NCPS NATIONAL COUNSELLING & PSYCHOTHERAPY SOCIETY

About the NCPS

The National Counselling & Psychotherapy Society (NCPS) represents over 18,500 counsellors & psychotherapists on Accredited Registers across the whole of the UK. We welcome the government's ambition to reinvent the NHS through the three shifts, but note that we will not be able to deliver these shifts at pace, or sustainably, without drawing on the counselling & psychotherapy workforce on Accredited Registers. This is an excellent and timely opportunity to re-think the way the NHS views and supports mental and emotional wellbeing, and we are happy to support this work in any way we can.

Executive Summary

What we're seeing now

Hospital → community

A decade of emphasis on low-intensity, manualised, high-throughput models has narrowed therapeutic choice and reduced access to relational support. The result is poorer engagement for people with complex needs, widening inequalities, and compounding issues when clients are 'stepped' between tiers. Evidence consistently shows that the therapeutic alliance, or therapeutic relationship, is one of the strongest predictors of outcomes, and that therapist choice and fit are important for engagement and recovery. The current system does not make best use of those facts.

Analogue → digital

Digital tools can improve access and efficiency, but untested or unregulated AI poses safety, equity, and accountability risks, *particularly* for children and young people. Digital must augment, not replace, human-provided support. Without safeguards, we risk digital-first tunnels that exacerbate isolation, miss embodied emotional cues, and create parallel, unaccountable pathways wherein people become disillusioned about mental health support.

Sickness → prevention

Long waits and limited early help are driving the over-medicalisation of mild-to-moderate distress, leading to escalation to crisis services, and so avoidable pressure on emergency and inpatient services. In contrast, preventative counselling in schools, primary care, and communities delivers demonstrable, significant value, both monetarily and societally, with evidence of positive outcomes and favourable cost/benefit – however, it remains under-used. There is a workforce of 60,000+ Accredited practitioners ready to provide preventative support immediately.

What good looks like

Relational care as the fundamental, organising principle

Across modalities and settings, including online, outcomes are linked with the quality of the therapeutic relationship. By guiding commissioners to support continuity, choice, and therapist-patient fit, we will raise the quality of therapy offered and reduce the number of Did Not Attends (DNAs) and drop-offs.

Digital as an enabler, but not as a substitute

Teletherapy (online video therapy) can maintain the relationship, and therefore, outcomes when delivered well. AI can safely support triage, measurement, admin, matching, and between-session engagement, provided they are done so within the Principles for Relational Safeguards i.e. with human oversight, and escalation protocols, robust regulation, bias auditing, and clear routes back to human support all firmly in place.

Prevention delivered locally

Direct access to counselling & psychotherapy via decentralised models such as schools, community hubs, or private therapy services can cut waits from months to weeks, offer valuable choice, and reduce demand on crisis services. The economic case is strong (e.g. high social and economic return), and the evidence is clear in that early relational support prevents escalation.

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Contents

Hospital to community

Counsellors & psychotherapists working in community settings (in schools, primary care, voluntary sector, local hubs) have for decades delivered relational, person-centred therapy that helps prevent escalation of distress into crisis. Over the past decade, a shift toward low-intensity, manualised, high-throughput models (for example as in NHS IAPT/Talking Therapies) has led to diminished, and still diminishing, numbers of high-quality relational therapists and a narrowing of therapeutic choice. This trend has had measurable impacts on outcomes, equity, and patient experience. We advocate for a reversal of this trend, and the development of community-based services that have relationships and relational working at the heart of the services they offer, especially when it comes to mental health support.

Impacts of proliferation of low-intensity services: what does the research say?

Attrition, engagement, and equity issues

A study of a low-intensity service in Scotland (Grant et al., 2011[1]) found high drop-out rates: many who were referred failed to opt in, attend their first appointment or dropped out mid-treatment. People from more deprived areas were less likely to engage, suggesting that simplified, manualised models struggle to retain marginalised clients.

In low-intensity CBT services, qualitative research has shown that between-session tasks (a core element of manualised CBT) suffer from low adherence (Bennion et al., 2025[2]). Practitioners report that many patients struggle to complete or engage with homework, particularly where social stressors, comorbidities, low mental health literacy or cultural mismatch intervene.

This weakens the efficacy of the treatment, especially for those with more complex needs, and amplifies inequalities in access and outcomes.

Limited flexibility for complexity, comorbidity, relational work

Low-intensity models are typically designed for mild-to-moderate anxiety and depression, with protocolised content and limited therapist discretion. Research (e.g. Clark's work on mass public benefit of psychological therapy (Clark, 2018[3])) shows that while low-intensity approaches have a place, most psychological treatments delivered under IAPT are CBT-based and rigid.

Clients with more complex needs, comorbidities, trauma histories, or relational difficulties often do not respond adequately to low-intensity models. The need for deeper therapeutic work, flexibility, formulation, and relational adaptation is sidelined in those models. Without enough relational therapists to 'step up' quickly, clients may languish on waiting lists longer, deteriorate, or fall through gaps.

Therapist choice, matching, low efficacy rates, and variable outcomes

Research consistently shows that which therapist a client sees can meaningfully influence outcomes, moreso than the therapy modality. Large multilevel studies have demonstrated that therapist effects (differences in outcomes

[1] Grant, K. *et al*, Greater Glasgow and Clyde NHS, Scotland (2011). Individual Therapy Attrition Rates in a Low-Intensity 2 Service: A Comparison of Cognitive Behavioural and 3 Person-Centred Therapies and the Impact of Deprivation. Available at ResearchGate (Accessed 01/10/2025)

[2] Bennion, M., Blakemore, A., Lovell, K. *et al.* (2025). Barriers and facilitators to engagement with between-session work for low-intensity Cognitive Behavioural Therapy (CBT)-based interventions: a qualitative exploration of practitioner perceptions. Available at BMC Psychiatry (Accessed 01/10/2025)

[3] Clark D. M. (2018). Realizing the Mass Public Benefit of Evidence-Based Psychological Therapies: The IAPT Program. *Annual review of clinical psychology*, *14*, 159–183. (Accessed 01/10/2025)

attributable to individual therapists) typically account for between 5 - 8% of outcome variance, and in some settings the figure is higher (Wampold & Imel, 2015[4]; Delgadillo *et al*., 2020[5]).

In a large naturalistic study involving 6,146 patients across 581 therapists, therapist variability explained 5.2% of outcome variance; clients seeing therapists in the top quartile improved on average twice as much as those seeing therapists in the bottom quartile (Mahon *et al*., 2023[6]). In primary care specifically, therapist effects can be particularly pronounced: one study found that after controlling for baseline and process variables, therapist variability explained 8.4% of patient outcomes (Owen et al., 2016[7]).

Individual therapist skill, relational capacity, flexibility, and cultural fit all contribute to outcomes (Baldwin, Imel, 2013[8]). Reducing the supply of relationally-trained therapists narrows client choice and amplifies the effects of poor matches. We should employ greater numbers of therapists trained relationally than those trained only in a single modality.

This has major implications for NHS workforce planning. If the system privileges throughput and standardisation over relational care, clients may be assigned therapists poorly matched to their needs, diminishing effectiveness. When the cost of a therapy session is so significant, it is wise to consider how to maximise effectiveness.

Continuity, fragmentation, and the limits of the stepped-care approach

The NHS Talking Therapies model has typically relied on a stepped-care approach, where patients begin with low-intensity interventions (often guided self-help or protocolised CBT) and are then 'stepped up' to high-intensity therapy if initial treatments are unsuccessful. In practice, this often involves switching therapist, undergoing new assessments, and enduring further waiting lists. These transitions disrupt continuity, rupture therapeutic relationships, and delay effective treatment.

In contrast, counsellors & psychotherapists are trained to work flexibly across a spectrum of intensity: from brief, focused support to longer-term, in-depth therapy. In all cases, the relational is the fundamental underpinning of that work. Rather than funnelling clients through rigid tiers of provision, counselling offers a more seamless model wherein the same practitioner can scale the intensity of support up or down as needed, guided by the therapeutic relationship / alliance and the client's changing circumstances or preferences (which also contributes to improved outcomes (Williams *et al*. 2016[9]).

Being flexible in this way avoids the inefficiencies of stepped care inherent in the current model. Evidence shows that continuity of therapeutic relationship is a key determinant of outcomes (Horvath & Symonds, 1991[10]; Wampold & Imel, 2015[11]), whereas the current model undermine this principle. Further research conducted internationally also

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[4] Wampold, B. E., & Imel, Z. E. (2015). *The Great Psychotherapy Debate: The Evidence for What Makes Psychotherapy Work* (2nd ed.). Routledge.
[5] Delgadillo, J., Rubel, J., Barkham, M., Lutz, W., & Saxon, D. (2020). Therapist variability in patient outcomes: A multilevel study of practice-based evidence in low-intensity psychological interventions. *Psychological Medicine*, 50(8), 1340–1347.
[6] Mahon, D., Minami, T., Brown, G. (2023). The variability of client, therapist, and clinic in psychotherapy outcomes: A three-level hierarchical model. Counselling and Psychotherapy Research. (Accessed 14/10/2025)
[7] Owen, J., Miller, S. D., Seidel, J. A., Chow, D. L., & Wampold, B. E. (2016). The role of therapist variability in psychotherapy outcomes: A multi-study analysis. *Cognitive Behaviour Therapy*, 45(6), 431–443.
[8] Baldwin, S. A., & Imel, Z. E. (2013). Therapist effects: Findings and methods. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (6th ed., pp. 258–297). Wiley.
[9] Williams, R., Farquharson, L., Palmer, L. *et al.* Patient preference in psychological treatment and associations with self-reported outcome: national cross-sectional survey in England and Wales. *BMC Psychiatry*. (Accessed 15/10/2025)
[10] Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, 38(2), 139–149.
[11] Wampold, B. E., & Imel, Z. E. (2015). *The Great Psychotherapy Debate: The Evidence for What Makes Psychotherapy Work* (2nd ed.). Routledge.

suggests that preserving therapist continuity improves engagement, reduces attrition, and provides a basis for trust, particularly for clients with complex needs (Swift & Greenberg, 2012[12]).

The NHS's reliance on a single modality (predominantly CBT) delivered through these stepped-care tiers misses the opportunities the counselling & psychotherapy workforce can offer. Counselling can deliver both low- and high-intensity care within one relational framework, thereby combining the accessibility of early support with the depth needed for more complex presentations.

Implications for quality of mental health support

- As relational therapists become fewer, and lower intensity models dominate, quality may decline, especially for patients with more complex or chronic problems.
- Because many patients never receive, or wait excessively long, for relational therapy, the community care model loses much of its preventative capacity: rather than preventing escalation, low-intensity models sometimes fail to intercept, leaving secondary and hospital services to pick up the tab.
- People who are disadvantaged, minoritised, or experiencing complex or comorbid issues or distress are less likely to engage with manualised models, so the shift may worsen mental health disparities, compounding inequity within the system.
- The decline of relational practitioners also reduces capacity for clinical innovation, supervision, professional development and reflective practice, which are essential for maintaining a high-quality workforce over time.

What must change

1. **Rebalance investment in counselling & psychotherapy within the NHS**

Prioritise counsellors & psychotherapists, experts in working relationally, rather than relying predominantly on low-intensity roles, ensuring the existing workforce of 60,000+ practitioners is mobilised.

2. **Replace the stepped-care model with flexible, continuous support**

Counselling & psychotherapy should be commissioned as a model that can scale from brief to more intensive interventions within the same therapeutic relationship, avoiding re-assessment, referral delays, and ruptures in continuity.

3. **Embed relational, person-centred approaches as a core element of NHS provision**

For clients with complex needs, a history of trauma, or multiple disadvantages, relational depth is essential for engagement and recovery. This should be understood and made a key part of designing services.

4. **Design pathways that prioritise choice and matching**

Referral and commissioning systems must allow clients to choose from a range of qualified counsellors to support efficacy and engagement.

[12] Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology*, 80(4), 547–559.

Analogue to digital

The ambition to move from analogue to digital must be governed by relational, ethical, and quality safeguards. Currently, the ambition seems to be being driven by technological enthusiasm and the heavy investment of a number of tech firms in the future of the AI mental health industry. Digital tools, including AI, could, and perhaps should, expand access and augment human-centred care and support. They must not replace it, especially for children and young people, vulnerable groups, and people with additional or complex needs (Clark 2025[13]; Dray, Symons 2025[14]; Moore *et al.* 2025[15]).

Unregulated or prematurely deployed AI mental health tools carry serious risks (Moore *et al*. 2025[16]; APA 2025[17]), and we would do well to be considered and pragmatic about their use.

Impacts of untested, unregulated adoption of AI mental health services

Safety risks and harmful responses

Systematic reviews note that many chatbots are launched with limited clinical evaluation, and that patient safety and crisis handling are rarely assessed, raising concerns about inappropriate or harmful responses in high-risk scenarios (Ali Abd-Alrazaq *et al*. 2020[18]).

In classic crisis-prompt testing of conversational agents, responses were inconsistent and incomplete across suicidality, domestic violence, and other urgent concerns, which highlights the danger of relying on unvalidated systems in moments of risk (Miner *et al*. 2016[19]). More recent evaluations of generative AI systems report that some models can still produce unsafe or risky outputs when confronted with sensitive mental-health content, highlighting the need for rigorous guardrails before clinical use (De Freitas *et al*. 2023[20]).

There are also developmental and relational risks. Paediatric experts caution that 'companion' chatbots can cultivate *illusory empathy* and misplaced trust among children and young people, potentially displacing help-seeking from humans and impairing social development; several reports recommend against their use with under-18s (Stanford Medicine, 2025[21]). Similarly, longstanding evidence shows algorithmic bias can differentially mis-serve minoritised groups, with well-known healthcare algorithms exhibiting substantial racial bias. It's clear that mental-health AI trained on non-representative data risks amplifying inequalities if we're not careful or thoughtful about it (Obermeyer *et al*. 2019[22]).

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[13] Clark, A. (2025). The Ability of AI Therapy Bots to Set Limits With Distressed Adolescents: Simulation-Based Comparison Study. *JMIR mental health*, *12*, e78414. (Accessed 01/10/2025)

[14] Dray, J., Symons, D. Review of Innovative Mental Health Support for Children and Young People: Generative AI Co-design Applications and Challenges. Current Developmental Disorders Reports (Accessed 01/10/2025)

[15] Moore, B. *et al*. (2025). The Integration of Artificial Intelligence-Powered Psychotherapy Chatbots in Pediatric Care: Scaffold or Substitute? The Journal of Pediatrics, Volume 280, 114509 (Accessed 01/10/2025)

[16] Moore, J., Grabb, D., Agnew, W. *et al*., Cornell University (2025). Expressing stigma and inappropriate responses prevents LLMs from safely replacing mental health providers, Arxiv.org. (Accessed 01/10/2025)

[17] APA (2024), Artificial Intelligence and the Field of Psychotherapy. https://www.apa.org/about/policy/statement-artificial-intelligence.pdf (Accessed 01/10/2025)

[18] Abd-Alrazaq, A. A., Rababeh, A., Alajlani, M., Bewick, B. M., Househ, M. (2020). Effectiveness and Safety of Using Chatbots to Improve Mental Health: Systematic Review and Meta-Analysis. *Journal of medical Internet research* (Accessed 15/10/2025)

[19] Miner, A.S., Milstein, A., Schueller, S. (2016) Smartphone-Based Conversational Agents and Responses to Questions About Mental Health, Interpersonal Violence, and Physical Health. *Jama Internal Medicine*. (Accessed 15/10/2025)

[20] De Freitas, J., Kaan Uğuralp, A., Uğuralp, Z., Puntoni, S. (2023) Chatbots and Mental Health: Insights into the Safety of Generative AI. *Harvard Business School.* (Accessed 15/10/2025)

[21] https://med.stanford.edu/news/insights/2025/08/ai-chatbots-kids-teens-artificial-intelligence.html (Accessed 15/10/2025)

[22] Obermeyer, Z., Powers, B., Vogeli, C., Mullainathan, S. (2019) Dissecting racial bias in an algorithm used to manage the health of populations. *Science.* (Accessed 15/10/2025)

The use of chatbots also re-raises some long-standing, unresolved privacy and data-protection issues: independent assessments of health and mental-health apps have documented extensive data sharing and weak privacy disclosures, creating additional risk when users disclose sensitive mental-health information (Huckvale *et al*. 2019[23], Grundy *et al*. 2019[24], Tangari *et al*. 2021[25]) .

Illusory empathy and misplaced trust

When chatbots are designed with anthropomorphic features or human-like conversational styles, users are more likely to perceive them as caring or understanding, even though the empathy they express is simulated. Studies show that chatbots with human-like avatars or language cues increase trust and compliance with recommendations by reducing psychological distance (e.g. users feel 'closer' to the bot) (Park *et al*. 2023[26]).

Moreover, recent work on *The Illusion of Empathy* reveals that conversational agents can strategically shape perception of empathy, leading users to overestimate their relational capacity (Liu, Giorgi, Aich *et al.* 2024[27]).

This effect is especially concerning for children and young people. In contexts of loneliness or low social support, they may overly anthropomorphise chatbots, believing the system cares about them or understands their emotional life. In some very concerning cases, people have become convinced their chatbot is sentient, and subsequently become very mentally unwell. Over time, excessive engagement can lead to psychological dependence: studies of users of social chatbots (e.g. Replika) show that loneliness, trust, and personification drive deeper attachment, which may displace or interfere with human relationships (Tianling, Pentina, Hancock 2023[28]).

There is a risk that these 'relationships' discourage them from seeking genuine relational support from counsellors or therapists (Cuadra *et al.*, 2024[29]), or even forming / maintaining relationships with family and friends.

The danger is that users, particularly younger ones, may gradually shift away from looking for help from human professionals believing the chatbot is sufficient, which then reduces opportunities for meaningful therapeutic relationship, critical reflection and challenge, and trust in human empathy. Because the 'empathy' offered by chatbots is illusory (a constructed mimicry rather than genuine attunement), substituting people with bots offers only shallow, superficial support, and therefore limited genuine improvement of mental health issues in the longer term. Further, the atrophying of social and relational skills (the converse of which is an important benefit of counselling & psychotherapy) could lead to significant interpersonal issues over the long term (Zhang *et al.* 2025[30]).

Equity and bias concerns

AI mental health tools are vulnerable to reinforcing existing inequalities because their models are often trained on non-representative data that under-captures the experiences, language, idioms, and how marginalised groups express distress. A review on AI chatbots in mental health cautions that bias in training data may lead to algorithmic

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[23] Huckvale, K., Torous, J., & Larsen, M. E. (2019). Assessment of the Data Sharing and Privacy Practices of Smartphone Apps for Depression and Smoking Cessation. *JAMA network open* (Accessed 15/10/2025)

[24] Grundy Q, Chiu K, Held F, Continella A, Bero L, Holz R et al. (2019) Data sharing practices of medicines related apps and the mobile ecosystem: traffic, content, and network analysis *BMJ* (Accessed 15/10/2025)

[25] Tangari G, Ikram M, Ijaz K, Kaafar M A, Berkovsky S. Mobile health and privacy: cross sectional study *BMJ* (Accessed 15/10/2025)

[26] Park, G., Chung, J., & Lee, S. (2023). Human vs. machine-like representation in chatbot mental health counseling: the serial mediation of psychological distance and trust on compliance intention. *Current psychology*. (Accessed 13/10/2025)

[27] Liu, T., Giorgi, S., Aich, A. *et al.* (2025). The Illusion of Empathy: How AI Chatbots Shape Conversation Perception. Proceedings of the AAAI Conference on Artificial Intelligence. (Accessed 13/10/2025)

[28] Tianling, X., Pentina, I., Hancock, T. (2023). Friend, mentor, lover: does chatbot engagement lead to psychological dependence?. Journal of Service Management. (Accessed 13/10/2025)

[29] Cuadra, A. (2024). The Illusion of Empathy? Notes on Displays of Emotion in Human-Computer Interaction. Proceedings of the 2024 CHI Conference on Human Factors in Computing Systems (CHI '24) (Accessed 13/10/2025)

[30] Zhang, Y. *et al*. (2025) The Rise of AI Companions: How Human-Chatbot Relationships Influence Well-Being. Stanford University. (Accessed 15/10/2025)

bias, resulting in people from ethnic minorities, low-income, or linguistically diverse backgrounds receiving inaccurate or harmful advice (through misinterpretation or omission) (Khawaja, Bélisle-Pipon 2023[31]). One study found that GPT-4's empathetic responses were measurably lower for Black and Asian users compared to white users, suggesting that the model's behaviour changes based on perceived race, potentially further disadvantaging non-white users (Gabriel, Puri *et al* 2024[32]).

AI emulation of empathy can itself embed bias: an experimental study found that bots tend to express empathy more in some demographic contexts (e.g. given users of one gender) than others, reflecting skewed model assumptions (e.g. GPT-4 empathy differing by perceived user gender) (Roshanaei, Seif El-Nasr, Rezapour 2025[33]).

In mental health apps broadly, many studies note that patient safety, equity and long-term outcomes are rarely evaluated; consequences for underserved groups may therefore be masked or ignored (Haque, Rubya 2023[34]; Thakkar, Gupta, De Sousa 2024[35]).

In settings where chatbots are deployed in health assessment or screening roles, it's really important to consider cultural validity. A paper on cross-cultural validity warns that diagnostic AI presents risk when emotional expression, idioms of distress, and symptom presentation vary by culture. What looks like one disorder in a Western context may present differently elsewhere, risking misdiagnosis, under-recognition, or overreach in some populations (Hamzah 2025[36]).

Evidence gap

While conversational, generative AI offers theoretical promise for supporting mental health, the evidence base, especially among children and young people, remains extremely limited.

A recent narrative review of conversational AI in paediatric mental health concludes that while applications for psychoeducation, skills practice, and bridging to human care show promise, the bulk of robust empirical research remains in adult populations; studies with children and young people are still in early phases, often limited to feasibility work or pilot trials (Mansoor, Hamide & Tran, 2025[37]).

For example, a feasibility randomised controlled trial of the STARS chatbot intervention among young people in Jordan showed acceptability and trial procedures are feasible, but did not demonstrate statistically significant clinical effects (i.e., the sample was underpowered for outcome claims) (de Graaff *et al*. 2025[38]).

[31] Khawaja, Z., & Bélisle-Pipon, J. C. (2023). Your robot therapist is not your therapist: understanding the role of AI-powered mental health chatbots. *Frontiers in digital health*. (Accessed 13/10/2025)
[32] Gabriel, S., Puri, I. *et al* (2024). Can AIRelate: Testing Large Language Model Response for Mental Health Support.
[33] Roshanaei, M., Seif El-Nasr, M., Rezapour, R. (2025). Talk, Listen, Connect: How Humans and AI Evaluate Empathy in Responses to Emotionally Charged Narratives. https://arxiv.org/abs/2409.15550v2 (Accessed 13/10/2025)
[34] Haque, M. D. R., & Rubya, S. (2023). An Overview of Chatbot-Based Mobile Mental Health Apps: Insights From App Description and User Reviews. *JMIR mHealth and uHealth* (Accessed 13/10/2025)
[35] Thakkar, A., Gupta, A., & De Sousa, A. (2024). Artificial intelligence in positive mental health: a narrative review. *Frontiers in digital health* (Accessed 13/10/2025)
[36] Hamzah, F. (2025). Cross-Cultural Validity of AI-Powered Mental Health Assessments. (Accessed 13/10/2025)
[37] Mansoor, M., Hamide, A., Tran, T. (2025) Conversational AI in Pediatric Mental Health: A Narrative Review. Children (Basel). (Accessed 13/10/2025)
[38] de Graaff A, Habashneh R, Fanatseh S, Keyan D, Akhtar A, Abualhaija A, Faroun M, Aqel I, Dardas L, Servili C, van Ommeren M, Bryant R, Carswell K Evaluation of a Guided Chatbot Intervention for Young People in Jordan: Feasibility Randomized Controlled Trial. JMIR Mental Health (Accessed 13/10/2025)

Meta-analytic evidence of conversational agents in young populations suggests modest reductions in psychological distress, but no consistent effect on broader well-being outcomes, and studies often vary in methodology, sample populations, delivery platforms, and follow-up duration (Li *et al.* 2025[39]*).*

A more recent systematic review of AI-driven conversational agents in adolescents and young adults notes that although short-term reductions in depressive symptoms have been observed, methodological quality is variable and long-term impacts remain uncertain (Feng *et al*. 2025)[40].

Beyond limited outcomes data, child and adolescent populations present unique developmental, ethical and implementation challenges that are underexplored. The paediatric narrative review emphasises that conversational systems need age-appropriate adaptation of language, emotional nuance, safeguarding protocols, and parental or guardianship consent pathways. Not just repurposed adult tools (Mansoor, Hamide, Tran 2025[41]).

Existing evidence is not yet strong or extensive enough to justify the broad deployment of AI mental health tools, particularly as stand-alone interventions.

Erosion of embodied and non-verbal communication

Therapists routinely pick up on nonverbal, embodied cues, like silence, facial micro-expressions, posture shifts, subtle tone changes, breathing patterns, nervous gestures, or incongruences between what is said and how it is said; things that may reveal particular emotional states, unspoken conflicts, distress etc.

Research in psychotherapy highlights the importance of nonverbal communication: for example, Foley (2010) describes how nonverbal behaviours in therapy can signal risk or emotional shifts that words alone may mask (Foley 2010[42]). Studies of embodied synchrony show that client–therapist bodily coordination (movement mirroring, posture alignment) is associated with stronger rapport, a sense of "shared affective space", and better outcomes (Nagaoka, Yoshikawa, Komori 2011[43]).

The field of embodied cognition in psychotherapy suggests that mental health is deeply tied to what the body expresses and senses in interaction, not just verbal ideas (Mende, Schmidt 2021[44]). In online therapy, several authors have pointed out that therapists must work harder to compensate for the loss or distortion of embodied cues in remote modalities, such as managing gaze, silence and compensating for lag or limited visual field (García *et al*., 2022[45])

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[39] Li, J., Li, Y., Hu, Y., Ma, D. C. F., Mei, X., Chan, E. A., & Yorke, J. (2025). Chatbot-Delivered Interventions for Improving Mental Health Among Young People: A Systematic Review and Meta-Analysis. *Worldviews on evidence-based nursing.* (Accessed 13/10/2025)

[40] Feng, Y., Hang, Y., Wu, W., Song, X., Xiao, X., Dong, F., Qiao, Z. (2025) Effectiveness of AI-Driven Conversational Agents in Improving Mental Health Among Young People: Systematic Review and Meta-Analysis. J Med Internet Res.(Accessed 13/10/2025)

[41] Mansoor, M., Hamide, A., Tran, T. (2025) Conversational AI in Pediatric Mental Health: A Narrative Review. Children (Basel). (Accessed 13/10/2025)

[42] Foley, G. N., Gentile, J. P. (2010). Nonverbal communication in psychotherapy. *Psychiatry*

[43] Nagaoka, C., Yoshikawa, S., Komori, M. (2006). Embodied Synchrony of Nonverbal Behaviour in Counselling: a Case Study of Role Playing School Counselling. Conference: the 28th Annual Conference of the Cognitive Science Society. (Accessed 13/10/2025)

[44] Mende, M. A., Schmidt, H. (2021). Psychotherapy in the Framework of Embodied Cognition-Does Interpersonal Synchrony Influence Therapy Success?. *Frontiers in psychiatry* (Accessed 14/10/2025)

[45] García, E., Di Paolo, E., De Jaegher, H. (2021). Embodiment in online psychotherapy: A qualitative study. *Psychology and Psychotherapy: Theory, Research, and Practice*. Accessed 14/10/2025

Implications for the quality of mental health support

- The therapeutic alliance is consistently one of the strongest predictors of outcomes in psychotherapy (Flückiger et al., 2018[46]; Ardito, Rabellino 2011[47]). This relationship holds true across modalities, including cognitive/behavioural, psychodynamic, and humanistic therapies, and remains significant in both in-person and remote contexts. Over-reliance on automated or AI-based interventions risks weakening what is the foundational element of effective, long-term mental health support, leaving those who are unable to afford to pay for this themselves in receipt of a second-rate, second-class support system.
- If NHS systems divert clients into digital-first pathways without adequate relational contact or follow-up, there is a risk of exacerbating loneliness, disengagement, and poorer adherence, particularly for those already socially isolated or experiencing complex needs. The evidence suggests that early alliance quality predicts both symptom improvement and reduced dropout (Horvath *et al.* 2011[48]). For children and young people, relational connection and continuity of care are essential for trust, safety, and long-term benefit (Shirk, Karver 2003[49]).
- If digital or AI tools supplant human contact, we lose embodied attunement, which is the therapist's capacity to hear what is not said; detecting the tremor in the voice, sensing the momentary bodily tension or withdrawal, responding to the moments between words etc. Without those cues there is no relational depth, empathy and nuance are lost, and the risk of misunderstanding or missing underlying distress increases.

Opportunities for innovation: how we can utilise technology in mental health support

Digital tools, if regulated and integrated in such a way as respects the value of relational support, have real potential to increase the number of people that can access support, engagement and uptake, and how efficient it is:

- Meta-analytic and systematic evidence shows that working alliance in video/telephone therapy is achievable and meaningfully related to positive outcomes. For example, a systematic review and noninferiority meta-analysis of videoconferencing psychotherapy (VCP) found that, while alliance ratings were slightly lower compared to in-person delivery, symptom reduction was noninferior (i.e. outcomes comparable) (Norwood et al. 2018[50]). More recently, a meta-analysis of teletherapy found a small but significant alliance-outcome effect (r = 0.15) across 31 studies (4,862 participants), highlighting that alliance still matters in digital settings (Aafjes-van Doorn *et al*. 2024[51]). These findings suggest that digital therapy can preserve relational depth, especially when therapists are supported to adapt relational skills to online modalities.
- Apps and digital platforms can provide adjunctive support between sessions: sending reminders, prompting self-reflection, mood tracking, practicing techniques, or offering scaffolding exercises. These features help maintain momentum and reduce dropoff. Literature on digital mental health interventions (DMHIs) points to engagement as a key challenge, but also notes that variable usage patterns exist, and that human support is

[46]Flückiger, C., Del Re, A.C., Wampold, B.E., Horvath, A.O. (2018) The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy (Chic)* (Accessed 13/10/2025)

[47]Ardito, R. B., Rabellino, D. (2011). Therapeutic alliance and outcome of psychotherapy: historical excursus, measurements, and prospects for research. *Frontiers in psychology* (Accessed 13/10/2025)

[48] Horvath, A.O., Del Re, A.C., Flückiger, C., Symonds, D. (2011) Alliance in individual psychotherapy. Psychotherapy (Chic) (Accessed 13/10/2025)

[49] Shirk, S.R., Karver, M. (2003) Prediction of treatment outcome from relationship variables in child and adolescent therapy: a meta-analytic review. J Consult Clin Psychol (Accessed 13/10/2025)

[50] Norwood, C., Moghaddam, N.G., Malins, S., Sabin-Farrell, R. (2018) Working alliance and outcome effectiveness in videoconferencing psychotherapy: A systematic review and noninferiority meta-analysis. Clin Psychol Psychother. (Accessed 14/10/2025)

[51] Aafjes-van Doorn, K., Spina, D.S., Horne, S.J., Békés, V. (2024) The association between quality of therapeutic alliance and treatment outcomes in teletherapy: A systematic review and meta-analysis. Clin Psychol Rev. (Accessed 14/10/2025)

a notable facilitator of sustained engagement (Boucher *et al*. 2024[52]).
A broader review of engagement with DMHIs points out that integrating human support, persuasive features, gamification elements, and careful design can improve engagement (Lipschitz *et al*. 2023[53]).

- Non-clinical tasks such as intake triage, questionnaire scoring, screening, routing to human support, or managing appointment scheduling could be delegated to AI or automated systems, freeing up counsellors & psychotherapists to focus on the relational work. This must be done under the guardrails of relational oversight (e.g. human-in-the-loop, escalation protocols). NCPS Principles for Relational Safeguards in AI Mental Health Tools can provide a blueprint for how this work could and should be conducted (NCPS 2025[54]).
- Intelligent recommendation engines or 'digital phenotyping' (with consent) could help match people to therapist styles, pacing, or content modules that are more compatible with their preferences or needs. App-based systems are being tested for recommending mental health tools matched to user profiles (Dwyer et al. 2024[55]).
- Passive data, e.g. from wearables, mood logs etc may help flag early signs of distress, which could then prompt relational outreach. These signals *must* feed into human decision-making per relational safeguards.

What must change

1. **Commission relational-first digital models**
   Digital transformation should expand, not replace, relational care. Human-provided support must remain the default mode, with digital tools positioned as adjuncts that enhance what is already offered. All NHS digital mental health initiatives should be required to demonstrate how they preserve the therapeutic relationship.

2. **Mandate human oversight and escalation**
   Every AI or digital mental health tool deployed within the NHS must have a human-in-the-loop design, with clear escalation procedures, transparency of responsibility. The NCPS Relational Safeguards framework provides a model to support this.

3. **Introduce robust regulation**
   AI tools used in mental health contexts should be subject to formal regulatory approval equivalent to medical devices, including pre-deployment testing, ongoing monitoring, and mandatory reporting of adverse incidents. Regulation must cover data protection, transparency, safety, and claims about efficacy. A clear national framework should define what constitutes a clinically safe, evidence-based AI tool before it can be made available to NHS patients.

4. **Protect children and young people**
   AI and automated tools should not be used as stand-alone interventions for children or adolescents. Until youth-

[52] Boucher, M., Raiker, J. (2024) Engagement and retention in digital mental health interventions: a narrative review. *BMC Digital Health* (Accessed 14/10/2025)
[53] Lipschitz, J.M., Pike, C.K., Hogan, T.P. *et al.* (2023) The Engagement Problem: a Review of Engagement with Digital Mental Health Interventions and Recommendations for a Path Forward. *Curr Treat Options Psych* (Accessed 14/10/2025)
[54] Moss, M. (2025) Principles for Relational Safeguards in AI Mental Health Tools. NCPS. (Accessed 14/10/2025)
[55] Dwyer, B., Flathers, M., Burns, J., Mikkelson, J., Perlmutter, E., Chen, K., Ram, N., Torous, J. (2024) Assessing Digital Phenotyping for App Recommendations and Sustained Engagement: Cohort Study. JMIR Form Res (Accessed 14/10/2025)

specific evidence and developmental validation exist, use must be limited to low-risk, adjunctive functions such as psychoeducation or guided self-help. Safeguarding, parental consent, and human oversight are essential.

5. **Equity, inclusion, and accessibility in digital design**
   Digital tools must be designed and tested for cultural and linguistic relevance, accessibility, and bias resilience. Regular bias audits, inclusive co-design, and multilingual functionality should be mandatory.

6. **Recognise the embodied nature of therapeutic care**
   Technology can assist but cannot replicate the embodied elements of therapy: the silences, gestures, facial micro-expressions, and tone of voice through which therapists perceive distress, build trust, and attune. Digital systems must acknowledge and compensate for these limits, ensuring that human practitioners remain central to assessment and decision-making.

Sickness to prevention

This section outlines the research demonstrating counselling & psychotherapy as powerful preventative interventions in the context of what the NHS is hoping to achieve, including evidence on effectiveness, cost-efficiency, and impact on community resilience. We explore how early, relational, community-based support helps people build coping skills and emotional resilience before reaching crisis point, and how this can reduce demand for higher-intensity or medicalised care.

Counsellors & psychotherapists already work across the full spectrum of need, from brief, low-intensity interventions to longer-term, high-intensity therapy. With over 60,000 practitioners on Accredited Registers, this workforce represents a hugely under-utilised national asset that could be rapidly mobilised through direct referral routes in primary care, schools, and community settings. Doing so would reduce waiting times, relieve pressure on secondary services, and improve the quality and continuity of care available to individuals and families.

Impacts of underinvestment in preventative support

Over-medicalisation of mild to moderate distress

When early access to talking therapy isn't available, people experiencing mild distress often present to GPs or emergency departments, where they may be prescribed medication or referred into higher-intensity services unnecessarily. This over-medicalisation of normal human struggle diverts resources from those in greatest need and misses the opportunity to build resilience and autonomy through relational support.

GPs report feeling pressure to medicalise distress because of limited psychological service capacity. A qualitative study in general practice reflected that variation in local pathways leads to different thresholds for when distress is treated as clinical, often pushing people toward pharmacotherapy rather than psychosocial referral (Bowers *et al*., 2025[56]). The lack of non-pharmaceutical options forces many to choose medical routes, especially in underserved areas.

Comparative effectiveness literature underscores the value of psychotherapy even in mild-to-moderate distress. For example, Cuijpers *et al*. (2023[57]) found that multiple therapy modalities (not just CBT) remain efficacious across depression severities, strengthening the case for relational interventions over default medication use. Likewise, a controlled trial comparing antidepressant medication and psychotherapy in major depressive disorder found no significant difference in symptom outcomes, suggesting that therapy is often an equitable alternative (Kappelmann *et al*., 2020[58]).

Escalation and crisis demand

Underinvestment in early access to talking therapies has led to escalating distress reaching emergency and inpatient services. Data from Rethink Mental Illness shows that people are eight times more likely to wait over 18 months for

[56] Bowers, H. *et al*. (2025) 'We're all doing different things' — exploring primary care practitioners' perspectives of managing distress: a qualitative study. British Journal of General Practice. (Accessed 14/10/2025)
[57] Cuipers, P. *et al* (2023) Psychological treatment of depression: A systematic overview of a 'Meta-Analytic Research Domain'. *Journal of Affective Disorders*. (Accessed 14/10/2025)
[58] Kappelmann, N., Rein, M., Fietz, J. *et al.* (2020) Psychotherapy or medication for depression? Using individual symptom meta-analyses to derive a Symptom-Oriented Therapy (SOrT) metric for a personalised psychiatry. *BMC Medicine*. (Accessed 14/10/2025)

mental health treatment than physical health treatment (Rethink Mental Illness, 2025[59]). During that time, mild to moderate problems often deteriorate into complex needs that require longer-term or more intensive interventions.

The economic and workforce costs of this reactive model are significant. The Centre for Mental Health estimates that preventable mental health crises cost the NHS and wider public services billions annually through hospital admissions, longer inpatient stays, and lost productivity (Centre for Mental Health, 2024[60]). At the same time, health and care staff report rising burnout and moral distress as they struggle to meet escalating need without adequate community infrastructure.

In contrast, embedding counsellors & psychotherapists within primary and community care could intercept distress earlier, reducing escalation, protecting NHS resources, and improving long-term outcomes.

Economic costs of late intervention

The cost of untreated or late-treated mental health problems is estimated at £117.9 billion annually across the UK economy (Mental Health Foundation, 2023[61]). School-based counselling programmes such as Place2Be show that early relational support improves emotional wellbeing and reduces later use of CAMHS and specialist services, saving public money in the long term (they have been shown to deliver £6 - £8 of social return for every £1 invested) (PBE, 2025[62]). Rethink Mental Illness's 'Right Treatment, Right Time' report found that 4/5 people living with mental illness reported their health deteriorating as they waited for treatment, resulting in significant personal and economic detriments (Rethink Mental Illness, 2025[63]). The report also shows the financial impact on families where people may end up going without food to pay for their own mental health support; something which could, and should, be avoided.

Limited reach of prevention initiatives

Current early support models such as NHS Talking Therapies and Mental Health Support Teams (MHSTs) are often structured around manualised, low-intensity interventions, which limits their flexibility in addressing complex, relational, or less typical presentations. For example, the NHS Talking Therapies programme explicitly operates a stepped-care model in which many people with milder depression or anxiety first receive low-intensity CBT (e.g. guided self-help, psychoeducation) before being 'stepped up' if needed (NHS Talking Therapies Manual, 2018[64]). But recent work has exposed that individuals with complex relational needs (for instance, personality difficulties or trauma histories) often struggle under low-intensity models, sometimes requiring higher intensity or relational intervention from the outset (Zavlis, 2023[65]).

Implementation research of MHSTs in schools similarly highlights challenges: local stakeholders frequently report rigid protocols and limited flexibility in support delivery, which constrains capacity to adapt relationally to student

[59] https://www.rethink.org/news-and-stories/media-centre/2025/02/new-analysis-of-nhs-data-on-mental-health-waiting-times (Accessed 14/10/2025)
[60] https://www.centreformentalhealth.org.uk/publications/the-economic-and-social-costs-of-mental-ill-health/ (Accessed 14/10/2025)
[61] https://www.mentalhealth.org.uk/explore-mental-health/publications/economic-case-investing-prevention-mental-health-conditions-UK (Accessed 14/10/2025)
[62] https://www.place2be.org.uk/about-us/impact-and-evidence/statistics-and-evidence/pro-bono-economics-report (Accessed 14/10/2025)
[63] https://www.rethink.org/media/hpapzday/right-treatment-right-time-2025-report.pdf (Accessed 14/10/2025)
[64] https://www.england.nhs.uk/wp-content/uploads/2018/06/nhs-talking-therapies-manual-v7.1-updated.pdf (Accessed 14/10/2025)
[65] Zavlis, O. (2023). Complex relational needs impede progress in NHS Talking Therapies (IAPT): implications for public mental health. *Frontiers in public health* (Accessed 14/10/2025)

needs (Ellins *et al*., 2024[66]). Because of these structural constraints, many people who would benefit from early relational intervention are excluded or 'filtered out' into higher-tier services (subject to their waiting lists) or dropped entirely.

Implications for the quality of mental health support

- Prevention in mental health is fundamentally relational. A preventative model should prioritise human connection, trust, and continuity. Preventative counselling builds resilience, emotional literacy, and coping strategies that reduce risk of relapse or escalation (Lambert, 2013[67]).

- Evidence shows that offering clients a choice of therapist and modality improves engagement, retention, and outcomes (Swift *et al*., 2018[68]; Lindhiem *et al*., 2014[69]). When people are able to select a therapist who fits their preferences, relationally, culturally, or linguistically, they are more likely to build trust and benefit from therapy. This principle of choice, already embedded in physical healthcare, should be extended to mental health care.

- Community-based counselling & psychotherapy services allow people to seek support where they live, work, or study, reducing stigma and normalising help-seeking. Localised provision also supports continuity between personal, educational, and primary care contexts.

Opportunities for Innovation

- NCPS's *Direct Access to Counselling* model demonstrates that integrating Accredited counsellors into primary care pathways can cut waiting times from months to as little as one to two weeks, with clients able to self-refer or be referred directly by GPs (NCPS, 2024[70]). This approach reduces pressure on GPs and secondary care while delivering timely, preventative intervention. Different to previous systems wherein counsellors & psychotherapists were embedded directly in primary care, often having office space within the buildings themselves, we advocate for a decentralised approach, which allows patients to refer themselves to counsellors & psychotherapists on an Accredited Register, operating much in the same way as Social Prescribing, allowing patients to see counsellors either online or in the therapist's own dedicated premises, thereby enabling both a choice of practitioner (leading to better outcomes, shorter waiting times), and limiting the cost burden on the NHS directly in terms of the cost of providing rooms and services.

- Evidence from practice-based evaluation (PBE) studies shows that short-term, person-centred counselling in primary care produces clinical outcomes comparable to NHS Talking Therapies CBT interventions, often at lower cost (Pybis et al., 2017[71]). Embedding counsellors in GP surgeries or community hubs allows early relational intervention before escalation.

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[66] Ellins, J., Hocking, L., Al-Haboubi, M., Newbould, J., Fenton, S. J., Daniel, K., … Mays, N. (2023). Implementing mental health support teams in schools and colleges: the perspectives of programme implementers and service providers. *Journal of Mental Health* (Accessed 14/10/2025)

[67] Lambert, M. J. (2013). Outcome in psychotherapy: The past and important advances. *Psychotherapy* (Accessed 14/10/2025)

[68] Swift, J.K., Callahan, J.L., Cooper, M., Parkin, S.R. (2018) The impact of accommodating client preference in psychotherapy: A meta-analysis. J Clin Psychol. (Accessed 14/10/2025)

[69] Lindhiem O, Bennett CB, Trentacosta CJ, McLear C. (2014) Client preferences affect treatment satisfaction, completion, and clinical outcome: a meta-analysis. *Clin Psychol Rev.* (Accessed 14/10/2025)

[70] Principles for Relational Safeguards in AI Mental Health Tools (Accessed 20/10/2025)

[71] Pybis, J., Saxon, D., Hill, A. *et al.* (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* (Accessed 14/10/2025)

What must change

1. **Invest in early access to relational support**
   Fund and commission counselling & psychotherapy as first-line, preventative interventions. Early access to relational care reduces escalation, supports recovery, and prevents over-medicalisation of mild to moderate distress. Using the existing workforce of over 60,000 practitioners on Accredited Registers would allow immediate delivery of flexible, person-centred support in local communities.

2. **Integrate counsellors into primary care and community settings**
   Embed counsellors within Primary Care Networks, Social Prescribing frameworks, and community hubs, ensuring people can access support near where they live, work, or study. Expanding *Direct Access to Counselling* schemes would enable GPs to refer directly to local Accredited counsellors, reducing waiting times from months to weeks.

3. **Adopt a decentralised delivery model**
   Replace the traditional in-clinic model with a decentralised approach, enabling clients to see counsellors either online, in their own therapy premises, or other community-based settings. This would expand choice, improve access, and reduce NHS overhead costs associated with estate and service provision.

Final thoughts

Counsellors & psychotherapists bring unique skills that are essential to delivering each one of these shifts: building trusted, boundaried relationships that create a space for change and resilience; working flexibly across community, school, primary care, and digital platforms; providing early intervention that reduces demand on hospital-based services, and supporting clients' autonomy and choice. This is the perfect opportunity to finally make better use of a workforce that is already trained, demonstrating their commitment to safe and ethical working through the Accredited Registers programme, and could make a tangible difference to every single one of the NHS's goals, as well as to those who need support for their mental health.

We look forward to working with the Government and the NHS on these plans, and are happy to support in any way we can. For further information about any of the information shared within this document, please contact Meg Moss, Head of Public Affairs & Advocacy, via meg@ncps.com.