani, G., Dosanjh, N. et al. (2016). *Psychological Wellbeing & Resilience Resetting The Balance*. [Online]. Retrieved 05-08-18 from: https://www1.bps.org.uk/system/files/Public%20files/ar_v10_resetting_the_balance_160516.docx.pdf

Reay, T. & Hinings, C.R. (2009). Managing the Rivalry of Competing Institutional Logics. *Organization Studies, 30,* no. 6, pp.629-652.

Rees, J. (2013). Public sector commissioning and the third sector: Old wine in new bottles? *Public Policy and Administration*, *29*, no. 1, pp. 45-63.

Reichertz, J. (2007). Abduction: The Logic of Discovery of Grounded Theory, *In:* Bryant, A., & Charmaz, K. (eds.) (2007). *The SAGE handbook of grounded theory*. Los Angeles: SAGE.

Repko, A. F. & Szostak, R. (2017). *Interdisciplinary research: process and theory*. Third edn. Los Angeles: Sage.

Rick, J., Hutten, R., Chambers, E. et al. (2010). *Implementing IAPT: lessons from the demonstration sites.* Project Report. NIHR Service Delivery and Research Organisation. Retrieved 05-05-2017 from: https://www.sheffield.ac.uk/polopoly_fs/1.120445!/file/IAPT-Interim-Report.pdf

Ritzer, G. (1993). *The McDonaldization of Society*. Pine Forge, London.

Rizq, R. (2012a). The perversion of care: Psychological therapies in a time of IAPT. *Psychodynamic Practice*, *18*, no. 1, pp 7-24.

Rizq, R. (2012b). The Ghost in the Machine: IAPT and Organizational Melancholia. *British Journal of Psychotherapy*, *28,* no. 3, pp.319-335.

Rizq, R.(2014). Perversion, neoliberalism and therapy: The audit culture in mental health services. *Psychoanalysis, Culture & Society, 19*, no. 2, pp.209-218.

Rogers, E. (2009). The need for reappraising psychological therapies in the light of IAPT. *The Journal of Mental Health Training, Education and Practice, 4*, no. 1, pp.19-26.

Rogers, A. & Murphy, D. (2017). Person-centred therapy and the regulation of counsellors and psychotherapists in the UK, In: Joseph, S. (2017). *The handbook of person-centred therapy and mental health: Theory, research and practice*. 2nd edn. Monmouth: PCCS Books.

Rogers, A. & Pilgrim, D. (2003). *Mental health and inequality*. Basingstoke, Hampshire, UK: Palgrave.

Ruzzene, A., Reiss, J. M., & Vromen, J. J. (2014). *Using case studies in the social sciences: Methods, inferences, purposes*. Doctoral thesis. University Rotterdam. Retrieved 02-02-19 from: https://repub.eur.nl/pub/77842/USING-CASE-STUDIES-IN-SOCIAL-SCIENCES.pd

Sainty, A. (2015). *Should IAPT services be included in the AQP framework?* Debate, article 1: Northern IAPT Practice Research Network. Retrieved 03-03-18 from: https://www.iaptprn.com/uploads/3/9/8/5/39859781/debate_aqp_feb2015_results.pdf

Salvatore, S., Tschacher, W., Gelo, O.C.G. & Koch, S.C. (2015). Editorial: Dynamic systems theory and embodiment in psychotherapy research. A new look at process and outcome. *Frontiers in psychology, 6*, pp.914.

Samuels, A., & Veale, D. (2009). Improving access to psychological therapies: For and against. *Psychodynamic Practice, 15*, 1, pp.41-56.

Saxon, D. et al. (2017). A pragmatic randomised controlled trial assessing the non-inferiority of counselling for depression versus cognitive-behaviour therapy for patients in primary care meeting a diagnosis of moderate or severe depression (PRaCTICED): Study protocol for a randomised controlled trial. *Trials, 18*, no.1, pp.93.

Scanlon, C. (2015). On the perversity of an imagined psychological solution to very real social problems of unemployment (work-lessness) and social exclusion (Worth-lessness): A Group Analytic Critique. *Group Analysis*. *48*, 1, pp.31-44.

Schoenwald, S.K. (2018). What are we even trying to implement: A Commentary. *Clinical Psychology: Science and Practice, 25*, no. 4, pp. e12263-n/a.

Schön, D. A. (2013). *The reflective practitioner: How professionals think in action*. Farnham: Ashgate.

Senior, B. (2002). *Organisational change*. Harlow: Financial Times Prentice Hall.

Shean, G. (2014). Limitations of Randomized Control Designs in Psychotherapy Research. *Advances in Psychiatry, vol. 2014,* Article ID 561452, 5 pages. Retrieved 15-06-18 from: https://doi.org/10.1155/2014/561452

Simonet, D. (2015). The New Public Management Theory in the British Health Care System: A Critical Review. *Administration and Society, 47,* 7, pp.802-826.

Shield, T., Campbell, S. & Rogers, A. et al. (2003). Quality indicators for primary care mental health services. *BMJ Quality & Safety 2003*. *12*: pp.100-106.

Sherif, M. (1958). Superordinate Goals in the Reduction of Intergroup Conflict", *American Journal of Sociology, 63,* no. 5, pp.349.

Silverman, D., & Marvasti, A. B. (2008). *Doing qualitative research: A comprehensive guide*. London: SAGE.

Singh, G., Owens, J. & Cribb, A. (2017). What Are the Professional, Political, and Ethical Challenges of Co-Creating Health Care Systems?. *AMA journal of ethics, 19,* no. 11, pp.1132-1138.

Skelcher, C. & Smith, S.R., (2015). Theorizing Hybridity: Institutional Logics, Complex Organizations, and Actor Identities: The Case of Nonprofits. *Public Administration 93,* no. 2, pp.433-448.

Smail, D. (2005). *Power, Interest and Psychology: Elements of a Social-Materialist Understanding of Distress*. Ross-On-Wye: PCCS Books.

Smith, H., Moller, N.P. & Vossler, A. (2017). Family therapy 'lite'? How family counsellors conceptualise their primary care family work. *British Journal of Guidance & Counselling, 45,* no. 5, pp.562-572.

Smith, J., Curry, N., Mays, N. & Dixon, D. (2010). *next for commissioning in the English NHS?*. Report for Nuffield Trust for Research and Policy Studies in Health Services & King Edward's Hospital Fund for London. London: The Nuffield Trust. Retrieved 24-01-19 from: https://www.nuffieldtrust.org.uk/files/2017-01/where-next-commissioning-english-nhs-web-final.pdf

Smyth, C. (2020). *No 10 power grab for NHS sparks backlash over 'turf war'*. [News article]. 8 February 2020. The Times Newspaper. Retrieved 25-05-20 from: https://www.thetimes.co.uk/article/no-10-power-grab-for-nhs-sparks-backlash-over-turf-war-wfbdn8f3m

Soth, M. (2007). Embracing the paradigm clash between the 'medical model' and counselling. *Therapy Today, 18,* Issue 10.

Speed, E., & Gabe, J. (2013). The Health and Social Care Act for England 2012: The extension of 'new professionalism'. *Critical Social Policy, 33,* 3, pp.564-574.

Speight, S. L. & Vera, E. M. (2004). A social justice agenda: Ready, or not? *The Counseling Psychologist, 32,* 1, pp.109-118. doi:10.1177/0011000003260005

Stacey, R. D. (2010). *Complex responsive processes in organizations: Learning and knowledge creation*. London: Routledge.

Stansfeld, S., Clark, C., Bebbington, P. et al. (2014). Common mental disorders. Chapter in: McManus, S., Bebbington, P., Jenkins, R. & Brugha, T. (eds). (2016). *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital. Retrieved 24-11-18 from: https://files.digital.nhs.uk/pdf/t/6/adult_psychiatric_study_ch2_web.pdf

Steel, C., Macdonald, J., Schröder, T. & Mellor-Clark, J. (2015). Exhausted but not cynical: burnout in therapists working within Improving Access to Psychological Therapy Services. *Journal of Mental Health, 24,* no. 1, pp 33-37.

Steen, S. A. (2015). *Understanding the processes involved in implementing an improving access to psychological therapies service: An exploratory study that investigates practitioner and client experience regarding its effect on patient pathways, service design and overall outcomes.* (Doctoral dissertation). University of Chester, United Kingdom.

Stratton, P. (2009). A mediocre performance The emphasis on cognitive behaviour therapy is sourcing efforts to widen access to psychological services. *Mental Health Practice, 13,* 3, pp.12-14.

Strawbridge, S. & Woolfe, R. (2010). Counselling psychology: origins, developments and challenges. In: Woolfe, R., Strawbridge, S., Douglas, B. & Dryden, W. (eds.) (2010). *Handbook of Counselling Psychology,* 3rd ed., London: Sage. pp.3-22.

Szostak, R., (2012). The Interdisciplinary Research Process. In: Repko, A. F., Newell, W. H., & Szostak, R. (2012). *Case studies in interdisciplinary research,* SAGE, London;Los Angeles, [Calif.];.

Tapson, C. (2016). Counselling and professionalism: A phenomenological analysis of counsellor experience. *The European Journal of Counselling Psychology, 4*, no. 2, pp.148-165.

Tasma, M., Swart, M., Wolters, G. et al. (2016). Do routine outcome monitoring results translate to clinical practice? A cross-sectional study in patients with a psychotic disorder", *BMC Psychiatry, 16*, no. 106, pp.107.

Taylor, M. (2001) Partnership: Insiders and Outsiders. Chapter in: Harris, M., & Rochester, C. (2001). *Voluntary organisations and social policy in Britain: Perspectives on change and choice*. Basingstoke: Macmillan.

Thatcher, M. & Manktelow, K. (2007). The cost of individualism. *Counselling Psychology Review, 22,* 4, pp.31-43.

The Economist. (2017). Policy transplant; The National Health Service. *The Economist*, vol. 425, no. 9065, pp. 56. Retrieved 04-08-18 from: https://www.economist.com/britain/2017/11/02/is-this-the-end-of-the-nhss-internal-market

The Health Foundation, The King’s Fund & Nuffield Trust. (2018). The health care workforce in England: make or break? Retrieved 23-02-19 from: https://www.kingsfund.org.uk/sites/default/files/2018-11/The%20health%20care%20workforce%20in%20England.pdf

The New Savoy Partnership. (2015). *NSP/BPS Staff Wellbeing Charter*. [Web page]. Retrieved 23-08-2020 from: https://www.healthcareconferencesuk.co.uk/conferences-masterclasses/subjects/psychological-therapies-new-savoy-partnership

The New Savoy Partnership. (2016). *New Savoy Conference Media Media Release.* Retrieved 03-01-19 from: https://www.nwppn.nhs.uk/attachments/article/1094/New_Savoy_Conference_Media_Release.pdf

Thompson, M. (2007). Exploring the trainees’ view of a socio-political approach within UK clinical psychology. *Journal of Community and Applied Social Psychology, 17*, pp. 67-83.

Thorlby, R., Smith, J., Williams, S. & Dayan, M. (2014). *The Francis Report: one year on The response of acute trusts in England. Research report.* Nuffield Trust. Retrieved 30-05-20 from: https://www.nuffieldtrust.org.uk/files/2017-01/francis-report-one-year-on-web-final.pdf

Timmins, N. (2012). *Never again? The story of the Health and Social Care Act 2012 – A study in coalition government and policy making.* London: The King’s Fund and the Institute for Government. Retrieved 15-01-15 from: www.kingsfund.org.uk/publications/never-again

Timmins, N. (2017a). *Commissioning: barking up the wrong tree? [*Blog post]. The King’s Fund. Retrieved 08-08-2018 from: https://www.kingsfund.org.uk/blog/2017/06/commissioning-barking-wrong-tree

Timmins, N. (2017b). *‘Teflon’ Jeremy Hunt and the de-politicisation of the NHS.* [Blog post]. The King’s Fund. Retrieved 08-08-2018 from: https://www.kingsfund.org.uk/blog/2017/02/teflon-jeremy-hunt-and-depoliticisation-of-nhs

Timmins, N. (2018). *The Lansley reforms succeeded in unintended ways* Policy and Regulation HSJ online article. 24 May 2018. Retrieved 17-03-2019 from: https://www.hsj.co.uk/policy-and-regulation/the-lansley-reforms-succeeded-in-unintended-ways/7022483.article

Todnem, R. (2005). Organisational Change Management: A Critical Review. *Journal of Change Management,* 5, 4, pp.369-380.

Todres, L., Galvin, K. T., & Dahlberg, K. (2014). “Caring for insiderness”: Phenomenologically informed insights that can guide practice. *International Journal of Qualitative Studies on Health and Well-Being, 9,* 1, 21421.

Tong, A., Sainsbury, P. & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19,* no. 6, pp.349-357.

Tudor, K., & Worrall, M. (2006). *Person-centred therapy: A clinical philosophy*. London: Routledge, an imprint of Taylor & Francis Books Ltd.

Turner, J. et al. (2015). The History of Mental Health Services in Modern England: Practitioner Memories and the Direction of Future Research. *Medical History, 59,* 4, pp.599-624.

Turpin, G. (2009). The future world of psychological therapies: Implications for counselling and clinical psychologists. *Counselling Psychology Review*, *24,* No. 1.

University of York (2017) The Improving Access to Psychological Therapies Manual DRAFT . Retrieved 24-06-18 from: https://www.york.ac.uk/healthsciences/pc-mis/news-articles/IAPT%20Manual_30OCT17.pdf

van Dijk, T. (2007). The study of discourse: an introduction. In: Teun A.van Dijk (ed.). (2007). *Discourse Studies. 5 vols. Sage Benchmarks in Discourse Studies.* (pp. xix-xlii). London: Sage. Retrieved 31-01-19 from: http://www.discourses.org/download/articles/

van Ingen, D.J., Freiheit, S.R. & Vye, C.S. (2009). From the lab to the clinic: effectiveness of cognitive-behavioral treatments for anxiety disorders. *Professional Psychology: Research and Practice*, *40,* pp 69-74.

Vaughan C. (2011). Dialogue, critical consciousness and praxis. Chapter in: Hook D, Franks B, & Bauer M. (eds.). *The Social Psychology of Communication.* Palgrave MacMillan: Basingstoke.

Verhaeghe, P. & Hedley-Prôle, J. (2014). *What about Me? : The Struggle for Identity in a Market-Based Society,* Scribe Publications, Brunswick, Victoria.

von Elm, E., Altman, D.G., Egger, M. et al. (2007). *The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) Statement: Guidelines for Reporting Observational Studies*. Public Library of Science.

Vos, T., Haby, M. M. & Magnus, A. et al. (2005). Assessing cost-effectiveness in mental health: helping policy-makers prioritize and plan health services. *Australian and New Zealand Journal of Psychiatry, 39,* 8, pp.701-712.

Walker, C., Artaraz, K., Darking, M. et al. (2018). Building spaces for controversial public engagement – Exploring and challenging democratic deficits in NHS marketization. *Journal of Social and Political Psychology, 6*, 2, pp.759-775.

Walklet, E., & Percy, C. (2014). Stress and Coping in IAPT Staff: a Mixed Methods Study. *Applied Psychological Research Journal, 2014,* pp.15-25.

Waller, G., & Turner, H. (2016). Therapist drift redux: Why well-meaning clinicians fail to deliver evidence-based therapy, and how to get back on track. *Behaviour research and therapy, 77*, pp.129-137.

Walumbe, J., Swinglehurst, D. & Shaw, S. (2016). Any qualified provider: a qualitative case study of one community NHS Trust's response. *BMJ open,* vol. 6, no. 2, pp. e009789.

Wampold, B. E. (2001). The great psychotherapy debate: Models, methods, and findings. Mahwah, NJ, US: Lawrence Erlbaum Associates Publishers.

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry, 14,* 3, pp.270-277.

Wang, R.. (2016). *Evaluating the implementation of Payment by Results in mental health services: A case study of Nottingham*. Thesis (Ph.D.). University of Nottingham, 2016. Retrieved 16-11-18 from: http://eprints.nottingham.ac.uk/35749/.

Watson, J. C., & Bohart, A. (2015). Humanistic-Experiential Therapies in the Era of Managed Care. 503-518. In: Schneider, K., J., Fraser, J. P. & Bugental, J., F., T. (eds.). (2015). *The Handbook of Humanistic Psychology: Theory, Research, and Practice*. pp.585-600. Los Angeles [California]: Sage. DOI: http://dx.doi.org/10.4135/9781483387864.n47

Watts, J. (2016). IAPT and the Ideal Image. In: Lees, J. (2016). *The future of psychological therapy: From managed care to transformational practice*. Hove, East Sussex: Routledge.

Webb, C. A., DeRubeis, R. J., & Barber, J. P. (2010). Therapist Adherence/Competence and Treatment Outcome: A Meta-Analytic Review. *Journal of Consulting and Clinical Psychology*, *78*, 2, pp.200-211.

Wenger, E. (1998). *Communities of practice: learning, meaning, and identity*. Cambridge: Cambridge University Press.

Wesson, M. & Gould, M. (2010). Can a ‘return-to-work’ agenda fit within the theory and practice of CBT for depression and anxiety disorders? *The Cognitive Behaviour Therapist, 3,* no. 1, pp.27.

West, D. (2017). The Commissioner: Next steps for STPs, part 1 – towards accountable care, *Health Service Journal*. Retrieved 08-07-18 from: https://www-hsj-co-uk.ezproxy.uwe.ac.uk/commissioning/the-commissioner-next-steps-for-stps-part-1-towards-accountable-care/7016284.article

Westra, D., Angeli, F., Carree, M. & Ruwaard, D. (2017). Coopetition in health care: A multi-level analysis of its individual and organizational determinants. *Social Science & Medicine*, *186*, pp.43-51.

Westwood, S., Morison, L., Allt, J., & Holmes, N. (2017). Predictors of emotional exhaustion, disengagement and burnout among improving access to psychological therapies (IAPT) practitioners. *Journal of Mental Health, 26,* 2, pp.172-179.

Williams, D. (2014). *Exclusive: CCG interest in 'any qualified provider' scheme dwindles. HSJ.* Retrieved 31-01-16 from: http://www.hsj.co.uk/sectors/commissioning/exclusive-ccg-interest-in-any-qualified-provider-scheme-dwindles/5074585.fullarticle

Willig, C. (2001). *Introducing qualitative research in psychology. Adventures in theory & method*. Buckingham, Phil: Open Univ. Press.

Willig, C. (1999). Beyond appearances: A critical realist approach to social constructionism. In: D. J. Nightingale & J. Cromby (eds.), *Social constructionist psychology: A critical analysis of theory and practice.* (pp.37-51). Buckingham, UK: Open University Press.

Wiltsey Stirman, S. & Comer, J. S. (2018). What are we even trying to implement? Considering the relative merits of promoting evidence-based protocols, principles, practices, or policies. *Clinical Psychology: Science and Practice. 25,* 4.

Winter, L. A. (2015). The Presence of Social Justice Principles Within Professional and Ethical Guidelines in International Psychology. *Psychotherapy and Politics International, 13,* 1, pp.55-66.

Woolf, S.H., Grol, R., Hutchinson, A. et al. (1999). Clinical Guidelines: Potential Benefits, Limitations, and Harms of Clinical Guidelines. *BMJ: British Medical Journal, 318,* no. 7182, pp.527-530.

World Health Organisation. (2019). *Health topics: Health policy.* [web page]. Retrieved 20-02-2019 from: https://www.who.int/topics/health_policy/en/

Worsley, R. (2017). Small-scale research as personal development for mental health professionals., In Joseph, S. (2017). *The handbook of person-centred therapy and mental health: Theory, research and practice*. 2nd edition. Monmouth: PCCS Books.

Zlatev, J., Blomberg, J. & Lund University, Cognitive Semiotics & Lunds universitet. (2016). Embodied intersubjectivity, sedimentation and non-actual motion expressions. *Nordic Journal of Linguistics. 39*, 2, pp.185-208.

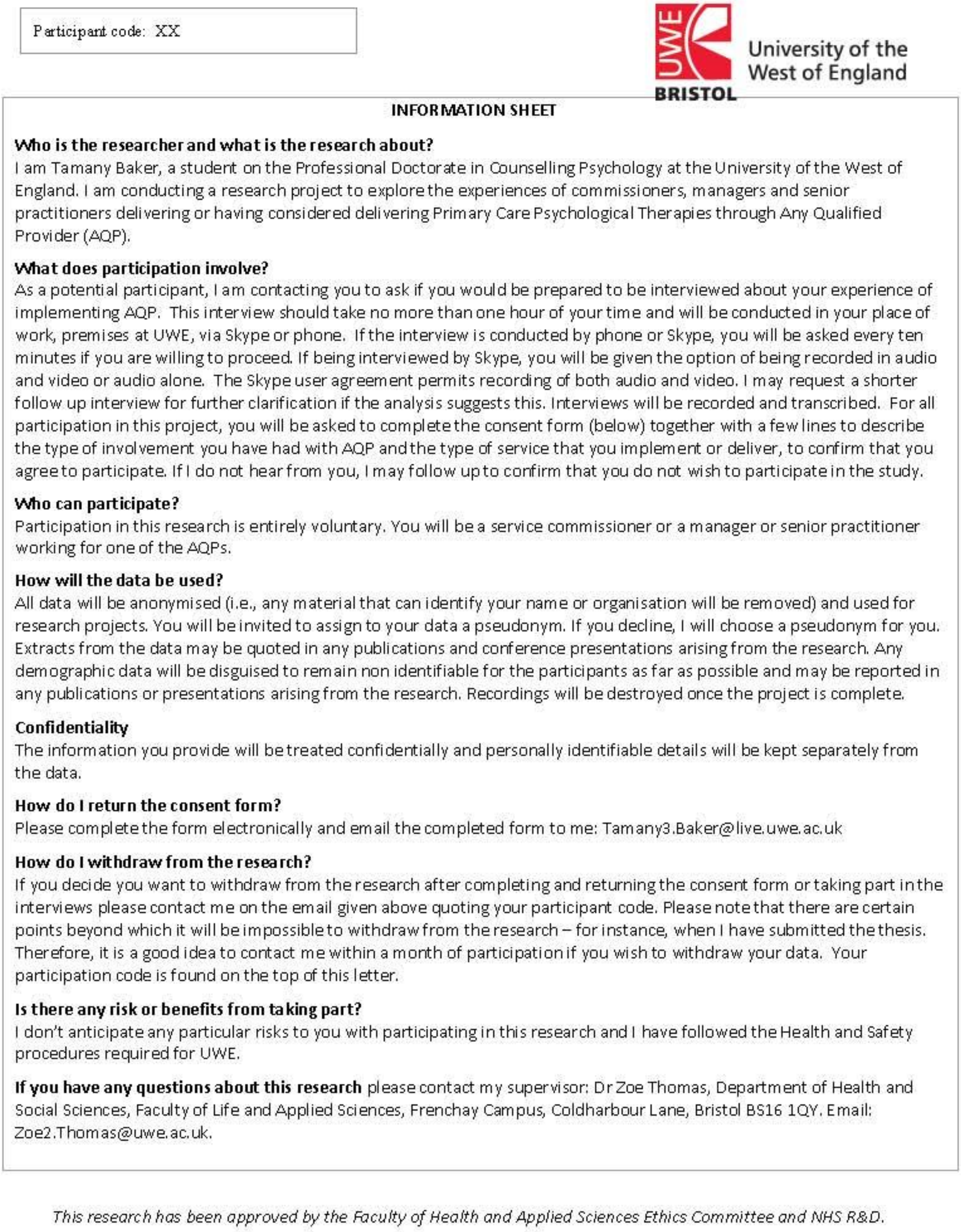
7.0. ABBREVIATIONS

AQP	Any Qualified Provider
BACP	The British Association of Counselling and Psychotherapy
BABCP	The British Association for Behavioural and Cognitive Psychotherapies
BPS	The British Psychological Society
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Groups
CMHD	Common Mental Health Disorder
CPI	Complex Psychological Interventions team
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation.
CoP	Counselling Psychology/Counselling Psychologist
CRP	Complex Responsive Processs
CRS	Complex Responsive System
DCoP	Division of Counselling Psychology
EBPP	Evidence-based practice in psychology
FYFVMH	Five Year Forward View for Mental Health
FYFV	Five Year Forward View
GP	General Practitioner
HI	High Intensity
HSCA 2012	Health and Social Care Act (2012)
IAPT	Improving Access to Psychological Therapies
KPI	Key Performance Indicator

LI	Low Intensity
NHS	National Health Service
PBPP	Practice-based psychological practice
PCPT	Primary Care Psychological Therapy services
PbR	Payment by Results
PWP	Psychological Wellbeing Practitioner
ROM	Routine Outcome Monitoring/Routine Outcome Measures
SMI	Serious Mental Illness
STP	Sustainability and Transformation Partnership
TA	Thematic Analysis

8.0 APPENDICES

Appendix 1: Participant information and consent form, page one.



Participant code: XX

University of the West of England
BRISTOL

INFORMATION SHEET

Who is the researcher and what is the research about?
I am Tamany Baker, a student on the Professional Doctorate in Counselling Psychology at the University of the West of England. I am conducting a research project to explore the experiences of commissioners, managers and senior practitioners delivering or having considered delivering Primary Care Psychological Therapies through Any Qualified Provider (AQP).

What does participation involve?
As a potential participant, I am contacting you to ask if you would be prepared to be interviewed about your experience of implementing AQP. This interview should take no more than one hour of your time and will be conducted in your place of work, premises at UWE, via Skype or phone. If the interview is conducted by phone or Skype, you will be asked every ten minutes if you are willing to proceed. If being interviewed by Skype, you will be given the option of being recorded in audio and video or audio alone. The Skype user agreement permits recording of both audio and video. I may request a shorter follow up interview for further clarification if the analysis suggests this. Interviews will be recorded and transcribed. For all participation in this project, you will be asked to complete the consent form (below) together with a few lines to describe the type of involvement you have had with AQP and the type of service that you implement or deliver, to confirm that you agree to participate. If I do not hear from you, I may follow up to confirm that you do not wish to participate in the study.

Who can participate?
Participation in this research is entirely voluntary. You will be a service commissioner or a manager or senior practitioner working for one of the AQPs.

How will the data be used?
All data will be anonymised (i.e., any material that can identify your name or organisation will be removed) and used for research projects. You will be invited to assign to your data a pseudonym. If you decline, I will choose a pseudonym for you. Extracts from the data may be quoted in any publications and conference presentations arising from the research. Any demographic data will be disguised to remain non identifiable for the participants as far as possible and may be reported in any publications or presentations arising from the research. Recordings will be destroyed once the project is complete.

Confidentiality
The information you provide will be treated confidentially and personally identifiable details will be kept separately from the data.

How do I return the consent form?
Please complete the form electronically and email the completed form to me: Tamany3.Baker@live.uwe.ac.uk

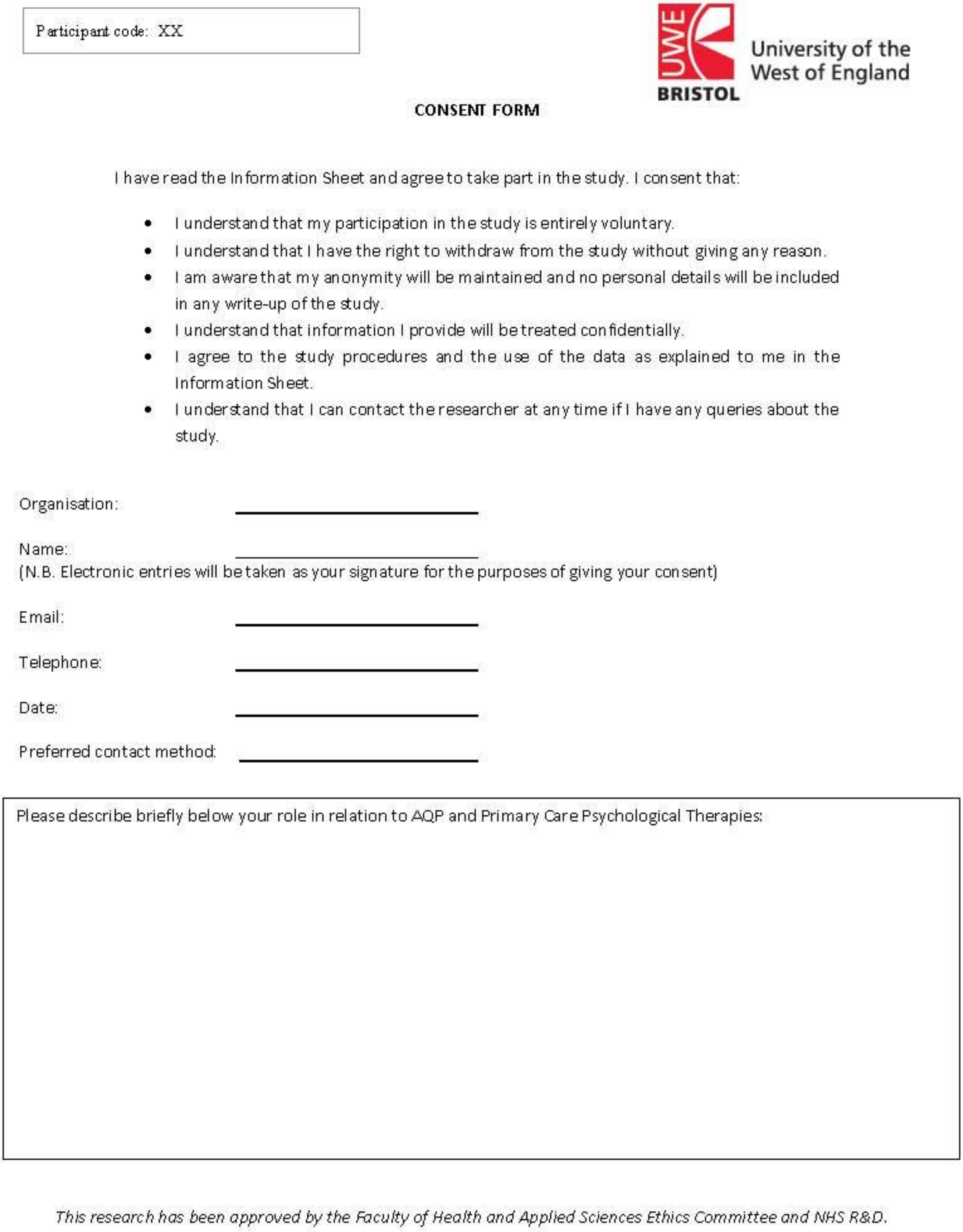
How do I withdraw from the research?
If you decide you want to withdraw from the research after completing and returning the consent form or taking part in the interviews please contact me on the email given above quoting your participant code. Please note that there are certain points beyond which it will be impossible to withdraw from the research – for instance, when I have submitted the thesis. Therefore, it is a good idea to contact me within a month of participation if you wish to withdraw your data. Your participation code is found on the top of this letter.

Is there any risk or benefits from taking part?
I don't anticipate any particular risks to you with participating in this research and I have followed the Health and Safety procedures required for UWE.

If you have any questions about this research please contact my supervisor: Dr Zoe Thomas, Department of Health and Social Sciences, Faculty of Life and Applied Sciences, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY. Email: Zoe2.Thomas@uwe.ac.uk.

This research has been approved by the Faculty of Health and Applied Sciences Ethics Committee and NHS R&D.

Appendix 1: Participant information and consent form, page two.



Participant code: XX

University of the West of England
BRISTOL

CONSENT FORM

I have read the Information Sheet and agree to take part in the study. I consent that:

- I understand that my participation in the study is entirely voluntary.
- I understand that I have the right to withdraw from the study without giving any reason.
- I am aware that my anonymity will be maintained and no personal details will be included in any write-up of the study.
- I understand that information I provide will be treated confidentially.
- I agree to the study procedures and the use of the data as explained to me in the Information Sheet.
- I understand that I can contact the researcher at any time if I have any queries about the study.

Organisation:

Name:
(N.B. Electronic entries will be taken as your signature for the purposes of giving your consent)

Email:

Telephone:

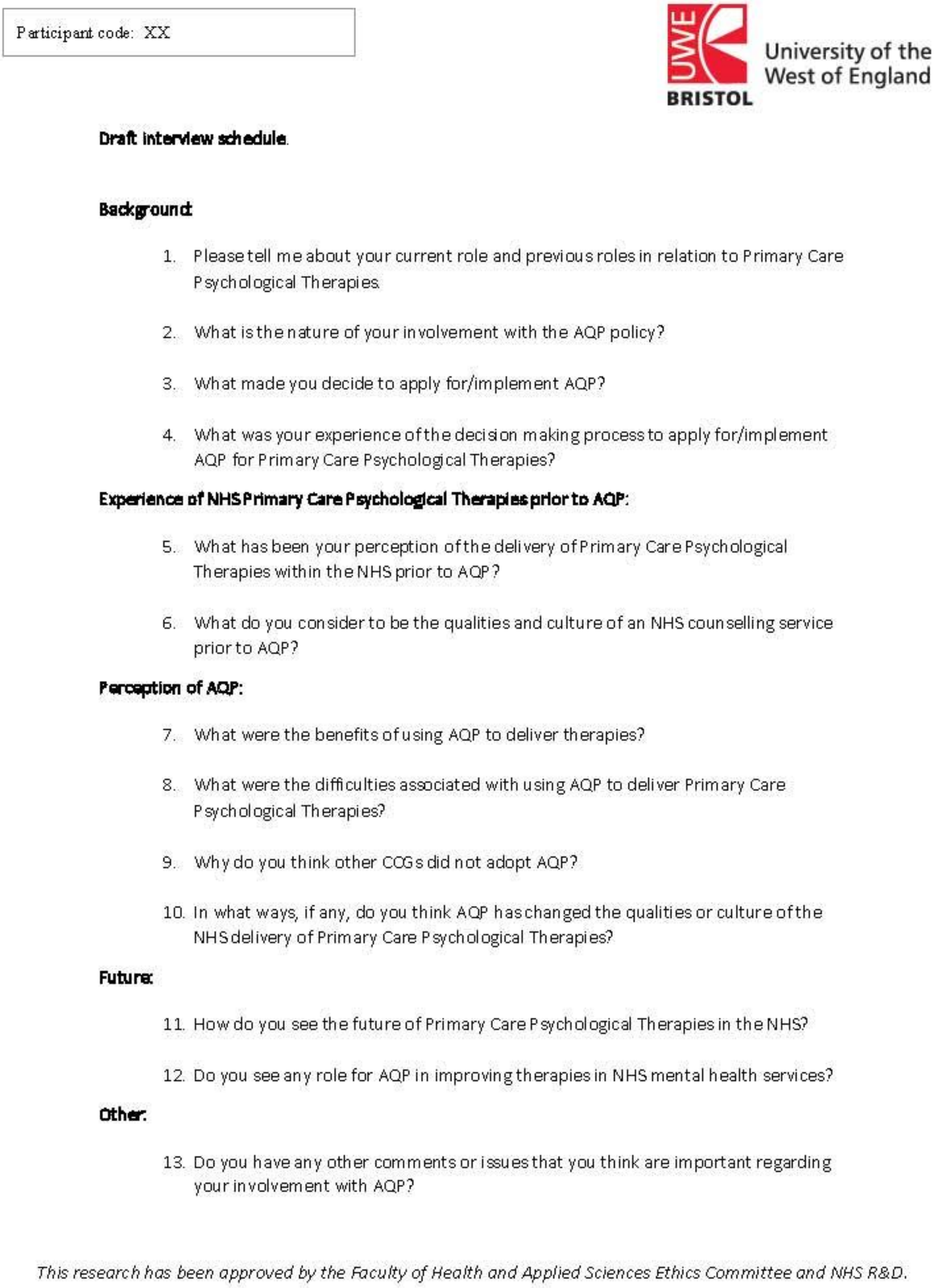
Date:

Preferred contact method:

Please describe briefly below your role in relation to AQP and Primary Care Psychological Therapies:

This research has been approved by the Faculty of Health and Applied Sciences Ethics Committee and NHS R&D.

Appendix 1: Participant information and consent form, page three.



Participant code: XX

Draft interview schedule.

Background:

1. Please tell me about your current role and previous roles in relation to Primary Care Psychological Therapies.
2. What is the nature of your involvement with the AQP policy?
3. What made you decide to apply for/implement AQP?
4. What was your experience of the decision making process to apply for/implement AQP for Primary Care Psychological Therapies?

Experience of NHS Primary Care Psychological Therapies prior to AQP:

5. What has been your perception of the delivery of Primary Care Psychological Therapies within the NHS prior to AQP?
6. What do you consider to be the qualities and culture of an NHS counselling service prior to AQP?

Perception of AQP:

7. What were the benefits of using AQP to deliver therapies?
8. What were the difficulties associated with using AQP to deliver Primary Care Psychological Therapies?
9. Why do you think other CCGs did not adopt AQP?
10. In what ways, if any, do you think AQP has changed the qualities or culture of the NHS delivery of Primary Care Psychological Therapies?

Future:

11. How do you see the future of Primary Care Psychological Therapies in the NHS?
12. Do you see any role for AQP in improving therapies in NHS mental health services?

Other:

13. Do you have any other comments or issues that you think are important regarding your involvement with AQP?

This research has been approved by the Faculty of Health and Applied Sciences Ethics Committee and NHS R&D.

Appendix. 2. Transcript extract to show interesting data and initial codes and cross referencing with other transcripts.

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Appendix. 3. Ongoing coding of transcripts.

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Appendix 4: Theme development - with data extracts of each transcript.

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Appendix 5 :Theme refinement. consolidating data (codes) into themes and subthemes.

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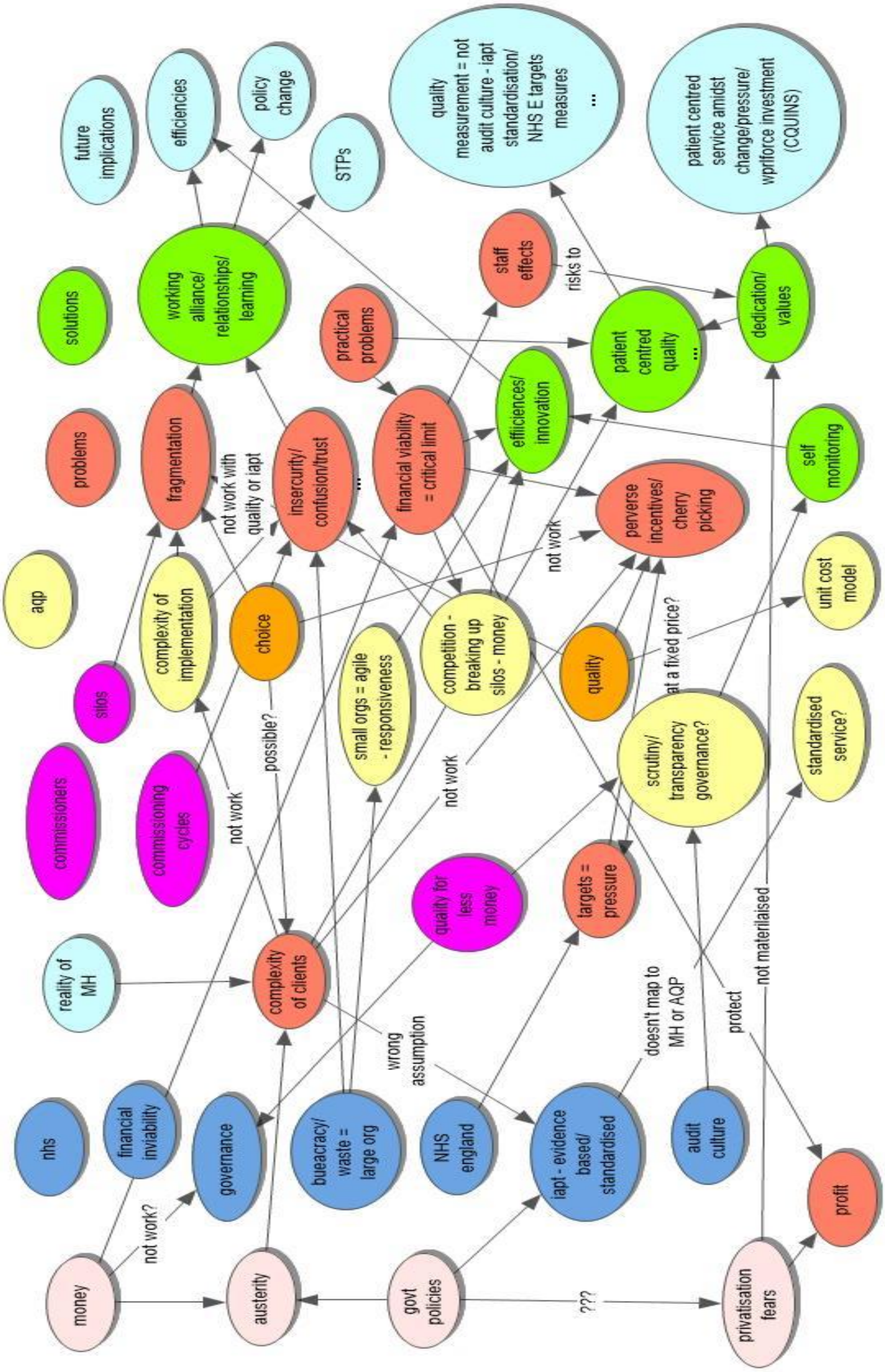
Appendix 6: Additional theme refinement - codes summarised from theme table (app. 5) to cut up and reorganise further.

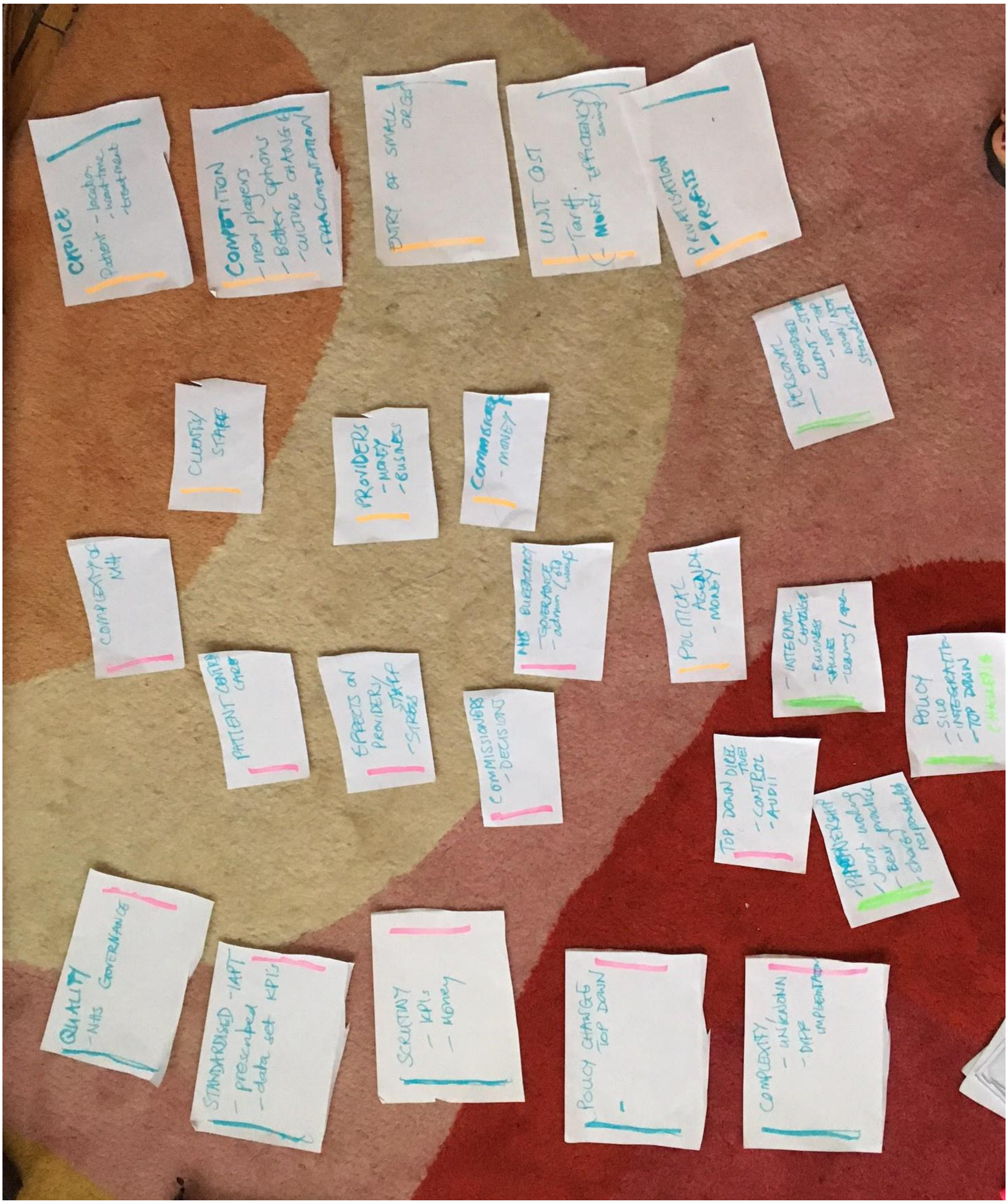
Ppt anxiety re interview
Reason for aqp
austerity
Complexity – hard to understand new
Complexity – MH as sector
Complexity – hard to manage
Complexity – diff implementations
Commissioning cycle Experience Unknown
diversity
Business modelling
Perception of NHS Political
unresponsive
Job protection
NHS – resistance to change
Top down lack of support
NHS bureaucracy
Financial tension for providers
Provider insecurity/pressure Money vs quality See also lack of trust Link to staff pressure
Pressure – accommodation Link to money pressure Link to GP relationships
Quality vs audit
Quality vs money

Appendix 7: Theme refinement - possible theme map, example 1

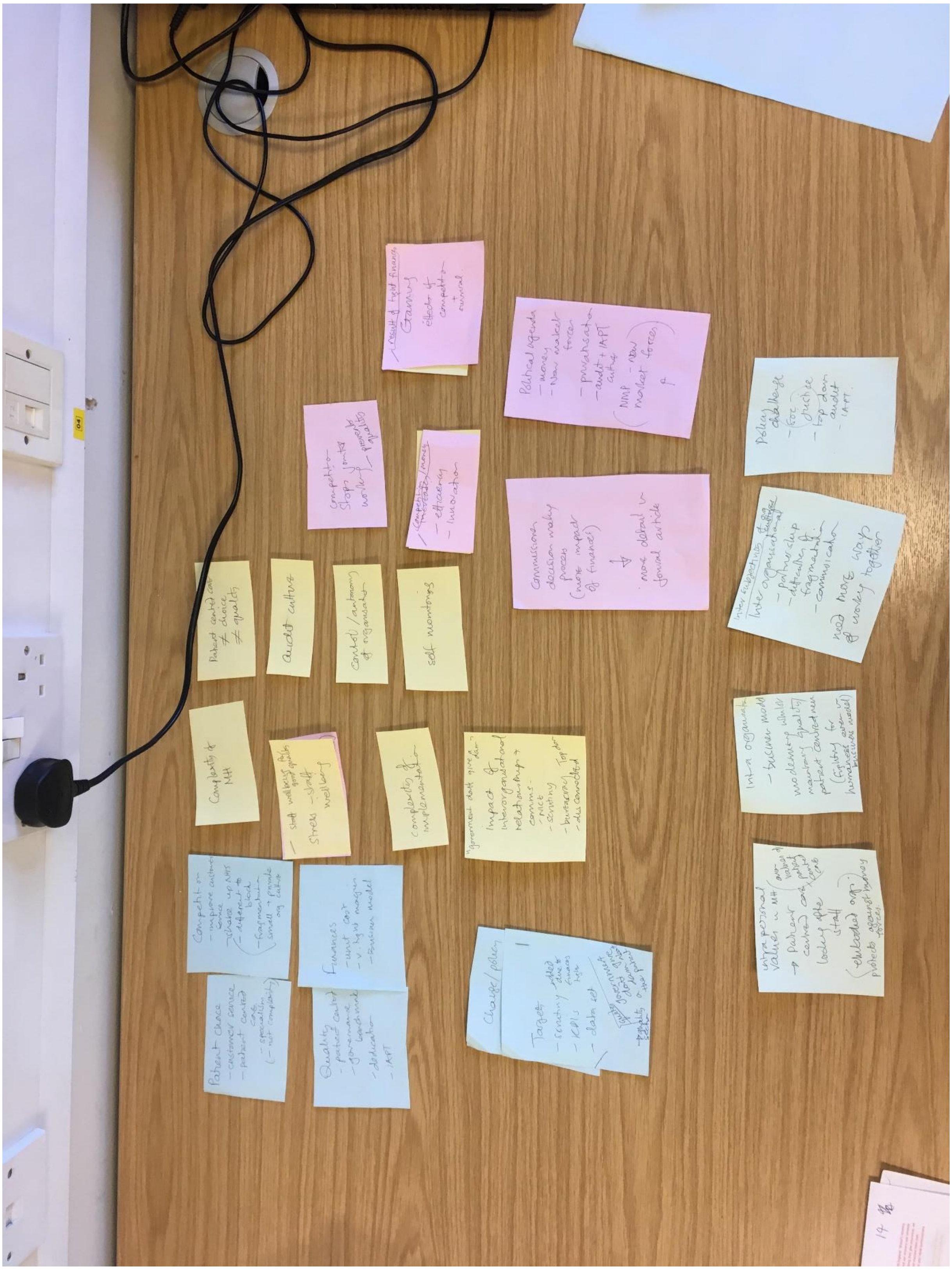


Appendix 8: Theme refinement - possible theme map, example 2

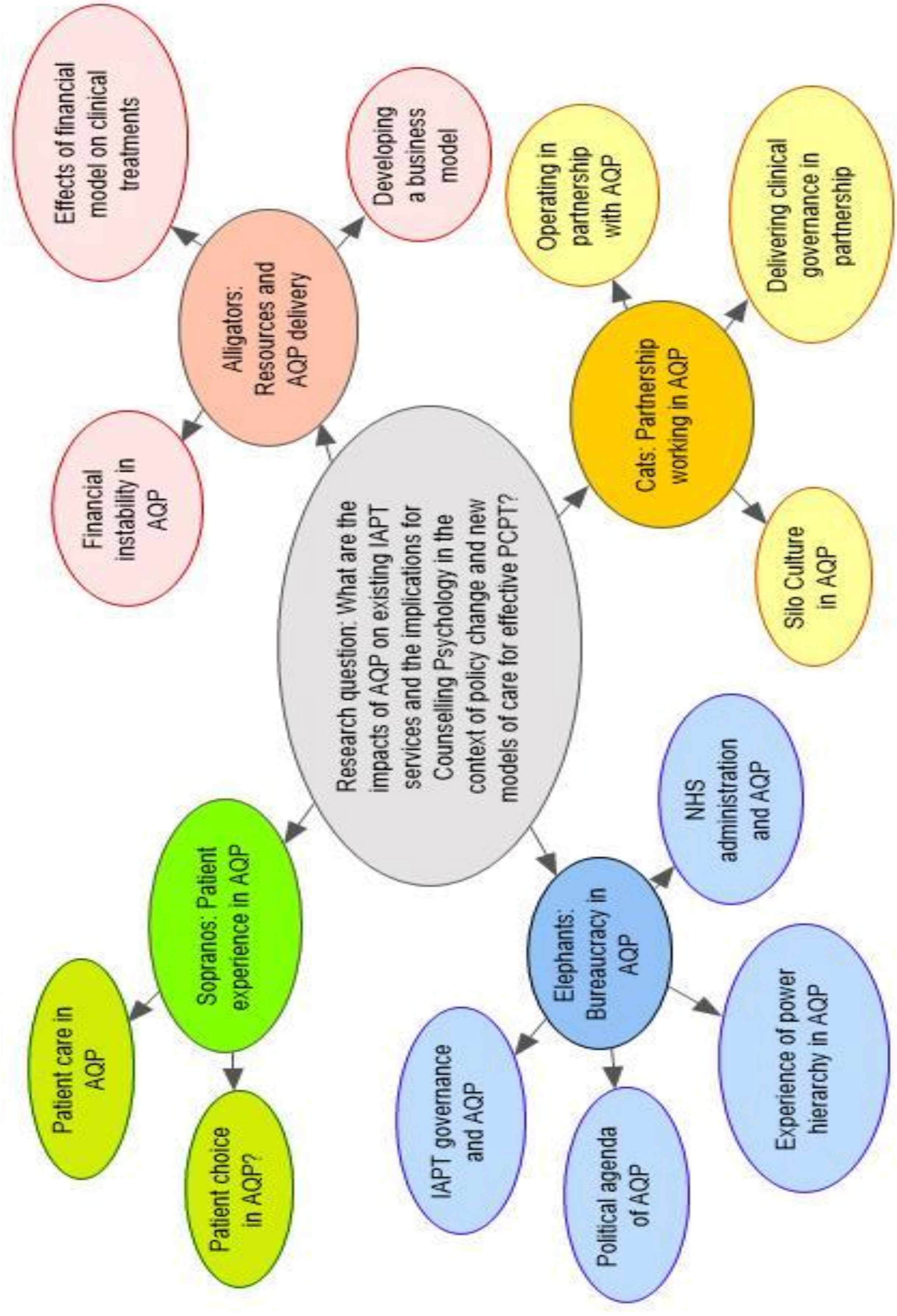
Appendix 9: Theme refinement - paper labels of themes



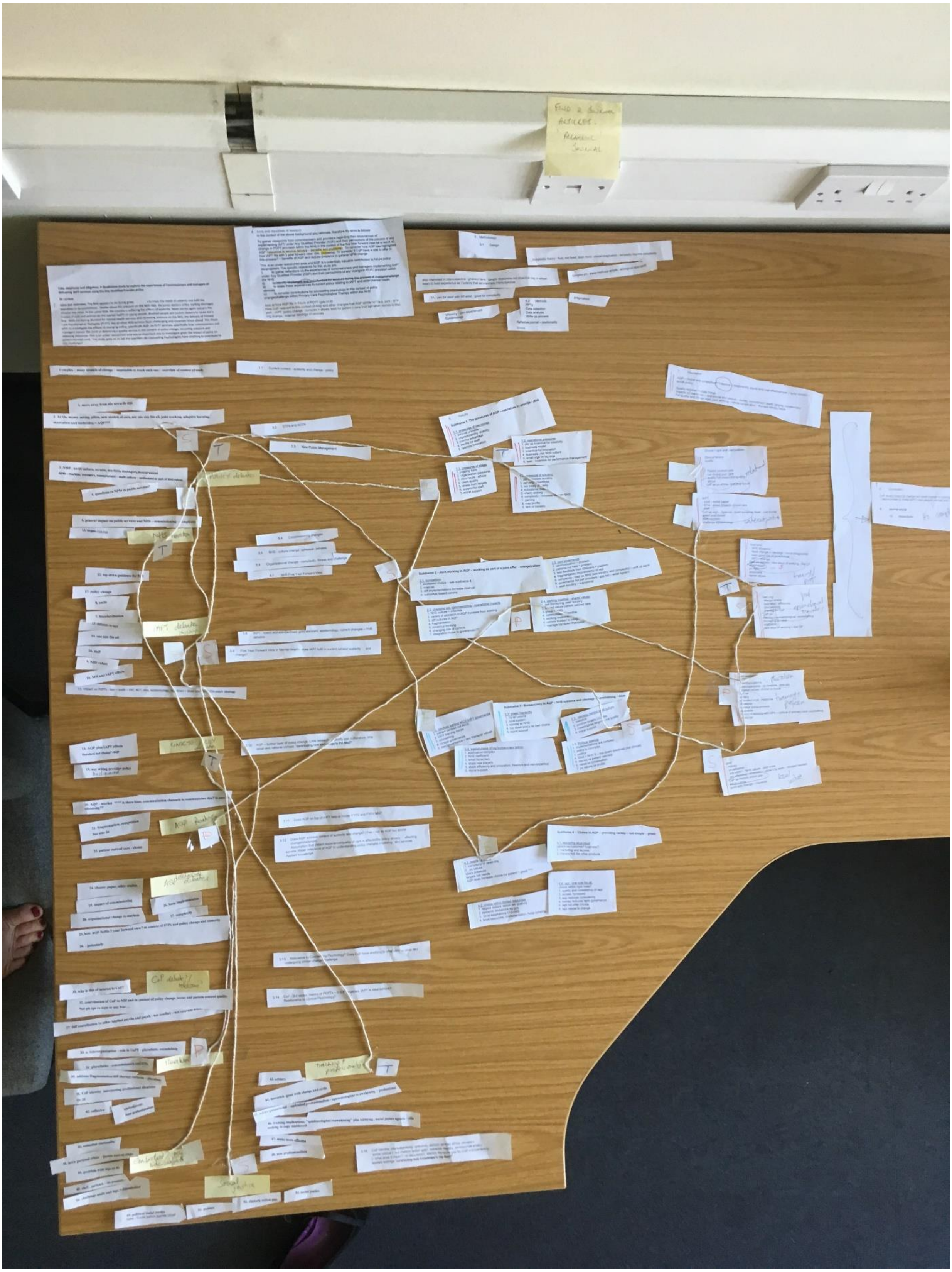
Appendix 10: Theme refinement - paper labels of themes, example 2



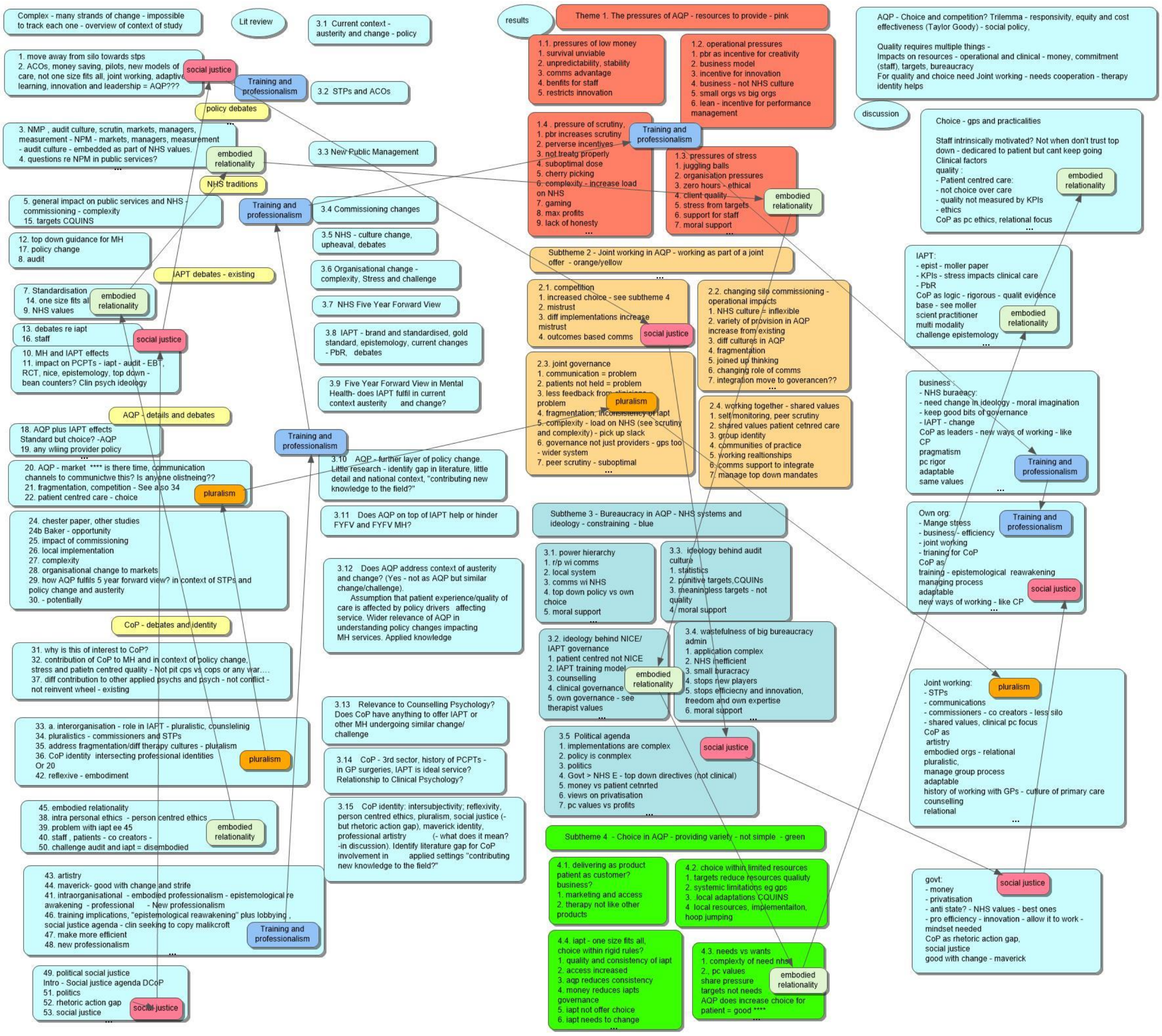
Appendix. 11. Final theme map.



Appendix. 12. Draft structure of final report, example 1



Appendix 13: Draft structure of final report, example 2



Complex - many strands of change - impossible to track each one - overview of context of study

1. move away from silo towards stps
2. ACOs, money saving, pilots, new models of care, not one size fits all, joint working, adaptive learning, innovation and leadership = AQP???

3. NMP , audit culture, scrutin, markets, managers, measurement - NPM - markets, managers, measurement - audit culture - embedded as part of NHS values.
4. questions re NPM in public services?

5. general impact on public services and NHS - commissioning - complexity
15. targets CQUINS

12. top down guidance for MH
17. policy change
8. audit

7. Standardisation
14. one size fits al
9. NHS values

13. debates re iapt
16. staff

10. MH and IAPT effects
11. impact on PCPTs - iapt - audit - EBT, RCT, nice, epistemology, top down - bean counters? Clin psych ideology

18. AQP plus IAPT effects
Standard but choice? -AQP
19. any wliing provider policy

20. AQP - market **** is there time, communication channels to communictwe this? Is anyone olistneing??
21. fragmentation, competition - See also 34
22. patient centred care - choice

24. chester paper, other studies
24b Baker - opportunity
25. impact of commissioning
26. local implementation
27. complexity
28. organisational change to markets
29. how AQP fulfils 5 year forward view? in context of STPs and policy change and austerity
30. - potentially

31. why is this of interest to CoP?
32. contribution of CoP to MH and in context of policy change, stress and patietn centred quality - Not pit cps vs cops or any war....
37. diff contribution to other applied psychs and psych - not conflict - not reinvent wheel - existing

33. a. interorganisation - role in IAPT - pluralistic, counslelinig
34. pluralistics - commissioners and STPs
35. address fragmentation/diff therapy cultures - pluralism
36. CoP identity intersecting professional identities
Or 20
42. reflexive - embodiment

45. embodied relationality
38. intra personal ethics - person centred ethics
39. problem with iapt ee 45
40. staff , patients - co creators -
50. challenge audit and iapt = disembodied

43. artistry
44. maverick- good with change and strife
41. intraorganisational - embodied professionalism - epistemological re awakening - professional - New professionalism
46. training implications, "epistemological reawakening" plus lobbying , social justice agenda - clin seeking to copy malikcroft
47. make more efficient
48. new professionalism

49. political social justice
Intro - Social justice agenda DCoP
51. politics
52. rhetoric action gap
53. social justice

3.1 Current context - austerity and change - policy

3.2 STPs and ACOs

3.3 New Public Management

3.4 Commissioning changes

3.5 NHS - culture change, upheaval, debates

3.6 Organisational change - complexity, Stress and challenge

3.7 NHS Five Year Forward View

3.8 IAPT - brand and standardised, gold standard, epistemology, current changes - PbR, debates

3.9 Five Year Forward View in Mental Health- does IAPT fulfil in current context austerity and change?

3.10 AQP - further layer of policy change. Little research - identify gap in literature, little detail and national context, "contributing new knowledge to the field?"

3.11 Does AQP on top of IAPT help or hinder FYFV and FYFV MH?

3.12 Does AQP address context of austerity and change? (Yes - not as AQP but similar change/challenge).
Assumption that patient experience/quality of care is affected by policy drivers affecting service. Wider relevance of AQP in understanding policy changes impacting MH services. Applied knowledge

3.13 Relevance to Counselling Psychology? Does CoP have anything to offer IAPT or other MH undergoing similar change/ challenge

3.14 CoP - 3rd sector, history of PCPTs - in GP surgeries, IAPT is ideal service? Relationship to Clinical Psychology?

3.15 CoP identity: intersubjectivity; reflexivity, person centred ethics, pluralism, social justice (- but rhetoric action gap), maverick identity, professional artistry (- what does it mean? -in discussion). Identify literature gap for CoP involvement in applied settings "contributing new knowledge to the field?"

Theme 1. The pressures of AQP - resources to provide - pink

1.1. pressures of low money
1. survival unviable
2. unpredictability, stability
3. comms advantage
4. benfits for staff
5. restricts innovation

1.2. operational pressures
1. pbr as incentive for creativity
2. business model
3. incentive for innovation
4. business - not NHS culture
5. small orgs vs big orgs
6. lean - incentive for performance management

1.4 . pressure of scrutiny,
1. pbr increases scrutiny
2. perverse incentives
3. not treatg properly
4. suboptimal dose
5. cherry picking
6. complexity - increase load on NHS
7. gaming
8. max profits
9. lack of honesty

1.3. pressures of stress
1. juggling balls
2. organisation pressures
3. zero hours - ethical
4. client quality
5. stress from targets
6. support for staff
7. moral support

Subtheme 2 - Joint working in AQP - working as part of a joint offer - orange/yellow

2.1. competition
1. increased choice - see subtheme 4
2. mistrust
3. diff implementations increase mistrust
4. outcomes based comms

2.2. changing silo commissioning - operational impacts
1. NHS culture = inflexible
2. variety of provision in AQP increase from existing
3. diff cultures in AQP
4. fragmentation
5. joined up thinking
6. changing role of comms
7. integration move to goverancen??

2.3. joint governance
1. communication = problem
2. patients not held = problem
3. less feedback from clinicians problem
4. fragmentation, inconsistency of iapt
5. complexity - load on NHS (see scrutiny and complexity) - pick up slack
6. governance not just providers - gps too - wider system
7. peer scrutiny - suboptimal

2.4. working together - shared values
1. self monitoring, peer scrutiny
2. shared values patient cetnred care
3. group identity
4. communities of practice
5. working realtionships
6. comms support to integrate
7. manage top down mandates

Subtheme 3 - Bureaucracy in AQP - NHS systems and ideology - constraining - blue

3.1. power hierarchy
1. r/p wi comms
2. local system
3. comms wi NHS
4. top down policy vs own choice
5. moral support

3.3. ideology behind audit culture
1. statistics
2. punitive targets,CQUINs
3. meaningless targets - not quality
4. moral support

3.2. ideology behind NICE/ IAPT governance
1. patient centred not NICE
2. IAPT training model
3. counselling
4. clinical governance
5. own governance - see therapist values

3.4. wastefulness of big bureaucracy admin
1. application complex
2. NHS inefficient
3. small buracracy
4. stops new players
5. stops efficiecny and innovation, freedom and own expertise
6. moral support

3.5 Political agenda
1. implementations are complex
2. policy is conmplex
3. politics
4. Govt > NHS E - top down directives (not clinical)
5. money vs patient cetnrted
6. views on privatisation
7. pc values vs profits

Subtheme 4 - Choice in AQP - providing variety - not simple - green

4.1. delivering as product patient as customer? business?
1. marketing and access
2. therapy not like other products

4.2. choice within limited resources
1. targets reduce resources qualiuty
2. systemic limitations eg gps
3. .local adaptations CQUINS
4 local resources, implementaiton, hoop jumping

4.4. iapt - one size fits all, choice within rigid rules?
1. quality and consistency of iapt
2. access increased
3. aqp reduces consistency
4. money reduces iapts governance
5. iapt not offer choice
6. iapt needs to change

4.3. needs vs wants
1. complexty of need nhs
2., pc values
share pressure
targets not needs
AQP does increase choice for patient = good ****

AQP - Choice and competition? Trilemma - responsivity, equity and cost effectiveness (Taylor Goody) - social policy,

Quality requires multiple things -
Impacts on resources - operational and clinical - money, commitment (staff), targets, bureaucracy
For quality and choice need Joint working - needs cooperation - therapy identity helps

Choice - gps and practicalities

Staff intrinsically motivated? Not when don't trust top down - dedicared to patient but cant keep going
Clinical factors
quality :
- Patient centred care:
- not choice over care
- quality not measured by KPIs
- ethics
CoP as pc ethics, relational focus

IAPT:
- epist - moller paper
- KPIs - stress impacts clinical care
- PbR
CoP as logic - rigorous - qualit evidence base - see moller
scient practitioner
multi modality
challenge epistemology

business :
- NHS buraeacy:
- need change in ideology - moral imagination
- keep good bits of governance
- IAPT - change
CoP as leaders - new ways of working - like CP
pragmatism
pc rigor
adaptable
same values

Own org:
- Mange stress
- business - efficiency
- joint working
- trianing for CoP
CoP as
training - epistemological reawakening
managing process
adaptable
new ways of working - like CP

Joint working:
- STPs
- communications
- commissioners - co creators - less silo
- shared values, clinical pc focus
CoP as
artistry
embodied orgs - relational
pluralistic,
manage group process
adaptable
history of working with GPs - cutlure of primary care
counselling
relational

govt:
- money
- privatisation
- anti state? - NHS values - best ones
- pro efficiency - innovation - allow it to work - mindset needed
CoP as rhetoric action gap,
social justice
good with change - maverick

Appendix 14: Faculty of Health and Applied Sciences, UWE, ethics approval letter, page one.

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Appendix 14: Faculty of Health and Applied Sciences, UWE, ethics approval letter, page two

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Appendix 15: Avon Primary Care Research Collaborative NHS ethics approval letter, page one

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Please contact the author for information about redacted appendices.

Appendix 15: Avon Primary Care Research Collaborative NHS ethics approval letter, page two

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Appendix 16: Health Research Authority NHS approval letter, page one

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Please contact the author for information about redacted appendices.

Appendix 16: Health Research Authority NHS approval letter, page two

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Appendix 16: Health Research Authority NHS approval letter, page three

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Please contact the author for information about redacted appendices.

Appendix 17: Poster presentation at DCoP conference, London 2014

TO AQP OR NOT TO AQP?

University of the West of England

BRISTOL

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A qualitative study using Thematic Analysis to investigate the psychological processes of the AQPs in the implementation of IAPTplus in Bristol

Background and rationale: One of the most recent changes to IAPT is the addition of the AQP (Any Qualified Provider) initiative, intended to increase patient choice in service delivery (1). A comprehensive report of the first CCGs to use AQP in delivering IAPT pointed to several challenges in its successful implementation (2). Bristol has chosen to implement AQP using a number of diverse providers and therefore provides a unique view of how providing patient choice works on the ground. The current study explores the psychological processes that AQP managers experience whilst holding the different levels of change for their therapists and clients.

Method: From the AQPs listed on the CCG website, participants were invited to complete a brief questionnaire. The first six respondents were interviewed using semi-structured interviews to explore the phenomenological experience of the application and delivery process. Thematic Analysis was used to identify themes to illustrate the shared meanings between the participants (3). The themes were tabulated and cross-referenced to identify the parameters guiding the participant's transitions towards the AQP role.

Results: Three main themes were found to determine the perceptions and experiences of the AQPs

POWER "The commissioner holds all the cards and all the money" Managers spoke of a lack of power in a changing commissioning landscape and wider political arena. Those AQPs who had previous experience of NHS culture experienced less tension around the "fit" of service delivery but all participants spoke of a perceived lack of autonomy as an AQP. "You either trust your AQPs or you don't"

ANXIETY "it's probably one of the toughest things I've ever done in my life" Participants spoke of anxiety about the financial and logisitical sustainability of being an AQP, the negative effects on staff and clients and of their own survivial as an organisation if they did not apply. "if we aren't involved in the NHS club then: "would we miss out in the future?""

CREATIVITY "Maybe we could be at a point where we are competing with each other, which would be a nicer place to be" Managers met the anxieties of AQP with pragmatism and a universal commitment to their clients. They identified benefits for client choice with AQP and for the diversity of therapy in Bristol's primary care. AQPs identified as a group to help manage challenges and offer peer support. "one model doesn't fit all"

Conclusions: The IAPTplus trial in Bristol indicates benefits, consistent with the aims of AQP. However, AQPs have to manage significant psychological issues to adapt their existing identity to the AQP role, which should be considered by commissioners if patient choice is to be promoted.

References: (1) NHS Supply2Health, 2013; (2) Griffiths, S.. (2013). Mental Health's Market Experiment: Commissioning Psychological Therapies Through Any Qualified Provider. Chester: University of Chester Press. (3) Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3, 2, 77-101.

Appendix 18: Journal Article.

The impact of Any Qualified Provider on Primary Care Psychological Therapy services: a commissioner and manager perspective.

ABSTRACT

Background: Primary Care Psychological Therapy services (PCPT) face pressure to deliver effective services due to the increasing prevalence, complexity and societal costs of Common Mental Health Disorders (CMHDs). Successive policy changes significantly shape PCPT design, such as Improving Access to Psychological Therapies (IAPT), although its effectiveness is debated. Commissioners and managers deliver services within a complex responsive system of evolving healthcare and policy practices. Any Qualified Provider (AQP) represents one policy solution to address financial pressures, extend patient choice and stimulate competition based on quality, not price. AQP shares features with future NHS developments, such as partnership working in Sustainability and Transformation Partnerships and the increased use of Payment by Results.

***Aims**:* This research investigated the impacts of AQP on existing IAPT services from the perspectives of managers and commissioners of IAPT services.

***Method and analysis**:* Semi-structured interviews with a cross section of commissioners and managers in different regions and organisations generated leadership perspectives on AQP. Thematic Analysis offered a broad overview of the impacts of AQP in IAPT.

***Results**:* Four superordinate themes were identified: *Alligators: Resources and AQP delivery*; *Cats: Partnership working in AQP*; *Elephants: Bureaucracy in AQP*; and *Sopranos: Patient experience in AQP*.

***Conclusions**:* AQP offers insights into the partnership working of clinical leaders in a local IAPT service and their adaptations to financial and bureaucratic pressures. To address increasing CMHDs, PCPT needs adequate funding to provide quality patient-centred care. Clinical leaders are willing and able to work within new quasi-market structures, but they prioritise clinical and relational values. They need to communicate these priorities robustly to policy makers, who in turn should embed these values in the policies which shape the implementation of PCPT.

Keywords: Any Qualified Provider (AQP); Improving Access to Psychological Therapies (IAPT); commissioning; mental health policy.

Background and Introduction

Aim.

Mindful of new models of care to address the increasing prevalence of Common Mental Health Disorders (CMHDs), this study explores how Any Qualified Provider (AQP) affects the dissemination and implementation of Primary Care Psychological Therapy services (PCPT). Whilst AQP as a policy directive is not widely used in PCPT, it shares features with major shifts in the design and delivery of future NHS services, such as Sustainability and Transformation Partnerships (STPs) and Payment by Results (PbR). Its ultimate aim is to inform the development of new models of care against the backdrop of a changing policy landscape.

Policy, organisational change and complexity.

Changes of governments often introduce corresponding changes in social structures and public services. Hunter (2015) says that politics is central to public health policy and that the emerging care systems are ‘messy’ complex adaptive systems, where new organisational forms arise from the negotiation of policy directives and power dynamics. Policy is often seen as a powerful top-down force that drives the implementation of new services, where recipients of policy directives are seen to simply adapt to the new requirements (McDaniel et al., 2009), ultimately at the behest of government (Rogers & Murphy, 2017). Whereas some psychology/therapy commentators see policy as an opportunity for public benefit (Layard & Clark, 2014), there is substantial criticism of the policy backdrop for the current form of PCPT services in IAPT (Binnie, 2015; Dalal, 2018b; House, 2016; Marziller & Hall, 2009; Rizq, 2012a).

A slightly different notion of a complex *responsive* system (Stacey, 2010) highlights opportunities for all parts of the system to effect change, often in unanticipated ways (Kingdon, 2014). As healthcare systems are becoming increasingly complex (Holmes et al., 2012; Plsek & Greenhalgh, 2001), improving these systems in the backdrop of changing policy is correspondingly more challenging. For instance, Ettelt et al. (2015) suggest that mixed agendas behind ‘policy experiments’ may not always correspond to the espoused aims of policy or to good care practices.

Service delivery in real-world complex responsive systems.

Evaluating service effectiveness is therefore of key importance to clinical leaders. With an awareness of the complexity of health systems, service effectiveness can be viewed at the micro, meso and macro levels (van Dijk, 2007). For instance, Fotaki (2014) categorises the activities at each level in public health as: interpersonal (micro), organisational (meso) and institutional (macro) levels. Delivery of services takes into account the commissioning, organisation and delivery of the service and may also be described as the dissemination and implementation of services (May & Finch, 2009).

The real-world effectiveness of clinical treatments at the micro level (Barkham et al., 2017; Lovell et al., 2017) require assessment of varied outcomes such as acceptability of treatment, both for the client and therapist (Bower & Gilbody, 2005) and choice of treatment (Goldman et al., 2016). Service effectiveness at the meso level includes cost-effectiveness, affordability and efficiency in real-world service contexts (Kendall & Frank, 2018) and balances the needs of different stakeholders alongside practical and operational demands (Vos et al., 2005). At the macro level, factors such as coordination between services, referral pathways and consultation exercises also contribute to overall service effectiveness (McDonald, 2007). The macro level also encompasses the aforementioned political drivers of service design. These wide-ranging factors have multiple – and sometimes subtle – effects on the way treatment is delivered and on professional identities (Murphy, 2011; Speed & Gabe, 2013). For example, burnout in therapists has been shown to result from organisational and top-down pressures (Steel et al., 2015; Westwood et al., 2017) and can adversely affect client outcomes (Delgadillo et al., 2018). Pybis, et al. identify differences in patient outcomes that are significantly attributable to service differences more than modality (2017).

There is a general paucity of research into measuring effectiveness at the service level that reflects a full range of stakeholder views and expectations (Petrosyan et al., 2017). Consensual agreement of what comprises an effective service involves compromise across a wide range of stakeholders (Barkham et al., 2017; Lovell et al., 2017). Because the design of future services is often based upon previous evaluations of service effectiveness, it is important that these evaluations reflect real-world measures of effectiveness (Delgadillo et al., 2018), and not a taken-for-granted, politically driven ideal. For effective implementation and dissemination of services, clinical leaders must therefore negotiate government policy, operational decision-making and clinical effectiveness (Steen, 2015).

To assess any impact of the AQP policy, it is first helpful to understand how changing policy has shaped the commissioning, organisation and delivery of PCPT in recent years.

Policy and Service Delivery: The Mental Health Context.

The Mental Health Taskforce states that nine out of ten adults with a mental health problem receive help in primary care services (2016, p.8). To address the increasing prevalence and the impacts of CMHDs, successive governments have therefore introduced wide-ranging changes to the commissioning, organisation and delivery of PCPT, most recently in 2007 with the introduction of Improving Access to Psychological Therapies (IAPT) (Department of Health, 2008). More recent changes in the wider NHS are shaping the future form of PCPT.

Prior to IAPT.

By 1992, nearly a third of GP practices in England and Wales offered so-called '"practice counsellors"' as part of a team of other psychological clinicians (Marsh & Bart, cited by Foster & Murphy, 2005, p.6). A white paper *The new NHS: Modern, dependable* aimed to provide more equitable access and consistent clinical governance at a centralised level in primary care. It created the National Institute for Clinical Excellence (NICE) 'to give a strong lead on clinical and cost-effectiveness, drawing up new guidelines and ensuring they reach all parts of the health service' (Department of Health, 1997). NICE still provides the standards against which NHS treatments are benchmarked, including those in IAPT.

The NICE guidelines relied predominantly on evidence-based practice in psychology (EBPP) (APA, 2006) to set standards and definitions of treatment quality. The link to 'cost-effectiveness' was more easily provided by the quantitative research base connected to CBT rather than counselling approaches, summarised by Shean as the 'idiographic approaches to therapy that do not lend themselves to RCT [Randomised Controlled Trials] designs' (2014, p.1). The limited definition of what counts as evidence in EBPP and the research bias towards CBT is an ongoing topic of debate (APA, 2006; Cuijpers et al., 2010; Gambrill & Littell, 2010).

By 2003, the economic and political decisions based on the 'rigour, independence and objectivity' of NICE's recommendations (NICE, 2018) contributed to what Dixon described as 'a top down managerial culture originating in Whitehall [that] was beginning to exclude the voices of clinicians and service users' (cited by Foster and Murphy, 2005, p.5). These changes were a product of wider New Public Management ideologies (NPM) (Lees, 2016; Peacock-Brennan, 2016) and radically changed the landscape of PCPT in the form of the Improving Access to Psychological Therapies programme (IAPT).

Improving Access to Psychological Therapies.

IAPT was originally designed to provide cost-efficient and effective provision of PCPT (Clark, 2011; Layard et al., 2007). McHugh and Barlow see IAPT as 'the most extensive and centralized effort in the dissemination and implementation of EBPTs [evidence-based psychological treatments] to date' (2010, p.75). IAPT is defined by three core principles: evidence-based NICE approved therapies; an appropriately trained and supervised workforce; and routine outcome monitoring (ROM) on a session-by-session basis (National Collaborating Centre for Mental Health, 2019, p.8). More recently, the 'IAPT outcomes-based payment approach' (NHS England and NHS Improvement, 2017, p.6) has been rolled out – more commonly known as payment by results (PbR). IAPT is presented as a 'strong brand' with 'an accreditation process' to protect its 'legacy' (Department of Health, 2012, p.33). It has received unprecedented levels of funding compared to previous PCPT and claims to have transformed services to offer a more standardised and equitable access to PCPT across England (Clark, 2018; NHS England, 2019).

Despite its political and economic endorsement, there is considerable debate concerning IAPT. Numerous authors have challenged the theoretical assumptions underpinning NICE guidelines in the resulting design of IAPT (e.g. Del Re, 2012; Guy et al., 2012; Rogers, 2009; Samuels & Veale, 2009). Marziller and Hall argue that quality clinical care requires a more idiosyncratic approach rather than the 'one-size-fits-all, techniques-driven approach' offered by IAPT (2009, p.399). McPherson et al. (2009) question the meaningfulness of the measures used in IAPT, whilst in contrast, Layard and Clark assert that: 'outcome measurement is probably the most important single feature of IAPT. It is really the only ultimate guarantee of quality' (2014, p.205).

Atkinson describes the IAPT database as 'a statistical light show' which is part of a game where 'statistics are essential to the political lie' and reflect a policy of 'contempt for mental health' (2014, pp.18-19). Other authors question the assumptions behind IAPT's use of Key Performance Indicators (KPIs) and its tariff (Griffiths & Steen, 2013a; Griffiths & Steen, 2013b; Radhakrishnan et al., 2013). Mollon argues that a lack of psychological thinking about the client in the available therapy models can actually slow down recovery (2009). Binnie believes that pressure from commissioners to hit targets has negative effects on the quality of clinical care (2015), described by Callan as ‘the tail that wags the dog’ (2013).

The effects of pressure to gather and report data, may not only cause perverse incentives in treatments, but may also cause stress for the workforce from: ‘relentless pressure to meet targets with inadequate resources, as well as loss of autonomy, degrading of the professional role of psychological staff, and excessive managerial control’ (The New Savoy Partnership, 2015).

A perceived employment agenda causes concern for many clinicians about their role as therapists (Khanom, 2015). Scanlon sees IAPT as a punitive and coercive route into therapy that is simply designed to slash the government's benefits bill (2015). According to Layard and Clark, the ever-present drive for value for money – that could be perceived as a hidden political agenda behind IAPT and NICE – might lead to commissioners ‘dumbing down quality’ (2014; Glover-Thomas, 2013). Binnie agrees that IAPT over simplifies the real-life complexity of quality therapy and borrows from Ritzer (1993) to argue that IAPT is a ‘McDonaldization process [where] everything is supposed to be manualised to the point of the idea of the “interchangeable therapist”’ (Binnie, 2015, p.82). This echoes Norcross’ description of manualised therapies as ‘disembodied therapists performing procedures’ (2002, p.4). Others link IAPT to neo-liberal paradigms that cause disconnection or emotional splitting for all stakeholders (House, 2016; Rizq, 2014).

These debates illustrate how policy and its ideologies have shaped PCPT. The continually evolving policy landscape introduced a further change to the commissioning, organisation and delivery of some PCPT services with the introduction of Any Qualified Provider (AQP).

Any Qualified Provider in IAPT.

AQP was an extension of New Labour’s ‘Any Willing Provider’ policy and renamed as Any Qualified Provider (Department of Health, 2010b). Any Willing Provider itself grew from earlier visions to diversify and improve efficiency in NHS services, which stated: ‘the internal market will be replaced by a system we have called “integrated care”, based on partnership and driven by performance’ (Department of Health, 1997). By 2011, the principles of ‘choice, co-operation and competition’ were seen to be central to NHS reforms by the government's *Co-operation and Competition Panel* (https://www.ccpanel.org.uk/about-the-ccp/index.html), together with a focus on efficiency and competition (Department of Health, 2010a). Legislation in the Health and Social Care Act 2012 (HSCA 2012) embedded the existing principles of quasi-markets into healthcare (Timmins, 2018) to promote efficiency and responsiveness via competition, while the state maintained top-down regulation (Le Grand, 1997).

AQP itself does not outwardly refer to competition but promotes patient choice 'to empower patients and carers, improve their outcomes and experience' (Department of Health., 2011, p.4). The policy directive requires that: providers meet quality and safety standards; commissioners set local pathways; referrers provide information on choice; and that competition should be based on quality, not price, because providers receive a fixed price for delivering interventions, usually via PbR.

Commissioners were required to use AQP to commission at least three primary care services from a choice of eight (Department of Health, 2011). Although commissioners are no longer required by the government to adopt AQP (NHS England, 2013) and Williams has suggested that the policy itself is waning (2014), AQP is still being used (UK government contracts finder website: https://www.contractsfinder.service.gov.uk/Search). AQP was still being used to commission IAPT services by at least eight CCGs between 2015-16.

AQP can therefore be summarised by five features: choice; competition; PbR; expected quality standards (including existing NICE and IAPT governance); and top-down governance (including NHS directives and government policy).

Future directions for PCPT: Five Year Forward View for Mental Health.

As we have seen, policy reforms and directives behind service redesign may change the core principles guiding PCPT. NHS documents such as the *Five Year Forward View* (FYFV) and the *NHS Long Term Plan* (NHS, 2014; NHS, 2019) aim to help NHS services meet increasing demand, to improve efficiency and to ensure adequate funding. However, the outward commitment to public consultation is seen as sham consultation by some (Hudson, 2018).

The *Five Year Forward View for Mental Health* (FYFVMH) recognises the increasing problems facing mental health provision (Mental Health Taskforce, 2016). and draws on public consultation to suggest ‘new models of care’ for mental health services (Mental Health Taskforce, 2015 & 2016, p.19). However, these new models of care are dependent on the evolving policy context, such as Sustainability and Transformation Partnerships (STPs) and increased use of PbR. Reform of the NHS is intended to ‘mobilise collective action on “health creation” and service redesign’ (NHS England, 2017, p.32). New models of care in PCPT are therefore subject to wider political influence than the FYFVMH acknowledges.

Evaluating impacts of policy on PCPT service effectiveness.

The restructuring of the NHS has been described as ‘perpetual cycles of redisorganisation’ (Oxman et al., 2005), seen by some to destabilise it (Oliver, 2018) and evokes language such as deception and despair (Davis et al., 2015). Geyer suggests that commissioners are operating in a zone much more complex and disordered than previously (2013). Given that policy reforms can shape the very form of an organisation (Brunsson, 2009), it is important to evaluate the impact of policy on services to find out how – or *if* – the benefits claimed by policy materialise in real-world contexts (Mofidi & Marrow, 2017). If they do not, it is then important NOT to embed ineffective policies. Understanding the interaction of existing policy effects on IAPT and the new effects of AQP – and any implications for new models of care – merits closer consideration.

There is very little research into the experiences and processes in AQP in general. AQP represents a contentious topic and is subject to emotive debate, perceived by some to be part of the NHS ‘privatisation’ agenda (Pym, 2014), although others claim that this threat has not materialised (Ham et al., 2015). Even fewer studies explore the experiences of commissioners and providers of AQP in IAPT. A study by Griffiths et al. (2013) from the very early stages of AQP/IAPT highlighted the challenges and difficulties experienced. In contrast, Jones and Mays reported generally positive appraisals of AQP (2013). The *Journal of Psychological Therapies in Primary Care* contains anecdotal reports and opinion pieces (see for example, a commissioner’s view by Keefe, 2013). AQP offers a useful snapshot to examine the impact of changing policy on PCPT and other mental health services.

Methodology

Study design.

A cross sectional qualitative study of the practices of clinical leaders – as the people most likely to engage with policy – was chosen to generate knowledge that is readily accessible to other clinical leaders and to provide practical applications to service improvement. Palinkas suggests that an 'emergent design' of iterative, qualitative research ideally suits the fluid nature of mental health contexts (2014, p.855). The research context of AQP – a complex messy health care system – therefore requires an approach that accounts for the multiple responses to policy (Holmes et al., 2012) that impact the clinical effectiveness of PCPT services.

Participants and procedure.

Purposive sampling was used to identify participants to represent a range of perspectives on the topic of study (Palinkas et al., 2015). This study interviewed seven clinical managers of providers and five commissioners who had experience of the AQP policy in PCPT from at least eight geographical areas, and included at least two NHS providers, two large charities and two small charities (see table 1).

Background research identified geographical areas that had opted to implement IAPT using AQP. Initial contact was made with CCGs or providers by telephone and approximately twenty respondents were then emailed participant information sheets. Semi-structured interviews, in person or by telephone, were used as 'an open and flexible research tool' (Banister et al., 1994, p.49) and conducted over a two-year period.

Analysis.

After consideration of alternative methods of analysis, Thematic Analysis (TA) was chosen for its epistemological flexibility (Braun & Clarke, 2006) to offer a broad engagement with the situated nature of AQP: within a system of diverse discourses; the study's applied aims; and the need for some degree of theory generation. This flexibility addresses some of the pitfalls of 'monomethod' research because it increases the degree of 'significance in evaluation research' (Onwuegbuzie & Leech, 2004, p.771), to maximise applications across mental health disciplines, and policy disciplines. I followed Braun and Clarke's six stage method for analysis (2006, table 2) detailed below.

Table 1. Table of participant's demographics, pseudonym and interview details.

Pseudonym	Type of participant
Mark	Commissioner
Paul	Commissioner
Emma	Commissioner
Sophie	Commissioner
Priya	Commissioner
Abdul	non NHS provider
Trisha	non NHS provider
Bridget	non NHS provider
Rachael	non NHS provider
Nick	non NHS provider
Liz	NHS provider
Peter	NHS provider

Table 2. Braun and Clarke's six stage method for Thematic Analysis (2006)

Stage one	Familiarizing yourself with your data.
Stage two	Generating initial codes.
Stage three	Searching for themes.
Stage four	Reviewing themes.
Stage five	Defining and naming themes.
Stage six	Producing the report.

The recordings were transcribed by myself to fully immerse myself in the data, following the transcription notation system given by Braun and Clarke (2013). Initial codes were identified and potential initial themes developed with each transcription. According to Braun and Clarke (2006), a theme should represent a significant feature of the data in relation to the research question, so efforts were made to use data extracts where possible to represent themes. Different ways of organising the data were considered and after triangulation with the research team, a final theme arrangement was reached to represent the important features identified in the data (see results table 3). The results of analysis were presented as an unfolding, complex narrative (Braun & Clarke, 2006).

Ethical Considerations.

Because of the unknown and potentially controversial implications of the study's findings, the identities of the participants and the geographical area were anonymised and information provided treated with utmost confidentiality.

Results

Analysis of the data that explored participant's experiences of AQP identified four main concerns that are represented in the superordinate themes of: *Alligators: Resources and AQP delivery*; *Cats: Partnership working in AQP*; *Elephants: Bureaucracy in AQP*; and *Sopranos: Patient experience in AQP* (summarised below in table 3 below).

Superordinate theme 1. *Alligators: Resources and AQP delivery.*

The first overarching theme of low resources negatively impacting the core service was summarised by Trisha with the aphorism: '*"if you are up to your neck in alligators, it's hard to remember that you are there to empty the pool"'*. The subtheme – ***Financial instability in AQP*** – reflects how the low tariffs and lack of predictability in AQP are a constant operational pressure for managers, as Rachael said: '*it's really tight. It is very tight'*. Trisha feared that pressure on managers also impacts staff: '*and I think there is a bit of contagion of our anxieties going down the line, I'm pretty sure that's what it is. And I feel some responsibility for that'*. The second subtheme – ***Effects of financial model on clinical treatments*** – captures the tension for participants between operational efficiencies and delivering quality clinical treatments. This impacts both patients – due to perverse incentives, suboptimal doses, and lack of service innovation – and staff, due to a lack of understanding of the relational nature of PCPT, as Commissioner Mark explained: '*we are not buying widgets, we are not buying computer bits. We are buying psychological therapies*'. A final subtheme – ***Developing a business model*** – represents the significant improvements in operational performance due to the transparency and outcomes nature of AQP, as Peter reflected: *'you are payment by results, so it's that business model'.* Although AQP is negatively associated with privatisation and zero-hours contracts, opportunities were identified for staff and providers to financially reward good performance and good service quality.

Table 3: Summary of superordinate themes and subthemes

Superordinate themes	**Subthemes**
Superordinate theme 1. ***Alligators: Resources and AQP delivery***	**1.1.** ***Financial instability in AQP***
	1.2. ***Effects of financial model on clinical treatments***
	1.3. ***Developing a business model***
Superordinate theme: 2. ***Cats: Partnership working in AQP***	**2.1.** ***Silo Culture in AQP***
	2.2. ***Operating in partnership with AQP***
	2.3. ***Delivering clinical governance in partnership***
Superordinate theme: 3. ***Elephants: Bureaucracy in AQP***	**3.1.** ***IAPT governance and AQP***
	3.2. ***NHS administration and AQP***
	3.3. ***Experience of power hierarchy in AQP***
	3.4. ***Political agenda of AQP***
Superordinate theme 4. ***Sopranos: Patient experience in AQP***	**4.1.** ***Patient choice in AQP***
	4.2. ***Patient care in AQP***

Superordinate theme: 2. *Cats: Partnership working in AQP.*

AQP/IAPT produces problems for the joint IAPT service, due to tensions of providers competing as separate businesses to improve choice and quality of treatment, but also expected to be part of a joint service that needs to deliver nationally mandated targets. In the second superordinate theme, ***Cats: Partnership working in AQP**, i*ncreased diversity of providers led to Mark describing AQP as: '*a little bit like herding cats*'. Participants identified problems of conflicting provider cultures in partnership working in the first subtheme: *Silo Culture in AQP*, as Nick explained:

> *well, how do we work together with the commissioners and with other partners, so we can begin to coordinate the service provision rather than having these silo commissioned, silo delivery services that barely talk to each other.*

As well as differences in communications and ways of working, the competition element of AQP increases mistrust due to limited resources and organisational survival summarised in the second subtheme, ***Operating in partnership in AQP***, as Abdul explains: ‘I think competition in talking therapies actually makes it harder to do the cooperative bit...they are going to be your competitors in the next bid’. The fragmentation of services with increased numbers of providers has negative impacts on clinical governance. This is presented in a final subtheme ***Delivering clinical governance in partnership***, as Liz reflects: ‘*we are all mucking in together and there is something nice about that. But the shadow side of it, is that it is very hard, the governance of it*’.

Superordinate theme: 3. *Elephants: Bureaucracy in AQP.*

One topic that occurred throughout the data was participant’s experience and perception of power and autonomy, represented in the superordinate theme – ***Elephants: Bureaucracy in AQP***. For example, Rachael summarises the frustrations of top-down acknowledgement of the inherent contradictions of meeting increasingly pressurising targets and looking after staff: *‘there are all those elephants in the room and the dots haven’t been joined up’.* Despite recognising the value of clinical governance structures, the first of four subthemes – ***IAPT governance and AQP*** – concerned the challenges of delivering choice of quality therapy in IAPT’s target driven one-size-fits-all epistemology, as commissioner Paul recognises: *‘patient-centred care might not mean a NICE approved approach’.* A second subtheme – ***NHS administration and AQP*** – reflects frustrations with the barriers of wasteful NHS systems. Despite their agility, small providers are seen to be burdened by the ‘*sledgehammers to crack nuts’* used by the NHS (Mark), and non-NHS providers in general are seen to be at an advantage, as commissioner Emma points out: ‘*NHS providers seem to be so bound in the red tape and bureaucracy. It’s the culture within the NHS unfortunately’.* Another subtheme, ***Experience of power hierarchy in AQP,*** gathers together participant’s experiences of negotiating top-down power structures. Both providers and commissioners struggle with perceived lack of influence in the implementation of policy, as Emma says: ‘*it doesn’t feel* *like a two-way process'*. Some providers experienced this negatively at provider-commissioner level, although Rachael empathised with commissioners because '*they are under the same gun we are'*. Whilst juggling different priorities, there was some reflection on the wider political drivers influencing practice, represented in a final *subtheme:* ***Political agenda of AQP***. This gathers participant's perceptions of political agendas concerning privatisation and upheaval in the commissioning process, most bleakly expressed by Trisha: '*the government doesn't give a damn about people having mental health problems'*. Despite this, participants were confident of their ability to maintain quality patient-centred services.

Superordinate theme 4. *Sopranos: Patient experience in AQP.*

The final superordinate theme reflects on the limits to the quality of patient care in the model of choice, as Liz commented:

> *and actually what you think you want is something really different again, because you've been watching The Sopranos, and you have seen Tony Soprano having therapy and you think you'd like a bit of that. Do you know what I mean?*

The first of two subthemes – ***Patient choice in AQP*** – represented participant's thoughts about the benefits and limitations of what Priya called a '*kind of trip advisor approach'*. Although choice is seen as a good thing for patients, viewing the patient as a customer in the eyes of policy is strongly rejected by all participants. Instead, the second subtheme – ***Patient care in AQP*** – emphasises the importance of person-centred clinical care in PCPT, as summarised by Bridget: '*if someone is making a choice about which wheelchair they want, then allowing them to choose where they go and buy their wheelchair is very different from if someone is in psychological distress'*. The overriding dedication to patient care is described by Rachael as: '*trying to give the best quality of care to the highest number of people at the same time'*.

Discussion

New models of care for effective services?

The Dalton review calls for new care models and 'organisational forms' that use flexible delivery methods, including more joint working and local autonomy rather than top-down directives, to translate 'ideas into reality' from the Five Year Forward View (Department of Health, 2014, p.4). The FYFVMH states that 'new models of care' are needed to meet the increasing prevalence of CMHDs (Mental Health Taskforce, 2016, p.19). Although AQP may not be popular in PCPT, its flexibility offers insight to new organisational forms, more so that the one-size-fits-all model of IAPT alone. As such, the experiences of participants in delivering quality person-centred care within tight financial constraints and partnership working are of potential benefit in the developing new models of care within a landscape of STPs and money-saving measures, such as PbR. However, there are considerable barriers from bureaucracy and top-down pressures that inhibit the adaptations made by commissioners and providers to enable efficient and cost-effective implementation and effective partnership working.

The effects of AQP policy on Service Delivery.

> *the question is whether "patient choice" through the means of competition under the AQP policy is a reality that benefits the care and engagement of patients through improvement in the delivery of psychological therapies*
>
> (Griffiths et al., 2013, p.8).

As Griffiths et al. (2013) point out, the multiple layers of policy in AQP/IAPT cannot be evaluated in isolation from each other. Participant's solutions to the problems arising from AQP/IAPT are discussed below in relation to the need to deliver effective services in new models of care, with a focus on the final two themes in the results.

The logic of choice or the logic of care?

Improvement in patient experience is a product of wide-ranging impacts on service effectiveness. Because the multiple pressures on providers threaten the quality of patient care, the policy rhetoric that: 'giving people more choice and control is key to putting them at the heart of the NHS' (Department of Health, 2010c, foreword), therefore belies the need for a choice of *quality* services.

The policy impetus toward the quasi-market model therefore may risk 'crowding out' some of the core features of the clinical relationship when patients behave and are treated as customers in a market place (Sandel, cited by Owens, 2015, p.27), reflecting participant's fears. Owens argues that the personalisation agenda of the NHS that 'choice should become a defining feature of the service' (Darzi, cited by Owens, 2015, p.23), erodes the intimacy of the doctor-patient relationship; what Fotaki (2014) defines as an erosion of trust in the clinical relationship.

Like Owens (2015), Mol raises questions about the relational nature of patient care, drawing a distinction between the ‘logic of choice’ embedded in the rhetoric of NPM, and the ‘logic of care’, which traditionally underpins health and social care work (2008). Mol argues that that the reality of giving and receiving care practices is multilayered, uncertain and complex but ‘the logic of choice simplifies the relation between means and ends’ (2008, p.47). The logic of choice behind the ethos of an AQP/IAPT service sees clients as ‘“discriminating customers”’ (Gabe et al., 2015). However, because this is ‘*not a traditional market’* according to Priya, choice in PCPT does not automatically lead to improved outcomes because of the relational nature of therapy, as Bridget noted.

Greener (2009) finds strong association of the word ‘*choice*’ with ‘*responsiveness*’ to patient’s needs in NHS discourse. Like Mol’s logic of care, ‘care provision becomes a process of negotiation between doctor and patient’ (Greener, 2009, p.321) and patients choose to be cared for and trust care professionals to take control over care practices. This reflects many participant’s views of clients who might just want to be looked after or to speak to someone, more than exert choice of evidence-based therapies. Participant’s commitment to clinical values protects the service from the crowding out of care practices.

Interaction of IAPT debates and AQP.

The lack of responsiveness in the rhetoric of choice was also seen to be inherent in IAPT’s one-size-fits-all approach by several participants, notably in Liz’s perception of client’s fantasies about *The Sopranos.* This echoes Lees’ suggestion that the rhetoric around IAPT’s ‘“revolution”’ is in itself a fantasy, due to its false promises (2016, p.2).

The ability to deliver IAPT standards under AQP was not easy, due to: overly rigid guidelines; lack of funding for service governance; activity that was centred on chasing targets sometimes perceived as meaningless; and perverse incentives. As Griffiths et al. suggested (2013), the wider range of providers in AQP from outside an NHS or IAPT background, raises questions about IAPT’s effectiveness – such as the meaningfulness of outcome measures and the choice of therapies available.

The frustration of participants with the reliance on measurements and bias towards CBT, echo the existing critiques of IAPT’s epistemological allegiance towards EBPP. IAPT’s promises of choice of treatment is further undermined by an underfunding of IAPT training in non-CBT therapy modalities (BACP, 2017; Barkham et al., 2017), despite the growing body of research that demonstrate the effectiveness of counselling (Pybis et al., 2017).

Managers and commissioners were aware that the measurement and audit focus of AQP/IAPT created stresses for staff, due to increased scrutiny and financial pressures. These are in addition to the existing morale issues in IAPT, such as targets; burnout; increasing complexity of cases; and lack of time to deliver good therapy; as reported by Rao et al. (2016). Due to the very nature of the work, many front-line mental health staff are at ‘risk of being flooded by intense and unmanageable anxiety’ (Bowden et al., 2015, p.490). In addition, McCafferty and colleagues (2012) argue that excessive performance management from commissioners can damage working relationships, which in turn affects service effectiveness.

The FYFVMH acknowledges the problems of staff wellbeing identified in the *NSP/BPS Staff Wellbeing Charter* (The New Savoy Partnership, 2015). The FYFVMH implementation document recognises the importance of ‘improving wellbeing, morale, retention and career development of the people who deliver services to improve stability’ in IAPT services, but there is an absence of specific interventions to reduce this stress beyond health checks, stress management and mindfulness to foster sustainable wellbeing (NHS England, 2016, p.17).

The lack of commitment to incorporating clinician's voices in co-production of service design is also evident in the terminology used in the FYFVMH implementation plan (NHS England, 2016). This may contribute to perceptions of IAPT as a juggernaut (Lees, 2016) and a tsunami (Dalal, 2018a), which undermines the importance of the therapist delivering relational therapy, rather than disembodied cogs in a wheel – or *widgets,* as Mark highlighted.

Thus, the elephants in the room for Rachael may represent the government's denial of the pressure of meeting targets whilst trying to take care of staff. The disavowal of the impossible traps of IAPT (Rizq, 2012b) and AQP, and the recruitment of therapy into a neoliberal pursuit of happiness and individuality (Layard, 2005; Pilgrim, 2008; Verhaeghe & Hedley-Prôle, 2014) are examples of political logics according to Glynos et al. (2015), that Speed and Gabe argue, weaken public trust in healthcare professionals and distances the government from their responsibility for health care (2013).

Navigating the elephants and alligators – solutions to the problems of AQP.

Whilst not new criticisms of IAPT, the wastefulness and pressures of top-down governance are particularly apparent in AQP, where competition is intended to be based upon quality, but where strict governance measures cannot be delivered within the tariff.

Kendall and Frank's notion of 'flexibility within fidelity' (2018) and trusting the clinical judgment of the experts to do their job (Paul), might return to the true meaning of EBPP as 'good clinical decision-making' (Henton, 2012, p.13) and allow quality standards to come from clinicians, and *not* from rigid policy ideals. This is reminiscent of Lipsky's street level bureaucracy (1980), where front-line staff are not seen as passive recipients of top-down policy, but instead respond to conflicts and challenges to their professional and ethical values in delivering care by pragmatic adjustments on the ground. The findings from this study suggest that street level bureaucracy in AQP challenges IAPT's one-size-fits-all definitions of quality and may offer flexibility for providers and commissioners to shift the institutional norms (Osipovič et al., 2016), whilst also retaining person-centred quality.

Conclusion.

The current study appears to confirm the suggestion by Griffiths et al. (2013) that the increased variety of organisational cultures has challenged the existing policies and procedures in favour of creative practice-led adaptations of the IAPT model. The diversity, dynamism and problem solving evident in this study of those participants who succeeded in delivering and innovating in AQP might go some way to address the dampening of creativity by the rigid protocols in IAPT reported by Gilburt et al. (2014). This might enable the patient-centred flexibility recommended for IAPT by Hamilton et al. (2011), and maximise effectiveness in the new models of care called for by the FYFVMH.

Clinical leaders are willing and able to adapt to a changing policy landscape by using clinical values and pragmatic local compromises to maximise effectiveness of services that can help address the increasing pressure on PCPT. However, the lack of funding and top-down responsivity to clinical voices by policy makers risks reducing the gains in effectiveness from these adaptations and clinical values. The government rhetoric of competition based on quality not price in PCPT with AQP needs to be challenged if there is not enough commitment by policy makers to adequately fund PCPT and to offer autonomy to clinical leaders to enable them to make pragmatic compromises and co-produce future services in the face of inflexible top-down directives. This may reduce perceptions of powerlessness against the top-down forces of policy and ‘institutionalization’ (May & Finch, 2009) that threaten practitioner’s sense of agency.

References:

APA [American Psychological Association]. (2006). Evidence-Based Practice in Psychology: APA Presidential Task Force on Evidence-Based Practice. *American Psychologist, 61,* 4 pp.271-285. Retrieved 12-02-19 from: https://www.apa.org/pubs/journals/features/evidence-based-statement.pdf

Atkinson, P. (2014). Lies Damned Lies, and IAPT. *Statistics. Self & Society*, *42*, pp.18-19.

BACP [British Association of Counselling and Psychotherapy]. (2017). Not so, NICE! *Therapy Today*, July 2017: *28*, Issue 6. Retrieved 03-02-19 from: https://www.bacp.co.uk/bacp-journals/therapy-today/2017/july-2017/not-so-nice/

Banister, P., Burman, E., Parker, I. et al. (1994). *Qualitative methods in psychology: A research guide.* Buckingham: Open University Press.

Barkham, M., & Margison, F. (2007). Practice-based evidence as a complement to evidence-based practice: from dichotomy to chiasmus. In: C. Freeman, & M. Power (eds.), *Handbook of evidence-based psychotherapies: A guide for research and practice*. (pp. 443–476). Chichester, United Kingdom: Wiley.

Barkham, M., Moller, N. P. & Pybis, J. (2017). How should we evaluate research on counselling and the treatment of depression? A case study on how the National Institute for Health and Care Excellence's draft 2018 guideline for depression considered what counts as best evidence. *Counselling and Psychotherapy Research*, *17,* 4.

Binnie, J. (2015). Do you want therapy with that? A critical account of working within IAPT. *Mental Health Review Journal, 20,* 2, pp.79-83.

Bowden, G. E., Smith, J. C. E., Parker, P. A., & Boxall, M. J. C. (2015). Working on the Edge: Stresses and Rewards of Work in a Front-line Mental Health Service. *Clinical Psychology & Psychotherapy, 22*, 6, pp.488-501.

Bower, P., and Gilbody, S. (2005). Stepped care in psychological therapies: access, effectiveness and efficiency: Narrative literature review. *The British Journal of Psychiatry, 186,* 1, pp.11-17.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* no. 2, pp.77-101.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners.* London: SAGE.

Brunsson, N. (2009). Constructing Organizations: The Example of Public Sector Reform. Chapter in: *Reform as Routine Organizational Change and Stability in the Modern World.* Oxford: Oxford University Press.

Callan, S. (2013). *Response to presentations at One-day conference: Social Justice Philanthropy Implications for Practice and Policy.* Friday 1 March 2013. National Council for Voluntary Organisations. Retrieved 21-02-19 from: https://www.kent.ac.uk/sspssr/philanthropy/esrc/Samantha%20Callan%20-%20Response.pdf

Clark, D. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: The IAPT experience. *International Review of Psychiatry, 23*, no. 4, pp.318-327.

Clark, D. (2018). Realizing the Mass Public Benefit of Evidence-Based Psychological Therapies: The IAPT Program. 19 January 2018. *.Annual Review of Clinical Psychology, 14,* 1.

Cuijpers, P., Smit, P., Bohlmeijer, E. et al. (2010). Efficacy of cognitive-behavioural therapy and other psychological treatments for adult depression: meta-analytic study of publication bias. *British Journal of Psychiatry 196,* pp.173-8.

Dalal, F. (2018a). *CBT: The cognitive behavioural tsunami : politics, power and the corruptions of science*. London: Routledge.

Dalal, F. (2018b). *Toxic Organizations: Hyper-rationality, Managerialism and the Fetishization of Measurement.* Video of conference presentation. 3rd Limbus Critical Psychotherapy Conference Toxic Organizations: Retrieved 03-12-18 from: http://www.limbus.org.uk/toxicorganizations/Videos.html

Davis, J., Lister, J. & Wrigley, D. (2015). *NHS for Sale: Myths, Lies & Deception*. Chicago: Merlin Press.

Delgadillo, J., Saxon, D. & Barkham, M. (2018). Associations between therapists' occupational burnout and their patients' depression and anxiety treatment outcomes. *Depression and Anxiety, 35*, no. 9, pp.844-850.

Del Re, A. et al. (2012). Therapist effects in the therapeutic alliance-outcome relationship: A restricted-maximum likelihood meta-analysis. *Clinical Psychology Review, 32,* 7, pp.642-649.

Department of Health. (1997). *The new NHS: Modern, dependable*. S.l.: Department of Health. Presented to Parliament by the Secretary of State for Health by Command of Her Majesty, December 1997 Cm 3807, published by The Stationery Office: ISBN 0 10 138072 0. Retrieved 23-11-18 from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/266003/newnhs.pdf

Department of Health. (2008). *IAPT Outline Service Specification: Improving Access to Psychological Therapies Programme (IAPT).* Care Services Improvement Partnership (CSIP) and National Institute for Mental Health in England (NIMHE). Retrieved 12-04-18 from: https://www.uea.ac.uk/documents/246046/11991919/iapt-pathfinder-outline-service-specification.pdf/9fc11891-ecc5-48e4-a974-9bbc8ab0c690

Department of Health. (2010a). *Equity and excellence: liberating the NHS*. Cm 7881. London: Department of Health. Retrieved 05-10-18 from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf

Department of Health. (2010b), *Extension of Any Qualified Provider Impact assessment 14/07/2010* IA No: 2026. London: Department of Health. Retrieved 05-10-18 from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216136/dh_128461.pdf

Department of Health (2010c). *Liberating the NHS: Greater choice and control - A consultation on proposal*. Department of Health, October 2010. Retrieved 28-02-19 from: https://webarchive.nationalarchives.gov.uk/20130105062415/http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_119651

Department of Health. (2011) *Operational guidance to the NHS: Extending Patient Choice of Provider - Best Practice Guidance.* London: Department of Health. Retrieved 28-02-19 from: https://www.gov.uk/government/publications/operational-guidance-to-the-nhs-extending-patient-choice-of-provider--2

Department of Health. (2012). *IAPT three-year report. The first million patients*. London: Department of Health. Retrieved 10-07-18 from:
from: http://www.mhinnovation.net/sites/default/files/downloads/innovation/reports/Three-year-report.pdf

Department of Health. (2014). *Examining new options and opportunities for providers of NHS care. The Dalton review*. London: Department of Health. Retrieved 15-01-19 from:: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/384126/Dalton_Review.pdf

Ettelt, S., Mays, N. & Allen, P. (2015). Policy experiments: Investigating effectiveness or confirming direction? *Evaluation, 21*, no. 3, pp.292-307.

Foster, J., & Murphy, A. (2005). *Psychological therapies in primary care: Setting up a managed service*. London, New York: Karnac.

Fotaki, M. (2014). Can consumer choice replace trust in the National Health Service in England? Towards developing an affective psychosocial conception of trust in health care. *Sociology of Health & Illness, 36*, no. 8, pp.1276-1294.

Gabe, J., Harley, K. & Calnan, M. (2015). Healthcare choice: Discourses, perceptions, experiences and practices. *Current Sociology, 63*, no. 5, pp.623-635.

Gambrill, E. & Littell, J.H. (2010). Do haphazard reviews provide sound directions for dissemination efforts?. *The American psychologist*, *65*, no. 9, pp.927-927.

Geyer, R. (2013). The complexity of GP commissioning. *Clinical Governance: An International Journal*, *18*, no. 1, pp.49-57.

Gilburt, H. et al. (2014). *Service transformation Lessons from mental health.* The Kings Fund, Retrieved 13-01-19 from: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/service-transformation-lessons-mental-health-4-feb-2014.pdf

Glover-Thomas, N. (2013). The Health and Social Care Act 2012: The emergence of equal treatment for mental health care or another false dawn? *Medical Law International*, *13*, no. 4, pp.279-297.

Glynos, J., Speed, E. & West, K. (2015). Logics of marginalisation in health and social care reform: Integration, choice, and provider-blind provision. *Critical Social Policy, 35*, no. 1, pp.45-68.

Goldman, S., Brettle, A., & McAndrew, S. (2016). A client focused perspective of the effectiveness of Counselling for Depression (CfD). *Counselling and Psychotherapy Research, 16,* 4, pp.288-297.

Greener, I. (2009). Towards a history of choice in UK health policy. *Sociology of health & illness, 31*, no. 3, pp.309-324.

Griffiths, S., & Steen, S. (2013a). Improving Access to Psychological Therapies (IAPT) Programme: scrutinising IAPT cost estimates to support effective commissioning. *The Journal of Psychological Therapies in Primary Care, 2*, 2, pp.142-156.

Griffiths S. & Steen S. (2013b). Improving Access to Psychological Therapies (IAPT) programme: setting key performance indicators in a more robust context: a new perspective. *The Journal of Psychological Therapies in Primary Care 2,* pp.133-141.

Griffiths, S., Foster, J., Steen, S & Pietroni, P. (2013). *Mental Health's Market Experiment: Commissioning Psychological Therapies Through Any Qualified Provider.* Chester: University of Chester Press. Retrieved 31-01-16 from: http://www.chester.ac.uk/cptpc/research/papers

Guy, A., Loewenthal, D., Thomas, R., & Stephenson, S. (2012). Scrutinising NICE: The impact of the National Institute for Health and Clinical Excellence Guidelines on the provision of counselling and psychotherapy in primary care in the UK. *Psychodynamic Practice, 18,* 1, pp.25-50.

Ham et al. (2015). *The NHS under the coalition government Part one: NHS.* The King's Fund. Retrieved 31-01-18 from: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/the-nhs-under-the-coalition-government-part-one-nhs-reform.pdf

Hamilton, S., Hicks, A., Sayers, R. et al. (2011). *A user-focused evaluation of IAPT services in London. Report for Commissioning Support for London. Rethink, March 2011.* Retrieved 31-01-16 from: https://www.rethink.org/resources/a/a-user-focused-evaluation-of-iapt-services-in-london

Henton, I. (2012). Practice-based research and counselling psychology: A critical review and proposal. *Counselling Psychology Review British Psychological Society New Series-, 27,* 3, pp.11-28.

Holmes, B.J., Finegood, D. T., Riley, B. L. & Best, A. (2012). Systems Thinking in Dissemination and Implementation Research. In: Brownson, R., Colditz, G. & Proctor, E. (2012). *Dissemination and implementation research in health: Translating science to practice*. Oxford: Oxford University Press.

House, R. (2016). Alternatives to Managed Care in Research and Practice. In: Lees, J. (2016). *The future of psychological therapy: From managed care to transformational practice*. Hove, East Sussex: Routledge.pp.146-165.

Hudson, B. (2018). Citizen accountability in the 'New NHS' in England. *Critical Social Policy, 38,* no. 2, pp. 418-427.

Hunter, D. (2015). Role of politics in understanding complex, messy health systems. *British Medical Journal, 7999,* pp.15-17.

Jones, L. & Mays, N. (2013). Early experiences of any qualified provider. *British Journal of Healthcare Management, 19,* 5, pp.217-224.

Keefe, A. (2013). Learning From Each Other: Introducing Any Qualified Provider (AQP) Into the Talking Therapies Market in Bristol. *The Journal of Psychological Therapies in Primary Care, 2,* no. 1, pp.19-34.

Kendall, P.C. & Frank, H.E. (2018). Implementing evidence-based treatment protocols: Flexibility within fidelity. *Clinical Psychology: Science and Practice*, *25*, no. 4, pp.e12271-n/a.

Khanom, J. (2015). *The Unemployment Agenda in Mental Health Services: The Therapist's Perspective.* Professional doctorate thesis, University of East London. Retrieved 13-12-18 from: http://roar.uel.ac.uk/4699/

Kingdon, J. W. (2014). *Agendas, alternatives, and public policies*. Harlow: Pearson Education Limited.

Layard, R. (2005). *Happiness: Lessons from a new science.* London: Penguin.

Layard, R., & Clark, D. M. (2014). *Thrive: The power of evidence-based psychological therapies*. London: Penguin. Kindle edition previewed. Retrieved 31-01-19 from: https://books.google.co.uk/books?id=tGL5AgAAQBAJ&printsec=frontcover&dq=contents+page+thrive+layard&hl=en&sa=X&ved=0ahUKEwirjaPimeHgAhWp3eAKHcKcCvIQuwUILjAA#v=onepage&q&f=false

Layard, R., Clark, D., Knapp, M. & Mayraz, G. (2007). Cost-benefit analysis of psychological therapy. *National Institute Economic Review*, *202*, pp.90-98.

Lees, J. (2016). *The future of psychological therapy: From managed care to transformational practice*. Hove, East Sussex: Routledge.

Le Grand, J. (1997). Knights, Knaves or Pawns? Human Behaviour and Social Policy. *Journal of Social Policy, 26*, no. 2, pp.149-169.

Lipsky, M. (1980). *Street Level Bureaucracy: Dilemmas of the Individual in Public Services*. Russell Sage Foundation. Retrieved 20-02-19 from http://www.jstor.org/stable/10.7758/9781610447713

Lovell, K., Bower, P., Gellatly, J. et al. (2017). Clinical effectiveness, cost-effectiveness and acceptability of low-intensity interventions in the management of obsessive-compulsive disorder: the Obsessive-Compulsive Treatment Efficacy randomised controlled Trial (OCTET). *Health Technology Assessment. 21*, pp.1-132.

Marziller, J. & Hall, J. (2009). The challenge of the Layard initiative. *The Psychologist, 22*, 5, pp.396-399.

May, C. & Finch, T. (2009). Implementing, Embedding, and Integrating Practices: An Outline of Normalization Process Theory. *Sociology, 43,* no. 3, pp 535-554.

McCafferty, S. et al. (2012). Implementing World Class Commissioning Competencies. *Journal of Health Services Research & Policy, 17*, no. 1_suppl, pp.40-48.

McDaniel, J., Reuben R, Lanham, H.J. & Anderson, R.A. (2009). Implications of complex adaptive systems theory for the design of research on health care organizations. *Health care management review, 34*, no. 2, pp.191.

McDonald, K. M. et al. (2007). *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies*. Technical Review 9 (Prepared by the Stanford University-UCSF Evidence-based Practice Center under contract 290-02-0017). AHRQ Publication No. 04(07)-0051-7. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved 03-03-19 from: https://www.ncbi.nlm.nih.gov/books/NBK44015/

Mental Health Taskforce. (2016). *The Five Year Forward for Mental Health.* Retrieved 11-07-18 from: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

McHugh, R. K., & Barlow, D. H. (2010). The dissemination and implementation of evidence-based psychological treatments: A review of current efforts. *American Psychologist, 65*, 2, p.73.

McPherson, S., Evans, C. & Richardson, P. (2009). The NICE Depression Guidelines and the recovery model: Is there an evidence base for IAPT? *Journal of Mental Health*, *18,* 5, pp.405-414.

Mental Health Taskforce. (2015). *The Five Year Forward View Mental Health Taskforce: public engagement findings*. Retrieved 11-07-18 from: https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2015/09/fyfv-mental-hlth-taskforce.pdf

Mental Health Taskforce. (2016). *The Five Year Forward for Mental Health.* Retrieved 11-07-18 from: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Mofidi, R. & Marrow, C. (2017). The effects of the NHS reforms on quality of care. *British Journal of Healthcare Management, 23,* 3, pp.120-130.

Mol, A. (2008). *The logic of care: Health and the problem of patient choice*. London: Routledge

Mollon, P. (2009). The NICE guidelines are misleading, unscientific, and potentially impede good psychological care and help. *Psychodynamic Practice, 15,* 1, pp.9-24.

Murphy, D. (2011). Unprecedented times in the professionalisation and state regulation of counselling and psychotherapy: The role of the higher education institute. *British Journal of Guidance & Counselling, 39,* 3, pp.227-237.

National Collaborating Centre for Mental Health. (2019). *The Improving Access to Psychological Therapies Manual.* Gateway reference: 08101 Version number: 2 First published: June 2018. National Collaborating Centre for Mental Health. Retrieved 23-02-19 from: https://www.england.nhs.uk/wp-content/uploads/2019/02/improving-access-to-psychological-therapies-manual.pdf

NHS. (2014). *Five year forward view*. London: NHS England. Retrieved 08-10-18 from: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

NHS. (2019). *The NHS Long Term Plan.* Retrieved 08-02-19 from: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf

NHS England. (2013). *Changes to AQP Support for 2014-15.* NHS England Gateway Publication Number: 00837. Retrieved 03-04-15 from: http://www.england.nhs.uk/wp-content/uploads/2013/11/aqp-sup-com-serv.pdf.

NHS England. (2016). Implementing the Five Year Forward View for Mental Health (gateway ref. 05574). NHS England. Retrieved 14-05-18 from: https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

NHS England. (2017). *Next Steps on the NHS Five Year Forward View*. Retrieved 13-02-18 from: https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/

NHS England. (2019). *Adult Improving Access to Psychological Therapies programme.* [Webpage]. Retrieved 24-04-2019 from: https://www.england.nhs.uk/mental-health/adults/iapt/

NHS England & NHS Improvement. (2017). *Developing an outcomes based payment approach for IAPT services*. NHS England publication. Retrieved 23-04-18 from: https://improvement.nhs.uk/documents/661/IAPT_Payment_Guidance.pdf

NICE [National Institute for Clinical Excellence]. (2018). *What we do.* [Webpage]. Retrieved 03-10-18 from: https://www.nice.org.uk/about/what-we-do

Norcross, J. C. (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. New York: Oxford University Press.

Oliver, D. (2018). Constant structural reorganisation won't improve or transform healthcare. *BMJ,* 2018; *361. doi:* https://doi.org/10.1136/bmj.k2433

Onwuegbuzie, A.J. & Leech, N.L. (2004). Enhancing the interpretation of "significant" findings: the role of mixed methods research. *The Qualitative Report, 9,* no. 4, pp.770.

Osipovič, D., et al. (2016). Interrogating Institutional Change: Actors' Attitudes to Competition and Cooperation in Commissioning Health Services in England. *Public Administration*, *94,* no. 3, 2016, pp.823-838.

Owens, J. (2015). Creating an impersonal NHS? Personalization, choice and the erosion of intimacy. *Health Expectations, 18,* 1, pp.22-31.

Oxman, A.D., Sackett, D.L., Chalmers, I., & Prescott, T.E. (2005). A surrealistic mega-analysis of redisorganization theories. *J R Soc Med*, 2005, *98*, pp.563-8.

Palinkas, L.A. (2014). Qualitative and Mixed Methods in Mental Health Services and Implementation Research. *Journal of Clinical Child & Adolescent Psychology, 43*, no. 6, pp.851-861.

Palinkas, L.A., Horwitz, S.M., Green, C.A. et al. (2015). Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research. *Administration and Policy in Mental Health and Mental Health Services Research, 42*, no. 5, pp.533-544.

Peacock-Brennan, S. (2016). *A genealogical investigation of the conditions of possibility for the emergence of Improving Access to Psychological Therapies (IAPT) services*. University of East London Professional Doctorate Thesis.

Petrosyan, Y., Sahakyan, Y., Barnsley, J. M. et al. (2017). Quality indicators for care of depression in primary care settings: a systematic review. *Systematic Reviews, 6,* 1, pp.1-14.

Pilgrim, D. (2008). Reading ‘Happiness’: CBT and the Layard thesis, *European Journal of Psychotherapy and Counselling, 10,* 3, pp.247-260. DOI: 10.1080/13642530802337967.

Plsek, P. & Greenhalgh, T. (2001). Complexity science: The challenge of complexity in health care. *British Medical Journal.* 2001, *323*, 7313, pp.625-628.

Pybis, J., Saxon, D., Hill, A., & Barkham, M. (2017). The comparative effectiveness and efficiency of cognitive behaviour therapy and generic counselling in the treatment of depression: evidence from the 2nd UK National Audit of psychological therapies. *Bmc Psychiatry, 17,* no.1, pp.1-13.

Pym, H., (2014). *The very public NHS privatisation debate*. BBC news article. 31 July, 2014. Retrieved 31-01-16 from: http://www.bbc.co.uk/news/health-28581878

Radhakrishnan, M., Hammond, G., Jones P. B. et al. (2013). Cost of Improving Access to Psychological Therapies (IAPT) programme: an analysis of cost of session, treatment and recovery in selected Primary Care Trusts in the East of England region. *Behaviour Research and Therapy*, *51*, pp.37-45. Retrieved 16-04-17 from: www.sciencedirect.com/science/article/pii/S0005796712001556

Rao, A.S., Bhutani, G., Dosanjh, N. et al. (2016). *Psychological Wellbeing & Resilience Resetting The Balance*. [Online]. Retrieved 05-08-18 from: https://www1.bps.org.uk/system/files/Public%20files/ar_v10_resetting_the_balance_160516.docx.pdf

Ritzer, G. (1993). *The McDonaldization of Society*. Pine Forge, London.

Rizq, R. (2012a). The perversion of care: Psychological therapies in a time of IAPT. *Psychodynamic Practice, 18*, no. 1, pp 7-24.

Rizq, R. (2012b). The Ghost in the Machine: IAPT and Organizational Melancholia. *British Journal of Psychotherapy, 28,* no. 3, pp.319-335.

Rizq, R.(2014). Perversion, neoliberalism and therapy: The audit culture in mental health services. *Psychoanalysis, Culture & Society, 19,* no. 2, pp.209-218.

Rogers, E. (2009). The need for reappraising psychological therapies in the light of IAPT. *The Journal of Mental Health Training, Education and Practice, 4*, no. 1, pp.19-26.

Rogers, A. & Murphy, D. (2017). Person-centred therapy and the regulation of counsellors and psychotherapists in the UK, In: Joseph, S. (2017). *The handbook of person-centred therapy and mental health: Theory, research and practice*. 2nd edn. Monmouth: PCCS Books.

Samuels, A., & Veale, D. (2009). Improving access to psychological therapies: For and against. *Psychodynamic Practice, 15,* 1, pp.41-56.

Scanlon, C. (2015). On the perversity of an imagined psychological solution to very real social problems of unemployment (work-lessness) and social exclusion (Worth-lessness): A Group Analytic Critique. *Group Analysis*. *48,* 1, pp.31-44.

Shean, G. (2014). Limitations of Randomized Control Designs in Psychotherapy Research. *Advances in Psychiatry, vol. 2014,* Article ID 561452, 5 pages. Retrieved 15-06-18 from: https://doi.org/10.1155/2014/561452

Speed, E., & Gabe, J. (2013). The Health and Social Care Act for England 2012: The extension of 'new professionalism'. *Critical Social Policy, 33,* 3, pp.564-574.

Stacey, R. D. (2010). *Complex responsive processes in organizations: Learning and knowledge creation*. London: Routledge.

Steel, C., Macdonald, J., Schröder, T. & Mellor-Clark, J. (2015). Exhausted but not cynical: burnout in therapists working within Improving Access to Psychological Therapy Services. *Journal of Mental Health, 24,* no. 1, pp 33-37.

Steen, S. A. (2015). *Understanding the processes involved in implementing an improving access to psychological therapies service: An exploratory study that investigates practitioner and client experience regarding its effect on patient pathways, service design and overall outcomes.* (Doctoral dissertation). University of Chester, United Kingdom.

The New Savoy Partnership. (2015). *NSP/BPS Staff Wellbeing Charter*. [Web page]. Retrieved 23-08-2020 from: https://www.healthcareconferencesuk.co.uk/conferences-masterclasses/subjects/psychological-therapies-new-savoy-partnership

Timmins, N. (2018). *The Lansley reforms succeeded in unintended ways* Policy and Regulation HSJ online article. 24 May 2018. Retrieved 17-03-2019 from: https://www.hsj.co.uk/policy-and-regulation/the-lansley-reforms-succeeded-in-unintended-ways/7022483.article

van Dijk, T. (2007). The study of discourse: an introduction. In: Teun A.van Dijk (ed.). (2007). *Discourse Studies. 5 vols. Sage Benchmarks in Discourse Studies.* (pp. xix-xlii). London: Sage. Retrieved 31-01-19 from: http://www.discourses.org/download/articles/
Vos, T., Haby, M. M. & Magnus, A. et al. (2005). Assessing cost-effectiveness in mental health: helping policy-makers prioritize and plan health services. *Australian and New Zealand Journal of Psychiatry, 39,* 8, pp.701-712.

Verhaeghe, P. & Hedley-Prôle, J. (2014). *What about Me? : The Struggle for Identity in a Market-Based Society,* Scribe Publications, Brunswick, Victoria.

Westwood, S., Morison, L., Allt, J., & Holmes, N. (2017). Predictors of emotional exhaustion, disengagement and burnout among improving access to psychological therapies (IAPT) practitioners. *Journal of Mental Health, 26,* 2, pp.172-179.

Williams, D. (2014). *Exclusive: CCG interest in 'any qualified provider' scheme dwindles. HSJ.* Retrieved 31-01-16 from: http://www.hsj.co.uk/sectors/commissioning/exclusive-ccg-interest-in-any-qualified-provider-scheme-dwindles/5074585.fullarticle

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