The current modelling focuses narrowly on NHS-employed roles, and overlooks the significant capacity and preventive impact of the counselling & psychotherapy workforce.

Via the Partnership for Counselling & Psychotherapy Bodies (PCPB), counselling & psychotherapy can, and should, be built into workforce planning assumptions. We would also like to see a change to the outdated models that treat talking therapy as a downstream intervention, one that is generally prescribed after medication. We would also like to see relational support, such as counselling & psychotherapy, being utilised earlier in the journey of support as a resilience-building, preventative measure.

Outdated workforce modelling logic

Traditional workforce modelling in the NHS overlooks non-statutory and community capacity, particularly counsellors & psychotherapists on Accredited Registers working either independently / privately, or in the third sector via charities or other organisations. There are approximately 75,000 practitioners on Accredited Registers meeting national standards of training, supervision, and governance. These practitioners already deliver public benefit across schools, GP surgeries, and voluntary sector hubs.

Current NHS models count only salaried staff, which leaves us underestimating the available mental health capacity and producing distorted supply-demand projections.

A realistic model of *total system capacity* must include the Accredited Register workforce.

Prevention leads to demand reduction

Relational early intervention directly reduces future demands on the system, as evidenced in Section 1 of our submission. When workforce plans treat early relational support as a preventative, counsellors & psychotherapists reduce demand further downstream, and the reduction in both short and long-term costs (from less reliance on crisis services to improved economic activity) means the cost implications are less significant. If we adjust the modelling to account for this, we will see both short-term and long-term changes in outcomes.

A challenge to the 'digital efficiency' assumption

Current modelling tends to equate 'digital-first' with efficiency, assuming that automation reduces workforce need. Digital systems simply create new forms of work; things like maintenance, oversight, training, monitoring, and governance. Someone will still need to review safety flags, moderate inappropriate content, follow up with at-risk users, and be responsible for determining whether or not the system is performing as intended. And that's not even considering the fact that automated triage systems are often designed to err on the side of caution, which increases false positives and increases the workload in that way.
As indicated in our Section 1 submission, digital interventions also show high-attrition rates, and people don't tend to stick with them very long – if initial help-seeking is met with a response that feels impersonal and automated, people may lose trust in the system and delay seeking help again in the future.