Mental Health Strategy for England: NCPS Submission

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Hospital to community: cross-sector pathways in practice

How can mental health services work more effectively across the wider NHS, including new neighbourhood health centres; services to support people with co-occurring mental health and neurodevelopmental conditions; and different sectors, including education, employers, local authorities, and the VCSE sector?

NCPS are launching an Open Access Therapy Framework (OAT Framework), which connects patients looking for mental health support with quality-assured therapists on Professional Standards Authority Accredited Registers, where referral to NHS Talking Therapies (NHS TT) isn't appropriate (those with complex presentations such as trauma/PTSD, bereavement and grief, relationship issues, often complicated by physical health conditions, neurological differences, or relational difficulties).

The model is an expansion of social prescribing and personal health budgets, using existing funding and spending it differently. It embeds choice of practitioner and type of therapy at a primary care level, and also saves the NHS money in terms of per-session cost, not including estates, training, admin costs that are difficult to quantify with the data available.

Current waiting times to treatment are, on average, 62.5 days; under the OAT Framework, that reduces to fewer than 14 days. Eight sessions with an NHS Talking Therapies CBT practitioner costs, on average, £508, not including additional costs incurred such as estates, management costs, training, admin etc, while eight sessions under the OAT Framework costs £480.

Savings are also found in a reduction of reliance on crisis services, as well as better health management for comorbidities. For GPs, five additional GP appointments for someone without adequate support adds over £220 in primary care costs alone.

There are over 75,000 counsellors & psychotherapists on Accredited Registers already providing this support via independent practice to those that can afford it; this provides a mechanism via the NHS where those that can't afford the high quality of care, underpinned by choice and autonomy, and would not be best served by the NHS Talking Therapies model, can access the support they need, quickly, and with a cost saving to the NHS, based upon principles that already exist within the NHS ecosystem.

Hospital to community: severe and enduring mental illness

What further support should be provided for people with severe and enduring mental illness?

Counselling and psychotherapy can play an important role for people who are suffering from enduring and severe mental illness. Not to treat but as an additional, parallel support for coping strategies and talking about their ongoing illness through the therapeutic relationship.

Early intervention and preventative care will have a significant impact on those who suffer severe and enduring mental health illnesses. A closer relationship between the public sector and private counselling practises will alleviate waiting times and improve access to the best support possible. Consultants at Barts Health NHS Trust and East London Foundation Trust discovered that the likelihood of being admitted to hospital with recurrent diabetic ketoacidosis (DKA) could be greatly reduced by mental health interventions. ST Barts also reported that significant savings were made to the hospital's resources with this strategy.

Results showed a 20% decrease in hospital admissions for those at great risk of DKA and the number of bed days halved. The consultants estimated that bed days reduced by 125 days within a year, which saved more than £159,000.

Counselling can also be the gateway into getting clients ongoing support for severe and enduring mental illness. Counsellors can be the GP's of the mental health network by referring clients to other networks and organisations for more specialised help when required. These opportunities present either during the initial assessment before the first session takes place, or during the counselling process. After a referral counsellors can still provide ongoing support during treatment which keep patients from getting to a mental health crisis.

In conclusion a coalition between NHS and the counselling/psychotherapy network for ongoing parallel support for people suffering from ongoing severe and enduring mental health illnesses.

Hospital to community: Barriers to continuity of care

What are the main barriers to continuity of care across transitions between hospital and community services, and between different levels of care, including child to adult services?

NHS Talking Therapies requires patients to begin at low intensity regardless of how complex or relevant the issue is that they're presenting, and then to be 'stepped up' only if the initial treatment fails; in practice, this means a new practitioner, a new assessment, and more waiting. The therapeutic relationships is one of the key predictors of whether or not therapy will be effective, and every move between stages removes whatever alliance has been established.

Research by Delgadillo and colleagues identifies two specific mechanisms of harm at these transitions: demoralisation, where experiencing an inadequate first intervention reduces expectations of recovery and undermines what follows; and, continued deterioration, where the person becomes more severely impacted before reaching the right level of support.

Data from the NCPS Annual Member Survey shows 78% of counsellors & psychotherapists have seen clients who completed NHS Talking Therapies but still needed further support, meaning, in the majority of cases, people are transitioning out of statutory services into the private and voluntary sector, putting financial pressure and additional workload on those services without remuneration or recognition.

For young people moving from CAMHS to adult services, the relational rupture can be particularly acute and often happens at a time of significant developmental change for young people, and with no guarantee that there will be support for them after being discharged.

Moving away from a stepped care model, and towards the use of therapies that operate relationally (such as through NCPS's Open Access Therapy Framework model), across the spectrum of need from low-to-high intensity, will allow for changing intensity, and would not be impacted by ageing out of services.

Analogue to digital: innovative examples of digital tools for adults & children

What evidence and innovative examples are there of digital and AI tools being used to improve mental health and wider societal outcomes; support access to effective mental health support, and complement relational care?

We would strongly caution against interpreting uptake of AI chatbots as evidence of preference. We have recently commissioned research, due to be published shortly, that found a significant proportion of young people using AI for mental health support did so because the human system had already failed them through long waiting times, limited availability, or services that didn't fit their unique needs. Young people did not see AI as a preference, nor would they choose it over human support.

The data does show that AI has a legitimate supporting role in lower-risk applications, such as appointments, triaging, administrative tasks, between-session, time-limited skills practice, and psychoeducation. These are uses where the potential for harm is lessened, and we can maintain human oversight and relationship with vulnerable people.

The evidence base for AI chatbots as standalone mental health interventions is not strong enough to support wider deployment, particularly for children and young people. Systematic reviews note that many are launched with limited clinical evaluation, where crisis response is inconsistently assessed, and paediatric-specific evidence remains largely at feasibility stage, with no reliable longer-term outcome data. There are additional and well-documented concerns around algorithmic bias, data privacy, and the risk that anthropomorphic design leads to illusory empathy and misplaced trust, which leads to young people no longer turning to humans for support, as they have the least amount of life experience in order to tell the difference between good quality human support and low-intensity AI-based support.

NCPS's Principles for Relational Safeguards in AI Mental Health Tools set out a framework for proportionate use, and we would be happy to share these principles, as well as all the evidence to support this section.

Analogue to digital: use of data to improve mental health & wider outcomes

How can data be used more innovatively to improve mental health and wider societal outcomes? Please provide examples.

Data from charities, professional bodies and the NHS helps build a fuller picture of UK mental health services.

Data collected from the NHS about patients that drop out of NHS talking therapies mid-way through a programme, and from patients that drop off the waiting list both before or after initial assessments will give an indication of how public sector mental health provisions are performing. Most NHS support is through the lens of Cognitive Behavioural Therapy (CBT) which isn't a 'one size fits all' therapy modality choice. Did they find a therapist faster through a charity or private sector? Were they not kept informed on where they were on the waiting list? Had they found the perfect therapist and/or a better modality of therapy? Information like this will strengthen future policy around patients having the choice to choose the therapist and modality they need.

Information via a patient satisfaction survey three months after receiving a full complement of NHS talking therapy will give a clear indication of how effective the therapy was and if they are seeking additional support. Many clients who seek out private therapists and have had NHS support say they don't believe CBT therapy was effective as it was too structured, not person-centred, time bound, and produced an unrealistic expectation that they would be 'fixed' after a specific course of therapy. Finally, a generic data collection across the public and private sector which identifies, waiting times, the effectiveness of the therapy, preferred modalities, monetary cost, geographical barriers, preferred delivery (in person, online) and overall satisfaction will help public, private and third sector organisations contribute meaningfully to future policy changes.

The Partnership of Counselling and Psychotherapy Bodies (PCPB) would be more than happy to contribute to data collection concerning the counselling and psychotherapy workforce.

Sickness to prevention: evidence for reducing incidence or severity

Which preventative approaches have the strongest evidence for reducing incidence or severity of mental health problems and promoting good mental health?

The strongest evidence for prevention comes from early access to relational support, which counselling & psychotherapy can evidence across primary, secondary, and tertiary levels.

At a primary level, school-based and community counselling builds emotional literacy, relational resilience, and coping skills before distress becomes entrenched. Place2Be and Pro Bono Economics found that for every £1 invested in school-based counselling, £6 - £8 of social return is generated over the life course, through improved educational outcomes, reduced CAMHS demand, and better long-term employment and health.

At a secondary level, existing early support models (NHS Talking Therapies, Mental Health Support Teams) are built around low-intensity, manualised approaches that exclude complex and relational presentations, while many of the young people most at risk are exactly the ones these models serve least well. This would be solved by access to counsellors & psychotherapists able to work relationally and flexibly from the point of first contact.

At a tertiary level, short-term person-centred counselling in primary care produces outcomes comparable to NHS Talking Therapies CBT, often at lower cost (Pybis et al., 2017), and choice of practitioner, independently associated with better engagement and retention (Swift et al., 2018), keeps people in treatment long enough to benefit.

4 in 5 people's conditions deteriorated while waiting for mental health treatment (Rethink Mental Illness, 2025), and untreated mental health problems cost the UK economy £117.9 billion annually (Mental Health Foundation, 2023), which shows that underinvesting has a significant cost.

There are over 75,000 counsellors & psychotherapists on Accredited Registers already working in communities, schools, and primary care, with capacity to take on additional work.

Please reach out to speak to the NCPS about the Open Access Therapy framework.

Sickness to prevention: evidence for reducing lives lost to suicide

Which preventative approaches have the strongest evidence for reducing the numbers of lives lost to suicide?

Evidence gathered by crisis support organisations like the Samaritans UK year on year for suicidal service users could help us identify the issues and rising trends.

Suicide prevention needs a comprehensive approach that combines early intervention and timely access to person-centred support *before people reach a crisis point* is one of the most preventative measures. Many people who die by suicide can experience significant psychological distress without necessarily meeting thresholds for specialist mental health services.

Accessible counselling and psychotherapy can play an important role by giving clients the space to engage in therapeutic work before getting into a crisis situation. Early intervention as opposed to crisis intervention. Counsellors and psychotherapists can also help refer clients onto other services when required. No single therapeutic modality prevents suicide on its own. Evidence suggests that effective care is more likely to involve an appropriate therapeutic approach often a mixture of integrative therapy with the right therapist.

Research consistently shows that many people who die by suicide have experienced, untreated depression and anxiety, trauma, relationship difficulties, financial or employment stress, and/or social isolation. All areas that counsellors are trained to help with and reduce the progression of distress into suicidal crisis. People who have access to other support networks for financial hardship, unemployment, housing insecurity and other life changing anxieties are less likely to die by suicide.

One of the robust findings suggests that the quality of the therapeutic relationship predicts outcomes better than any therapy model. Feeling understood, listened to and accepted without judgment, developing coping strategies and problem-solving skills, nurturing a therapeutic relationship based on trust can improve chances of a therapist seeing early warning signs, give support and will have emergency contacts/referrals where necessary.

Sickness to prevention: how to better support the missing middle

How can services better support the 'missing middle' - those with sustained needs (that affect their participation in community life, for example, in education or work) who may not meet the criteria for NHS mental health services?

When access to support is organised around diagnosis and limited treatment models, people whose distress doesn't directly match those frameworks either can't get support or don't feel entitled to ask for it. For many (e.g. men, people from racially minoritised communities, people dealing with life transitions, relationship difficulties, or workplace pressures rather than diagnosable conditions) the need to view their experience in clinical terms is a barrier in and of itself.

Counselling & psychotherapy works with the person's experience, things such as grief, relationship breakdown, identity questions, financial stress, or even simply a sense that things aren't right, and builds sustained, relational support that allows people to stay in work, maintain relationships, and participate in community life without deteriorating to crisis, without requiring a diagnosis.

It's equally well-suited to people who aren't in acute distress but want to build resilience, develop personally, or work through patterns that are holding them back; the therapeutic relationship is as useful for growth as it is for recovery.

Over 75,000 counsellors & psychotherapists on Accredited Registers are already providing exactly this support, but largely to people who can pay privately or access voluntary sector provision. The 'missing middle' is, in practice, the group that the current system expects to self-fund or go without. Data from the NCPS Annual Member Survey shows 78% of practitioners are seeing clients who still needed

support after completing NHS Talking Therapies, and who are absorbing the unmet and continuing need post the statutory system.

NCPS's Open Access Therapy Framework looks to use NHS funding that follows the person to a practitioner of their choice on an Accredited Register, without a diagnostic gateway, reaching people the current system isn't designed to serve.

Factors enabling good practice

What commissioning, funding and oversight or accountability arrangements (nationally and locally) best support safe and integrated mental health services that improve outcomes across mental health, participation in work, education and community life, and social functioning?

The most significant enabler would be changing how NHS money moves, and making sure that funding follows people into the services supporting them, rather than staying within the NHS while the referral goes elsewhere.

For example, social prescribing currently operates as a signposting function: people are referred to third sector organisations, voluntary services, community providers, but no NHS funding follows. Those organisations, including rape crisis centres, bereavement services, counselling charities, specialist trauma providers, are all absorbing a significant proportion of the mental health need that the NHS has itself generated (through long waits, threshold exclusions, and limited modality choice), while being funded through dwindling grant pots and competitive bids that consume time and capacity better spent on direct support. The NHS has, in effect, delegated a substantial part of its mental health function to the third sector without delegating any of the budget.

This is particularly acute for services supporting women and girls who've experienced violence or sexual abuse. Rape crisis centres provide the sustained, trauma-informed relational support this population needs, but they routinely face year-on-year funding uncertainty and are rarely commissioned in a way that reflects the scale or complexity of what they're doing.

The commissioning change that would make the biggest difference is NHS funding following the person, as in the Personal Health Budget model, and as NCPS's Open Access Therapy Framework is designed to enable. Rather than the NHS holding the budget while referring outward, funding is allocated to the person that needs it, and travels with them to a quality-assured provider. Accountability and oversight are built into this model through the PSA Accredited Registers framework, which sets national standards for training, supervision, and ethical practice. This changes the third sector from an underfunded overflow into a properly resourced, accountable part of an integrated system.

Your local mental health strategy or delivery plan

Provide your local mental health strategy and/or delivery plan
Although the National Counselling and Psychotherapy Society in a national organisation, we do see examples of more localised coalitions through our work.

One example in Devon is the Devon Mental Health Alliance. A partnership of voluntary, community and social enterprise (VCSE) organisations working alongside NHS Partners to improve mental health services across devon. Established in 2022 as part of the NHS Community Mental Health Framework which aims to create more joined-up person-centred support.

Many effective mental health organisations were operating independently. Making services difficult to navigate and leaving gaps in support. Bringing charities, community organisations and NHS providers together, the alliance seeks to provide earlier intervention, improve access to care and reduce pressure on crisis and specialist services.

The Alliance operates through local teams across Devon, allowing support to be tailored to the needs of each community. Rather than acting as a simple referral network, the alliance is a collaborative partnership with shared governance and shared responsibility for improving mental health outcomes. It demonstrates how voluntary organisations and statutory services can work together to create a more integrated, preventative and accessible mental health system.

The Alliance provides a strong example of how counselling and psychotherapy can be embedded within the integrated community mental health services, supporting earlier intervention, greater patient choice and more effective local partnerships.