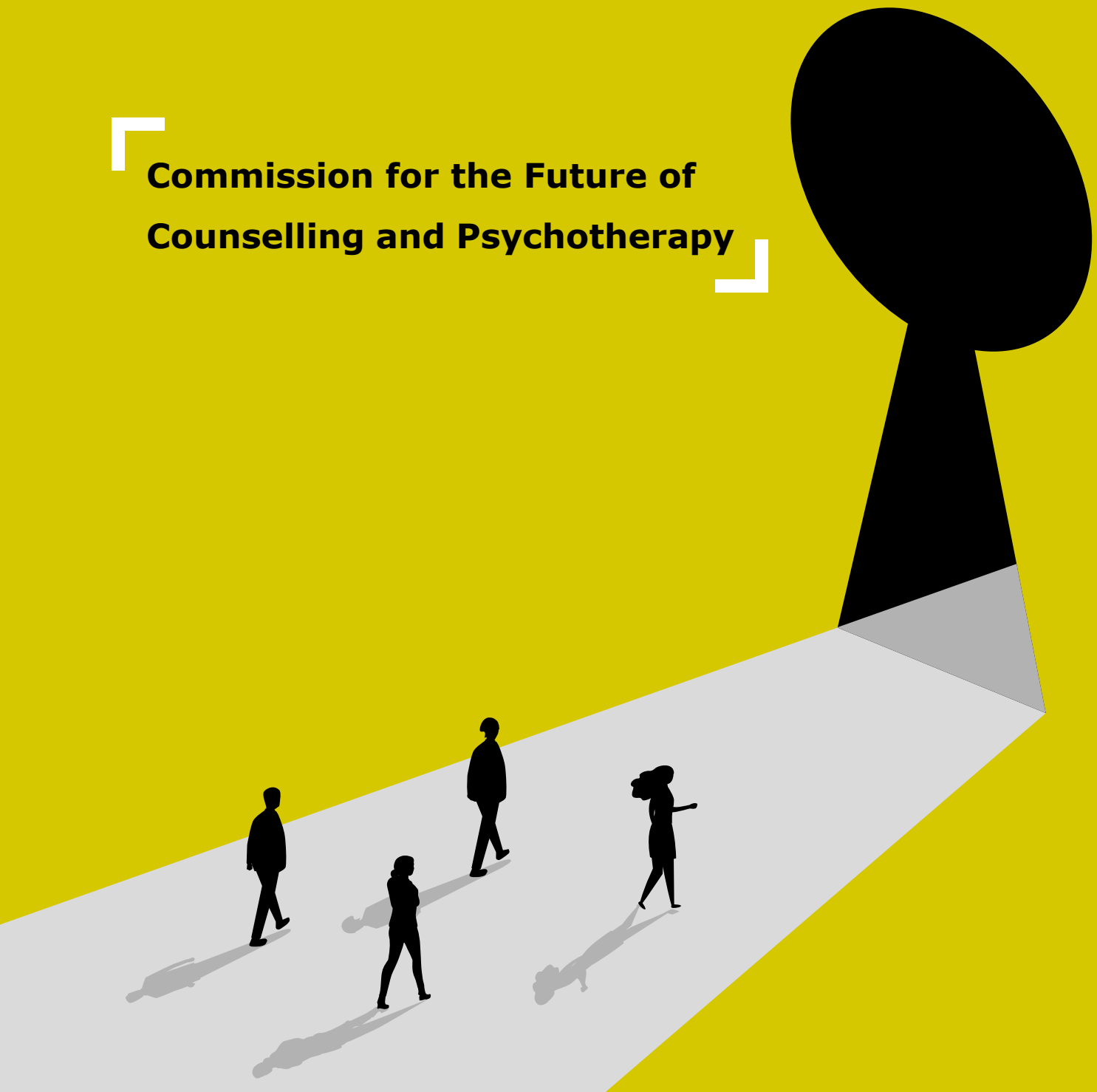
Unlocking Potential: Transforming Lives

Commission for the Future of Counselling and Psychotherapy



November 2026

Commissioned by the Partnership of Counselling and Psychotherapy Bodies (PCPB)



Partnership of Counselling and Psychotherapy Bodies













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Introduction

Open letter from the Independent Co-Chairs of the Commission

Across England, Scotland, Wales and Northern Ireland, we are witnessing a profound shift in the scale and complexity of mental health need. Behind the statistics are people waiting too long for help, families struggling to cope, children whose education is disrupted, employees leaving work through ill health and communities carrying the consequences of unmet need. Mental health is no longer a challenge for individuals and health services alone; it is a challenge for our economy, our public services, our communities and our collective future.

The publication of the Independent Review into prevalence and support for mental health conditions, ADHD and autism, in October 2026, offered a candid assessment of a mental health service under immense pressure.[1] Prime Minister Andy Burnham expressed a similar view in August 2026 as he announced a £343m investment in NHS mental health centres across England.[2]

We know these pressures are felt in Scotland, Wales and Northern Ireland too. Wider social and economic challenges – including rising youth unemployment, discrimination, social injustice, health inequalities, forced migration, increasing recognition of neurodiversity, persistent physical ill health, loneliness, financial insecurity and the continuing cost-of-living pressures – reinforce the scale of the mental health challenge facing the four nations of the UK. NHS, social care and community services continue to operate beyond capacity, with growing demand placing increasing pressure on councils, schools, employers, charities and community organisations. Too often, people are offered treatment that does not meet their needs. Too often, they receive no treatment at all. The consequences can be profound, leading to limited life opportunities for many and, in the most tragic circumstances, loss of life for some.

Yet alongside these challenges lies a unique opportunity.

The United Kingdom already has a highly skilled and trained workforce of counsellors and psychotherapists whose expertise remains significantly underused. Together, the six organisations that came together to establish this Commission represent around 82,000 registered practitioners working across health, social care, local government, education, justice, children's services, higher education, workplaces, the voluntary and community sectors, and private practice.

Evidence gathered to inform the work of our Commission demonstrates that this workforce has considerable untapped capacity. More than half of therapists who responded to our Call for Evidence told us they could provide at least five additional hours of paid client work each week, while fewer than one quarter said they were unable or unwilling to take on further client hours.

Collectively, this represents hundreds of thousands of additional therapeutic appointments every week – capacity that already exists and could be mobilised to improve access to timely, effective mental health treatment across the UK. Counselling and psychotherapy can play a key role in narrowing the mental health treatment gap.

This is not simply a question of increasing capacity. It is also about recognising the unique contribution that counselling and psychotherapy make.

Therapists provide evidence-based treatment that adapts to the needs of the individual. Whether treating children and young people, adults experiencing common or more severe mental health difficulties, people living with trauma, those managing long-term physical conditions, or individuals navigating bereavement, relationships, identity or life's many transitions, counselling and psychotherapy offer interventions that are both clinically effective and deeply human.

At a time when people's mental health needs are becoming more complex, that flexibility has never been more valuable.

The profession itself has also reached an important point in its development. The introduction of the Scope of Practice and Education (SCoPEd) framework in 2022 marked significant progress towards greater consistency, professionalism and public confidence across counselling and psychotherapy. Building on that foundation, this Commission was established to examine the future of the profession, identify the barriers preventing it from making its fullest contribution, and recommend practical actions that will strengthen both the profession and the nation's mental health.

More than **4,000** individuals and organisations contributed through our Call for Evidence

Over the course of our work, we have examined some of the most significant questions facing counselling and psychotherapy today. We have considered how the workforce can be better integrated into mental health services and wider public policy. We have explored the future of professional regulation and how best to protect the public from unqualified and unregistered practitioners. We have examined how the evidence base should continue to evolve, how diversity and inclusion must be strengthened across the profession, and how emerging technologies – including artificial intelligence – may reshape both mental health and the delivery of therapeutic support. These are not challenges for the profession alone; they are questions that affect everyone who may one day need mental health treatment.

Our conclusions have been informed by an extraordinary range of evidence. We have heard from people with lived experience, practitioners, researchers, employers, commissioners, educators, regulators, policymakers and organisations from across all four nations. More than 4,000 individuals and organisations contributed through our Call for Evidence, while many others gave their time through written submissions, roundtables and witness sessions. We have also heard from many great services, delivering life-changing therapy, some of which have been included as case studies to illustrate the strong return on investment that counselling and psychotherapy can make in different sectors and settings throughout the UK.

Throughout this process, the voices of people with lived experience have remained central to our work. Their experiences have sharpened our thinking and reminded us that every recommendation contained within this report must ultimately be judged by one measure alone: whether it transforms people's lives.

We were particularly keen to ensure that our report informs change across each of the four nations of the UK. We were grateful to our Commissioners from Northern Ireland, Scotland, and Wales for hosting roundtables in the devolved nations to ensure that we fully considered the specific context and need for counselling and psychotherapy in each nation.

We are deeply grateful to every witness who gave evidence, every organisation that shared its expertise, every individual who completed our surveys, and every Commissioner who brought their experience, insight and commitment to what has often been thoughtful, challenging and constructive debate. We also extend our sincere thanks to the Commission Secretariat, whose dedication and professionalism made this work possible.

While the Partnership of Counselling and Psychotherapy Bodies (PCPB) has commissioned this report the findings and recommendations contained are those of the Independent Commission alone. They represent our collective judgment about what must change if the counselling and psychotherapy sector is to fulfil its potential in improving the nation's mental health.

This report is not intended to be the end of the conversation. It is intended to be the beginning of action.

The recommendations we make will require leadership from governments, regulators, employers, commissioners, educators, professional bodies and, crucially, practitioners themselves. No single organisation can deliver the change required in isolation. None can afford to leave this opportunity untaken. And all need to ensure that people with lived experience continue to shape the future.

The case for change is compelling. The workforce exists. The evidence continues to grow. The need has never been greater.

And whilst the challenge is significant, so too is the opportunity. If everyone is prepared to work together, we can see a future in which the current treatment gap narrows so many more people receive the timely, compassionate and effective mental health interventions they deserve – and in doing so, we can transform not only individual lives, but the health, resilience and prosperity of our communities across the UK.

That is the future this Commission believes is both possible and necessary. We commend this report to you.





Phil Hope **Andrea Sutcliffe CBE**

Independent Co-Chairs of the
Commission for the Future of Counselling
& Psychotherapy



Falkirk Wheel, Scotland,
United Kingdom

Foreword by Professor Adam Boddison OBE

Independent Chair, Partnership of Counselling and Psychotherapy Bodies

The Partnership of Counselling and Psychotherapy Bodies (PCPB) was established because six leading professional bodies recognised that the future of counselling and psychotherapy would increasingly depend on what we could achieve together rather than individually. While each organisation has its own identity and history, we share a common purpose: to promote high standards of professional practice, to protect the public, and ensure that people across the United Kingdom have access to safe, effective and compassionate psychological therapy. Our establishment of this independent Commission reflects that important, shared ambition.

Stepping up to the challenge

The Commission was not established because the profession is in decline. Quite the opposite. Demand for counselling and psychotherapy has never been greater. Mental health has rightly become one of the defining public policy challenges of our generation, and counsellors and psychotherapists are supporting people every day in our health and social care services, schools, universities, workplaces, communities, charities, justice settings and private practice. Yet demand alone is not enough to secure the future of any profession.

As the evidence presented by the Commission shows, public understanding of counselling and psychotherapy remains inconsistent. Too many people struggle to distinguish between safe, qualified, registered practitioners and those with little or no recognised training. The evidence base continues to evolve but must grow further to influence policy and commissioning. Financial barriers still prevent many talented people from entering the profession, while workforce shortages exist alongside qualified practitioners who are unable to use their full capacity. Advances in digital technology and artificial intelligence are creating exciting opportunities, but they also raise profound questions about ethics, public safety and the future relationship between technology and human connection.

Our endorsement

The real measure of this Commission's success will not be the publication of its report. It will be the collective action that follows.

As Independent Chair of the PCPB I am pleased to confirm the Partnership welcomes the ambitious recommendations presented by the Commission. Together they provide a vital strategic steer to inform our collective action to address many fundamental issues facing counselling and psychotherapy and to better use our collective influence to advocate for the profession, the practitioners we represent and their clients.

We will consider how best to further the wider recognition of the contribution counsellors and psychotherapists can make in helping to narrow the mental health treatment gap, while continuing to promote high standards of safety and quality. We recognise that this must include strengthening the evidence and economic case for our professions, improving diversity and access, exploring how training may need to evolve, responding thoughtfully to artificial intelligence and increasing public understanding of the value of professional psychological support.

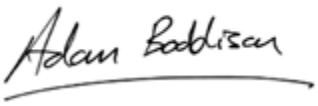
We welcome the opportunity to explore how the counselling and psychotherapy sector can work more effectively together in the future, including but not limited to the recommendation to explore the development of a Counselling and Psychotherapy Federation. This will include considering how the PCPB's existing partnership might support a more coordinated collective voice across all four nations, while working with people with lived experience and the wider sector to understand where there may be shared ambitions and opportunities for collaboration.

We will progress work to strengthen our engagement with governments on the future of regulation and public protection and contribute to a stronger national conversation about the role counselling and psychotherapy can play in the nation's mental health.

No single organisation can deliver this agenda alone. The PCPB commits to work with governments, commissioners, professional bodies, training providers, researchers, practitioners and people with lived experience to translate these recommendations into practical and lasting change.

On behalf of the Partnership of Counselling and Psychotherapy Bodies, I would like to pay tribute to our Commission Co-Chairs, Andrea Sutcliffe and Phil Hope and our Commissioners for the tremendous care, rigour and independence they have brought to their work and for leading on the development of such an authoritative report.

I would also like to acknowledge the important role played by the Commission Secretariat in helping to deliver the extensive programme of work which has informed this Report. My thanks additionally go to everyone who contributed evidence, shared their experiences and supported the work of the Commission.



Professor Adam Boddison OBE

Independent Chair of the Partnership of Counselling and Psychotherapy Bodies

Executive summary

Unlocking the UK's hidden mental health capacity

The future of counselling and psychotherapy and narrowing the treatment gap

The opportunity

The UK faces a growing mental health challenge. Demand for support is outstripping publicly-funded capacity across England, Scotland, Wales and Northern Ireland, contributing to long waiting lists, widening inequalities and growing pressure on public services, employers and communities. It is estimated that there are 1.8 million people on a waiting list for mental health services in England.[3] Whilst there isn't equivalent data published for Northern Ireland, Scotland and Wales, the Mental Health Foundation estimates the level of mental health need across the UK to be just short of 14,000,000 people.[4] The consequences extend well beyond healthcare, affecting employment and productivity, educational attainment, physical health, personal safety and community wellbeing.

The Commission for the Future of Counselling and Psychotherapy was established by the Partnership of Counselling and Psychotherapy Bodies (PCPB) to examine the future of the counselling and psychotherapy profession and how it could make a substantially greater contribution to tackling this challenge. It gathered evidence from more than 4,000 people and organisations, including practitioners, researchers, commissioners, employers, policymakers and people with lived experience.

Its central finding is potentially significant for policymakers: the UK already has much of the skilled workforce it needs to increase access to psychological support but is not making full use of it.

Around 82,000 qualified practitioners are registered on Professional Standards Authority-accredited registers operated by the six PCPB organisations. More than three-quarters of respondents to the Commission's Call for Evidence wanted additional paid client work, while more than half would undertake at least five additional hours of therapeutic practice each week. The Commission argues that this represents the potential for over 370,000 hours of additional therapy appointments every week – without training a single additional practitioner – to narrow the UK's mental health treatment gap. Our analysis shows that deploying 10% of this existing available capacity could support over 150,000 more people annually across the nations of the UK. The cost of delivering this would equate to less than 1% of the existing national mental health budgets.

For governments facing rising demand, workforce shortages and constrained public finances, this points to an important policy opportunity: before looking only to expand the workforce, much better use of the workforce that already exists could be made. Unlocking this potential will transform lives.

From a health issue to a government-wide economic and social priority

The Commission argues that counselling and psychotherapy should not be viewed simply as benefitting the nation's health alone. Effective psychological support can generate benefits across public services and the economy. The evidence points to a compelling economic case across a range of settings, including evidence that every £1 invested in counselling for children and young people could generate a £14 return,[5] while workplace counselling could generate £5 for every £1 invested.[6] This is comparable with the UK Government's evidence for evidence-based talking therapies delivered through NHS Talking Therapies, which includes Counselling for Depression. This delivers a return of approximately £5 to £6 in wider economic and social benefits, associated with people who have undergone treatment being more likely to work and less likely to require welfare benefits.[7]

The evidence cited by the Commission links preventative and early intervention services with improved educational outcomes, reduced sickness absence, improved employment retention and reduced demand on statutory services. It highlights economic returns from investment in school counselling, workplace mental health support and community-based psychological services.

This has an important implication for government policy. Mental health investment should be regarded as an investment across government, rather than solely as expenditure for the NHS or government departments for Health and Social Care. Poor mental health is closely associated with economic inactivity, lower workplace productivity, poorer educational outcomes, physical ill-health, social exclusion and involvement with the criminal justice system.

Counselling and psychotherapy are already being delivered across the NHS, schools, colleges, universities, workplaces, voluntary organisations, justice settings and private practice. However, provision remains fragmented and inconsistent, often dependent on short-term, local commissioning decisions. The result is significant variation in access.

Around **82,000** qualified practitioners are registered on Professional Standards Authority-accredited registers operated by the six PCPB organisations

Why is existing capacity not being used?

The Commission identifies a series of structural barriers preventing the profession from making its full contribution.

The most immediate is insufficient and unsustainable public commissioning and investment. This is compounded in some services by reliance on unpaid work and volunteering. The Commission also points to the limitations of the current voluntary regulatory framework and inconsistent understanding of professional standards, which can undermine confidence in the safety and quality of services.

Other barriers include:

- no formal workforce planning and development for the large and diverse counselling and psychotherapy workforce
- unnecessary barriers to entering the profession and limitations in workforce diversity
- a lack of statutory regulation which is holding the profession back, is not providing sufficient public protection and contributes to a lack of easily accessible information for the public
- insufficient use of evidence about cost-effectiveness in commissioning and policy decisions
- inadequate investment in clinical and economic research and service evaluation
- uncertainty about the opportunities and risks presented by digital mental health technologies and AI, and
- fragmentation within the profession, weakening its collective voice and influence on policy.

The Commission's argument is therefore not simply that more money should be spent on counselling and psychotherapy. It is that government needs a more coherent system for commissioning, regulating, developing, evaluating and deploying this existing workforce.

The profession also needs to embrace this opportunity positively by raising standards, widening diversity, demonstrating impact and providing a stronger collective voice.

It is estimated that there are **1.8 million people** on a waiting list for mental health services in England

A six-part roadmap for reform

The Commission proposes six strategic priorities:

1. Improve commissioning and funding.

Increase access to evidence-based counselling and psychotherapy across health, education, workplace and community settings.

2. Strengthen public protection.

Introduce statutory regulation and strengthen professional standards.

3. Build a sustainable and diverse workforce.

Improve education, training, workforce development and diversity.

4. Strengthen the evidence base.

Increase research and evaluation and ensure evidence is better reflected in commissioning and policymaking.

5. Raise public and political recognition.

Increase awareness of the contribution counselling and psychotherapy can make to mental health and wellbeing.

6. Give the profession a stronger collective voice.

Create a Counselling and Psychotherapy Federation to improve coordination and influence.

Alongside these UK-wide priorities, the Commission makes recommendations for each of the four nations, recognising their unique context and different policy, regulatory and commissioning arrangements.

What does this mean for policymakers?

The Commission presents a challenge to governments: narrowing the mental health treatment gap will require more than expanding existing medical services.

A broader psychological workforce, providing a wider range of interventions in different settings, is needed if governments are to reduce waiting times, improve outcomes and respond to rising demand. Counselling and psychotherapy already represent an established national resource that could contribute much more to prevention, early intervention, community mental health, education, workplace wellbeing and NHS services.

The policy proposition is relatively straightforward:

The question is no longer whether the UK has additional mental health capacity. It is whether government policy, commissioning and investment will enable the capacity that already exists to be used effectively.

Realising that opportunity requires coordinated action by governments, commissioners, NHS organisations, regulators, employers, educators and professional bodies. The profession itself also needs to strengthen standards, improve diversity, demonstrate impact and develop a stronger collective voice.



Infinity Bridge, Stockton-on-Tees,
England, United Kingdom

What does this mean for practitioners?

The Commission sets out a stronger future for the profession: greater recognition, better opportunities and a more sustainable workforce. Its recommendations would enable counsellors and psychotherapists to make fuller use of their skills across a wider range of settings and services, while strengthening professional standards and training, improving workforce diversity and supporting a stronger evidence base. The prize is clear and should be embraced positively: a valued and properly paid and utilised workforce, better able to meet growing demand and improve outcomes for people and communities.

What does this mean for people needing mental health treatment?

The Commission's recommendations are ultimately about better access to safe, effective and high-quality therapeutic support. They seek to reduce barriers to care, strengthen public confidence and protection, improve choice, and ensure services are better equipped to meet the needs of diverse communities. For the public, the ambition is straightforward: the right support, at the right time, from trusted and appropriately qualified professionals — with genuine choice over the help they receive.

A watershed moment

The Commission describes this as a watershed moment for counselling and psychotherapy – and for the people and communities who rely on mental health support. Its recommendations offer the opportunity to make better use of an established national workforce, expanding access to safe, effective and timely psychological support while strengthening the profession for the future. Unlocking this potential will transform lives.

For people, this means greater access to the right support at the right time, with more choice, stronger public protection and services better equipped to respond to diverse needs.

For practitioners, it means greater recognition of their skills, more opportunities to contribute across health, education, employment and community settings, and a more sustainable, diverse and properly valued workforce.

For policymakers, the reward is a stronger mental health system with greater capacity, earlier intervention, improved access and potentially better value for public investment. At a time of rising demand and pressure on public services, the Commission makes a clear case for treating counselling and psychotherapy as a core component of the UK's mental health infrastructure – backed by the funding, workforce planning, regulation and evidence needed to realise their full potential.

The opportunity is therefore not simply to expand the profession, but to unlock an existing national asset for the benefit of practitioners, the public and the wider health and economy of the UK.

A small investment, a big return: unlocking untapped capacity

Unmet mental health need

It is estimated that there are 1.8 million people on a waiting list for mental health services in England.[8] There isn't equivalent data published for Northern Ireland, Scotland and Wales but the Mental Health Foundation estimates the level of mental health need across the UK to be just short of 14,000,000 people.[9]

Unused treatment capacity

> Across the PCPB organisations we estimate that 92.3% of the 82,000 trained and qualified members have additional capacity to help address some of this demand.[10]

> Our analysis indicates that there is an estimated minimum of 15,333,635 additional hours capacity within the existing counselling workforce, and when converted to Whole Time Equivalent (WTE) posts, the capacity is equal to 18,210 additional practitioners.

> We calculate that this number of sessions annually would enable the delivery of courses of counselling and psychotherapy to 1,533,364 people across the UK, based on a 10-session average.

Cost and deployment

> Applying a conservative target of using just 10% of the existing available capacity we've identified above, would mean over 150,000 additional courses of therapy delivered annually; **over 150,000 more people helped**.

> When this is allocated proportionally based on population size of each devolved nation, we estimate annual costs as follows:

- **England** - £102.55m,
- **Northern Ireland** - £3.39m
- **Scotland** - £10.4m
- **Wales** - £5.74m.

> As demonstrated in table 1 below, across all nations, this investment represents **less than 1% of existing national mental health budgets**.

Table 1: Breakdown of therapy costs, coverage and staffing needs by UK nation

	Population weighted share of 150,000 courses of therapy	Cost per 10-session course of therapy	Total cost of delivering population weighted share of 150,000 courses of therapy	Cost as a proportion of mental health spend	FTE roles to deliver population weighted share of 150,000 courses of therapy
England	126,917.21	£807.98	£102,546,905.30	0.54%	1,507.24
Northern Ireland	4,174.06	£811.59	£3,387,612.59	0.87%	51.67
Scotland	12,009.48	£867.07	£10,413,034.46	0.69%	144.27
Wales	6,899.24	£832.61	£5,744,371.39	0.52%	83.17
UK total ***cost per 10 sessions as a UK average**	150,000.00	£829.81	£122,091,923.75	0.56%	1,811.67

More detail on the methodology underpinning the calculations in this table is provided in Annex D, with detailed data tables provided in Annex E. (See page 105)

Return on investment

Counselling and psychotherapy can generate extensive benefits across public services and the economy. Existing evaluation evidence demonstrates a compelling economic case across a range of settings, including evidence that every £1 invested in counselling for children and young people could generate a £14 return,[11] while workplace counselling could generate £5 for every £1 invested.[12] This is comparable with the UK Government's evidence for evidence-based talking therapies delivered through NHS Talking Therapies, which includes Counselling for Depression. This delivers a return of approximately £5 to £6 in wider economic and social benefits, associated with people who have undergone treatment being more likely to work and less likely to require welfare benefits.[13]

Recommendations for the United Kingdom

Improve commissioning and funding

1. Narrow the mental health treatment gap by deploying counsellors and psychotherapists: Governments across the UK should increase the availability of publicly funded counselling and psychotherapy to rapidly narrow the growing mental health treatment gap. Governments working with the PCPB should act to identify and remove barriers and create pathways to better use and mobilise the untapped resource of trained counsellors and psychotherapists within the mental health workforce, to benefit people of all ages who draw upon our health and social care, education, justice and welfare systems.

2. Create sustainable counselling and psychotherapy services: Commissioners of public sector services should protect the future of vital voluntary and private sector counselling and psychotherapy services by extending funding cycles to ensure better long-term financial stability, staff retention, continuity of care and the preservation of established community initiatives; and by embedding specialist counselling and psychotherapy services into statutory pathways and ending unfunded referrals.

Strengthen public protection

3. Ensure public safety: The UK Government should work with counselling and psychotherapy professional bodies and experts by experience to identify options for establishing a statutory regulated framework. This would be the next step toward the greater goal of establishing statutory regulation of counselling and psychotherapy to ensure the safety and quality of services for clients and practitioners.

Build a diverse workforce

4. Increase the diversity of the workforce: The PCPB should tackle the lack of diversity in the profession, to ensure it better reflects the communities it serves. There should be a review of the demographic data of members and registrants in the PCPB to explore barriers to accessing and thriving in the profession for people from marginalised groups, creating a multi-year strategy to improve the diversity of practitioners and improve cultural competency in counselling and psychotherapy provision across the UK. Improving the diversity of the workforce should help to strengthen confidence in the profession for those groups who are currently underrepresented as clients.

5. Review the place of volunteering: The PCPB should undertake an in-depth review into the extent and role of volunteering within the professions, understanding its impact on training and workforce development, diversity and access to the profession, pay, professional recognition and the sustainability of services.

6. Evolve the training landscape: Training providers and awarding bodies working in collaboration with accrediting organisations and the PCPB partnership should modernise and improve accessibility of counselling and psychotherapy training by updating the core curriculum, Continuing Professional Development (CPD) and post-qualification specialist training to further include key emerging client needs, such as neurodiversity, trauma, suicide, self-injury, severe mental illness and cultural competency; expanding flexible learning options; and introducing standardised reporting on placement availability and quality.

Strengthen the evidence base

7. Present the compelling economic case for counselling and psychotherapy: The PCPB should commission and secure funding for a large-scale cost-effectiveness study of counselling and psychotherapy services to demonstrate the significant health, social and economic return on investment they create for the UK.

8.Maximise the evidence-base: The PCPB should provide strategic leadership in strengthening the evidence-base for counselling and psychotherapy, setting clear priorities for research, investment and sector-wide collaboration. A more coordinated approach should make better use of real-world evidence, widen participation in research and service evaluation across the profession, support a stronger culture of evidence-informed practice, demonstrate clinical and cost-effectiveness and ensure that future research funding and development opportunities are targeted where they can make the greatest contribution.

9. Innovate and adapt to digital working and artificial intelligence: The PCPB should evaluate the opportunities and risks of the adoption of digital working and artificial intelligence as an innovation in counselling and psychotherapy practice, identifying where this can have positive benefits for increasing access to care and reducing administrative burdens, and producing shared guidance, standards and principles for the safe and ethical use of artificial intelligence (AI) in therapy. Proper and thorough consideration should be given to the ethical, environmental and socioeconomic implications of AI for professionals and clients, while recognising the fundamentally human foundations of counselling and psychotherapy. The PCPB should seek to play a leading role in shaping the future regulation of the use of AI in mental health as a whole.

Raise public and political recognition

10. Raising public awareness of counselling and psychotherapy: Supported by the Governments across the UK and the Professional Standards Authority, the PCPB should lead a national public awareness campaign to boost understanding of counselling and psychotherapy. This should cover the benefits of seeking professional psychological support for a range of mental health problems, the serious risks of accessing help from unregistered practitioners, and how members of the public can find qualified practitioners on a PSA accredited counselling and psychotherapy register until a statutory register is available.

Give the profession a stronger collective voice

11. Strengthening the voice of the sector: There should be greater collaboration across the counselling and psychotherapy sector to speak with a collective voice to improve the lives of those who draw upon and who provide those services. The PCPB should build upon its current structure to create a stronger federation of counselling and psychotherapy organisations that will take forward issues of shared and mutual interest, informed by people with lived experience, for the benefit of the professions and the people who seek their services. A strong counselling and psychotherapy federation should reflect the devolved nations in its representation and structure.

Recommendations for each UK nation

England

UK Government has a significant opportunity to strengthen counselling and psychotherapy as part of the ongoing reform of the mental health system in England. The Commission has identified several specific priorities for England which sit alongside the broader UK-wide changes we identify in our headline report recommendations.

12. Modernise the Talking Therapies Programme to strengthen delivery of neighbourhood health ambitions: The UK Government should increase access to counselling and psychotherapy through the expansion of relational therapies within the NHS Talking Therapies programme, and create local pathways to psychological therapies to help support the evolution of Community Mental Health Centres, Neighbourhood Health Services and 24/7 Neighbourhood Mental Health Centres as these are expanded across England. Integrated Care Boards should ensure that qualified counsellors and psychotherapists are recognised as core members of neighbourhood multidisciplinary teams.

13. Enhance Mental Health Support Teams in Schools (MHSTs) to maximise outcomes for Children and young people: The UK Government should ensure that school counselling provision in England is brought in line with the rest of the UK by funding and commissioning school-based counselling in every school. The rollout of Mental Health Support Teams across England provides an ideal vehicle to deliver this ambition.

14. Use and mobilise therapists to deliver the Government's core employability priorities: The UK Government should call upon the counselling and psychotherapy professions to help fulfil its policy priorities as indicated in Get Britain Working and the Milburn and Mayfield Reviews to address mental health barriers to employment and improve labour market participation for all ages, and ultimately strengthen economic activity and growth.

Scotland

Scotland has a significant opportunity to strengthen counselling and psychotherapy to help the Government achieve its mental health ambitions. The Commission has identified several specific priorities for Scotland which sit alongside the broader UK-wide changes we identify in our headline report recommendations.

15. Recognise counselling and psychotherapy within mental health workforce planning: The Scottish Government, working with NHS Education Scotland, professional bodies (the PCPB and COSCA) and training providers, should establish a clearer picture of the counselling and psychotherapy workforce in Scotland across all statutory and community settings. The important contribution of counsellors and psychotherapists should be explicitly recognised within the proposed Mental Health and Wellbeing Service Blueprint and future iterations of the mental health workforce plan as they are in the Mental Health Strategy – with clear targets for job growth to address demand.

16. Review the recognition of counselling within Scotland's Psychological Therapies Matrix: The Scottish Government and NHS Education Scotland should review how counselling and psychotherapy are represented within the Psychological Therapies Matrix to ensure that it reflects the reality of therapeutic practice in Scotland and helps narrow the treatment gap in psychological therapies.

17. Ensure counselling can continue to deliver great outcomes to children and young people in Scotland: The Department for Education should restore funding to counselling across Higher and Further Education settings, whilst committing to ensure a long-term funding commitment for school counselling, uprated to take account for inflation and rising service delivery costs.

Wales

Wales has a significant opportunity to strengthen counselling and psychotherapy to contribute to the delivery of its mental health objectives. The Commission has identified several specific priorities for Wales which sit alongside the broader UK-wide changes we identify in our headline report recommendations.

18. Reform the Mental Health Measure to expand counselling and psychotherapy in the NHS: The Welsh Government should reform Part 1 of the Mental Health (Wales) Measure 2010 to enable appropriately qualified, accredited and registered counsellors and psychotherapists to undertake Local Primary Mental Health Support Service (LPMHSS) assessments. Expanding the range of professionals able to undertake assessments would increase workforce capacity, improve responsiveness and reduce unnecessary waiting times, while ensuring that people are directed to the most appropriate form of support at the earliest opportunity.

19. Recognise counselling and psychotherapy as a core component of the psychological therapies workforce: NHS Wales, Local Health Boards and Health Education and Improvement Wales (HEIW) should formally recognise counsellors and psychotherapists as a core part of the psychological therapies workforce and ensure that they are consistently represented within workforce planning, service redesign and utilised within multidisciplinary teams.

20. Create sustainable commissioning for community counselling services across Wales which takes account of rising delivery costs: The Welsh Government should work with Local Health Boards and Regional Partnership Boards to establish longer-term commissioning arrangements for counselling and psychotherapy across community and education settings which is uprated to take account of the rising service costs resulting from the cost-of-living crisis. Moving towards multi-year commissioning with more realistic costings would improve outcomes for service users, improve workforce stability, strengthen collaboration between statutory and voluntary services and increase access to preventative mental health support within local communities.

Northern Ireland

Northern Ireland has a significant opportunity to strengthen counselling and psychotherapy as part of the future mental health system. The Commission has identified several priorities which sit alongside the broader UK-wide changes we identify in our headline report recommendations.

21. Narrow the funding gap within the Mental Health Strategy: The UK Government and Northern Ireland Executive need to urgently commit to fully funding the Mental Health Strategy. This should be addressed through a ringfenced multi-year budget in recognition that the unique challenges facing Northern Ireland are a shared responsibility due to the legacy of the Troubles. This urgently needs to facilitate investment in sustainable community counselling services, with funding proportionate to the scale of need.

22. Recognise the counselling and psychotherapy as a strategic workforce: The Department of Health should fully embed counselling and psychotherapy within future mental health workforce planning as core contributors to mental health provision. This should include therapists working across both the statutory and voluntary sectors. They should work closely with the PCPB to develop reliable workforce intelligence covering numbers, employment settings, skills, vacancies and future workforce requirements.

23. Create sustainable routes from training into employment: The PCPB should work closely with relevant departments, statutory services, universities, training providers and employers to address the various components which perpetuate a low pay and no pay culture in Northern Ireland. Investment should support placements, supervision and funded opportunities for newly qualified practitioners.

24. Expand access through primary care and community services: The current proposed model for neighbourhood health for Northern Ireland focuses too much on existing staff within Health and Social Care and is focused primarily on physical health. The Department of Health should fully embed counselling and psychotherapy within the proposed neighbourhood care model, utilising the expertise of the voluntary and community therapists to support earlier intervention, reduce pressure on secondary services and ensure communities get the help they urgently need.

Mental health: the scale of the challenge

The state of mental health within the UK is worsening,[14] in terms of both prevalence and complexity. Numerous factors contribute to the worsening of mental health, such as precarious employment, living and housing costs, treatment availability, and changing lifestyle factors.[15] At the same time, poor mental health has a range of complex and interlinked knock-on effects including school avoidance and exclusion, health inequalities, unemployment, social isolation, worsened physical health, exposure to abuse, forced migration, substance misuse, self-injury and suicide.

This complicated, multi-directional relationship between poor mental health and various health and socio-economic challenges requires a cross-departmental response by the UK and devolved governments. Reducing the severity and prevalence of poor mental health will likely have a positive impact across education, employment, criminal justice, and the health and social care system.[16]

Beyond this, and most importantly, tackling the mental health crisis means helping people to feel better on a day-to-day basis, improving wellbeing, resilience and life satisfaction. As others have highlighted, mental health therapeutic provision should be better funded, staffed, and resourced to come close to achieving the desired parity of esteem with physical health.[17] [18]Counselling and psychotherapy, currently underutilised by our NHS and in other settings such as schools, universities, community services, prisons, and more, could be key to achieving this ambition.

Prevalence

The UK and devolved governments have acknowledged and often articulated the extent of the challenge. The 2024 Darzi Review into the NHS in England found that by April of that year, there were one million people on mental health waiting lists. Of those, 345,000 had been on the list for over 12 months.[19] Findings from the independent review into mental health conditions, ADHD and autism, published in October 2026, showed that the prevalence of depressive and anxiety disorders among adults in England rose from '15.5% in 1993 to 22.6% in 2024', and among 16–24-year-olds it increased from 'around one in six to one in four'.[20]

Data from the National Survey for Wales found that 'average mental wellbeing scores have declined since 2016-17, reaching their lowest point in 2022-23 and remaining at a similar level in 2024-25 (the latest available data)'.[21] The 2022 Scottish Health Survey found that 22% of adults in Scotland exhibited signs of a possible psychiatric disorder.[22] In Northern Ireland, 38% of adults reported having concerns about their own mental health in 2024/25,[23] an increase from 32% in 2022/23. The regional 'postcode lottery' for treatment also creates regional inequalities for those with severe mental illness.[24] While health systems and policies are devolved across the four nations and provision varies, mental health is a universal, growing concern.

Government modelling in 2023 found an estimated 1.16% of England's population had a severe mental illness (SMI) – for example schizophrenia, bipolar disorder, or other psychosis.[25] Among registered GP patients in Scotland in 2026, this figure is 1.1%. In Wales, government estimates of the incidence of SMI are as high 2%. 2023 research by the Mental Health Foundation found an incidence rate of 0.9% in Northern Ireland.[26] There is a 'hidden health crisis' created by the severe mental illness mortality gap; those diagnosed with an SMI, on average, have a life expectancy 15-20 years lower than their peers.[27] This association is complex and is not necessarily attributable to SMI itself as a direct cause of death. Rather, excess mortality is largely driven by preventable physical health conditions, including cardiovascular and respiratory disease, diabetes, liver disease and some cancers. These outcomes are associated with a combination of modifiable risk factors, such as higher rates of smoking, obesity, physical inactivity and alcohol or substance misuse, alongside medication-related metabolic effects and inequalities in access to timely physical healthcare.[28]

Contributing factors

This is not simply a 'health and social care' problem. Evidence shows that poor mental health is both a driver and consequence of the key socioeconomic challenges facing the United Kingdom. A 2026 House of Lords briefing described some of the socioeconomic impacts of poor mental health and wellbeing, namely:

- education disruption and school absence
- disengagement from work and training
- high rates of young people not in education, employment or training (NEET)[29]

42.6% of disabled young people who are NEET (Not in Education, Employment,or Training) report struggling with a mental health condition

Educational attainment and school absence

Emotionally-based school avoidance (EBSA) is a growing concern among school-aged children, with former Education Secretary Bridget Phillipson describing school absenteeism more widely as 'endemic'.[30] Due to social difficulties, anxiety, trauma, and other wellbeing concerns, children experiencing EBSA find themselves unable to face going to school. 2023 research by the Health Foundation found children with a suspected mental health disorder were 'seven times more likely to be absent from school for more than 15 days than children without'.[31]

School absenteeism has a negative impact for children in the immediate and long term. Good attendance supports better educational outcomes, confidence, and safeguarding against exploitation and radicalisation.[32] UK government research suggests each 'additional day' of absence a pupil takes between Year 7 and Year 11 translates to a total lifetime loss of £750 (2024 prices) in future earnings,[33] and that persistently absent children will be more likely to become NEET (not in employment, education or training) as adults. For children who are not routinely attending school, including as a consequence of vulnerable circumstances or intersecting health inequalities, this is a barrier to accessing school-based counselling provision. As such, it is important that children and young people can access counselling and psychotherapy through alternative pathways such as youth services and primary care.

Unemployment

On youth unemployment, the UK Government commissioned the Milburn Review, with a focus on 16 to 24-year-olds who are NEET. The interim report from the review, published in May 2026, found that of disabled people who were NEET, 42.6% cited a mental health condition as the primary reason in 2025, compared to 24.3% in 2011. Milburn described the relationship between poor mental health and NEET status being 'self-reinforcing'.[34] 'Disengagement' from employment worsens mental health, and poorer mental health makes it harder to access employment. This creates a vicious cycle which drives young people further away from work.

Economic impact of poor mental health

The Centre for Mental Health estimates that poor mental health costs the UK an estimated £300 billion each year, broken down into 'economic costs' (such as unemployment, presenteeism, and staff sickness), 'human costs' (unnecessary suffering and detriment to quality of life), and 'health and care costs' (the direct spend on health and social care services).[35] 2022 analysis from the Mental Health Foundation, applying a narrower working definition of economic costs, puts this figure at £117.8bn (£100.8 billion in England; £8.8 billion in Scotland; £4.8 billion in Wales and £3.4 billion in Northern Ireland), equivalent to roughly 5% of the UK's gross domestic product (GDP).[36] Both analyses demonstrate the significant economic impact of poor mental health.

Lasting impacts of the pandemic

Evidence reviewed by the Centre for Mental Health found that around two in five adults in England experienced likely symptoms of depression or anxiety at some point during the first year of the pandemic.[37] The report also found that social isolation, financial insecurity, bereavement, and disruption to employment contributed to poorer wellbeing, while around 30% of adults reported clinically significant mental health symptoms. Demand for mental health services subsequently rose to record levels and has remained high.[38]

The longer-term mental health consequences of the pandemic may therefore extend well beyond the immediate period of lockdown and social restriction.[39] Some impacts, including trauma among those most affected by Covid-19 and the psychological effects of disrupted education and socialisation among young people, are likely to be longer-lasting, while some longer-term impacts may not yet have manifested themselves.[40]

Poor mental health costs the UK an estimated **£300 billion** each year

Since the outset of the pandemic, physical distancing requirements, the redeployment of medical, nursing, and allied health staff, shortages of crucial equipment, and the delay of elective treatments generated a significant backlog for the NHS. The Royal College of Psychiatrists described a surge in demand for NHS mental health services during the pandemic, with waiting list numbers hitting 1.6 million in 2021.[41] At the time, the Westminster Government announced a £5.4bn spend to tackle the NHS backlog in England, however no specific commitment to mental health was made. A similar approach was followed in the other UK nations with £100 million to address hospital waiting times and develop new diagnostic hubs in Wales[42], £61.5 million was earmarked to tackle long hospital waiting lists in Northern Ireland [43] and £200 million for elective recovery in Scotland [44]. In all cases, mental health was sidelined.

Health sector staff and volunteers working during the pandemic report a range of mental health impacts including burnout, post-traumatic stress (including post-traumatic stress disorder (PTSD)), vicarious trauma, grief, moral injury, and depression.[45] [46] While the NHS workforce in England has grown at an increasing rate since the onset of the Covid-19 pandemic,[47] there has been a 'sharp upswing' in voluntary resignations from the NHS since 2020/21.[48] Combined with longstanding concerns over pay, working conditions, discrimination and work-life balance, this is an additional hurdle facing an already over-burdened, under-resourced service. The 2025 Nursing and Midwifery Council (NMC) 'Professionals who left the NMC register' survey found '84% of leavers across the UK who reported poor health as a reason to leave said their role as a nurse, midwife or nursing associate had a negative impact on their mental health. This includes over 60% who said the negative impact was strong'.[49]

Similar pressures are evident across the UK nations. In Scotland, the NMC found in 2025 that 28% of nursing and midwifery professionals were at high risk of burnout, compared with 23% across the UK, while 40% reported dissatisfaction with their jobs.[50] In Wales, anxiety, stress, depression and other psychiatric conditions accounted for 34.9% of NHS sickness absence in 2025 [51], while Northern Ireland continues to face significant Health and Social Care workforce vacancies, despite substantial growth in staffing which has increased by 11.3% since the pandemic[52]. Taken together, these findings point to a UK-wide challenge around workforce wellbeing, retention and the sustainability of health services.

While the Covid-19 pandemic has had significant repercussions on poor mental health across the country, the upward trend in illness began prior to the pandemic.[53] We may also yet see the full impact of the pandemic, with extensive social isolation, economic downturn, illness, educational disruption, and bereavement, leaving a lasting footprint of collective distress and trauma.[54] [55] The UK Covid-19 Inquiry identified enduring impacts of the pandemic on children and young people's mental health, education and social development, alongside disruption to mental health support, demonstrating that the consequences of Covid-19 extend beyond the immediate crisis.[56]

Health inequalities

Global majority communities

Significant disparities exist between various global majority groups concerning the prevalence of poor mental health, access to mental health treatment, and mental health outcomes. The Race Equality Foundation found that global majority people are less likely to access mental health interventions in primary care (such as through their GP) and are more likely to access crisis care than white people. It also found that global majority people are also 40% more likely to access mental health services through the criminal justice system than white people. Black and Black British people are 3.5 times more likely to be detained under the Mental Health Act.[57] [58]

People belonging to multiple ethnic groups are an 'at-risk' group for suicide. The Gypsy, Romani and Traveller (GRT) community is described as facing some of the 'starkest mental health inequalities of any ethnic group in the UK',[59] with Gypsies and Travellers being twice as likely to report depression as non-GRT people, and three times as likely to report anxiety. Emerging research also demonstrates the vital role of culturally responsive, trauma-informed and transculturally informed counselling and psychotherapy in supporting refugees, asylum seekers and other displaced people, promoting recovery, resilience, belonging and integration while responding to the complex impacts of trauma, loss and forced migration.[60] [61]

Rethink Mental Illness identifies systemic factors driving poor mental health among global majority people, including:

- inequalities in wealth and living standards
- bias, discrimination and racism
- stigma about mental health, and
- the criminal justice system. [62]

Global majority practitioners are underrepresented in counselling and psychotherapy from training to retirement. In psychological professions, this can weaken cultural competency as predominant ways of working often embed Western and Eurocentric cultures. This report will later explore the factors driving this disparity and identify ways to ensure the profession better reflects the public to ensure that counselling and psychotherapy best meet the needs of global majority people. Crucially, global majority people are not a homogenous group, and experiences of marginalisation, risk factors, and protective factors can vary between individuals and communities. Any serious attempt to rectify these inequalities should consider the specific needs and experiences of different global majority groups. Equity will be achieved with differing, adaptive and sensitive approaches that treat people with global majority backgrounds in a way that is mindful of their specific cultural context, rather than treating them as a monolith with a shared, singular experience.

People from the global majority often also experience other inequalities differently, and so their experience, for instance, of belonging to the LGBT+ community or being female may differ from White British peers. This 'intersectional' dynamic means a responsive, culturally competent approach is even more important to ensure that counselling and psychotherapy recognise the complexity of clients' identities and the ways in which multiple forms of disadvantage can interact.[63] For example, research with Black women in the UK has identified the intersection of ethnicity and gender as shaping experiences of mental health stigma and support-seeking, alongside a preference for culturally sensitive practitioners.[64] Similarly, NHS guidance recognises that ethnicity can further shape the experiences of LGBT+ people seeking mental health support.[65] [66] Therefore, practitioners need to avoid treating cultural or demographic groups as homogeneous and instead explore how intersecting identities, social contexts and experiences of discrimination may shape each individual's therapeutic experience.

Case Study: Breaking barriers to baby loss support: How culturally sensitive counselling and psychotherapy can improve outcomes for Black and Black Mixed-Heritage parents

Petals, the baby loss counselling charity, delivered specialist baby loss counselling to 21 Black and Black Mixed-Heritage parents who had experienced miscarriage, neonatal loss, ectopic pregnancy or pregnancy after loss. This was undertaken as part of a12-month project, funded by BACP, between November 2024 and November 2025. The majority (95%) were individual clients, with referrals made through healthcare professionals, primarily via a partnership with *Tommy's* the pregnancy and baby charity. Most clients had experienced early miscarriage (67%) and entered therapy with clinically significant levels of psychological distress.

Black and Black Mixed-Heritage parents face a disproportionately higher risk of pregnancy and baby loss while also encountering barriers to accessing appropriate psychological support. Clients reported challenges including financial constraints, difficulty finding culturally relevant specialist counsellors, problems building therapeutic relationships, and being redirected from generic mental health services that could not meet their specific needs. Before therapy, 95% of clients scored above the clinical threshold for distress, reflecting significant emotional and psychological impact.

Petals provided a specialist, evidence-based counselling programme tailored to the needs of bereaved parents following baby loss. Clients attended an average of 4.5 counselling sessions delivered over several weeks by trained perinatal counsellors with expertise in grief and trauma. Therapy offered a safe, culturally sensitive space to process bereavement, understand grief, address trauma, and develop healthy coping strategies. The programme was delivered through a partnership with Tommy's (pregnancy and baby charity) and Five X More (specialists in Black maternal health), to improve access for Black and Black Mixed-Heritage families.

The programme achieved 63% clinical improvement and 56% reliable improvement in Clinical Outcomes in Routine Evaluation (CORE) clinical outcome scores. Client feedback demonstrated high satisfaction, with 98% reporting they could begin thinking positively about the future, 93% saying counselling helped them process trauma, 92% gaining a better understanding of their grief, and 91% finding healthier ways to live with their loss. Many clients also highlighted the importance of culturally aware counselling, describing feeling understood, safe, heard and empowered throughout their recovery journey.



"She was very amazing, and I felt that she understood me. I received a lot of helpful and practical advice on dealing with my grief. She provided a safe space for me to share my feelings and fears." **– A parent who used the service.**

"My counsellor was great I feel somebody of my ethnicity and sex was beneficial." **– A parent who used the service.**

"Lupe was phenomenal, being culturally aware made everything easier, she knew the complexities of coming from a community-based culture the extra burdens we carry and she was incredibly empathetic. Lupe was clear, patient and offered expertise that helped me to process and step out of the complete darkness I was in. Without these counselling sessions to help me work through it would have been even harder to process and work through our loss. I felt heard and seen - and for once I didn't feel crazy. It would be better if there were more sessions - if there was funding for 10 sessions to help people not feel so restricted." **– A parent who used the service.**

Older people

Factors such as social isolation, declining physical health and stressful life transitions are a significant driver of poor mental health in our older population. Ageist assumptions that worsening mental health is an inherent part of growing older normalise suffering and discourage help-seeking.[67] However, with access to the right care, older people can still enjoy good mental health and wellbeing.

Eighty-five per cent of older people experiencing depression receive no mental health treatment.[68] Older people are less likely to be offered access to Talking Therapies, even though they have a greater likelihood of recovery compared to other age groups.[69] The Centre for Mental Health and Age UK described how 'person-centred and holistic approaches to mental health in later life need to be promoted so that no one's needs are overlooked or inadequately met'. Counselling and psychotherapy can provide exactly this type of therapeutic care, and with an ageing population, the demand for good mental health interventions in later life will continue to grow.

Gender, sexual, and relationship diversity

Lesbian, gay, bisexual, transgender, and other gender and sexuality diverse people (LGBT+) are more likely to experience poor mental health than their non-LGBT+ peers. 2018 research found that 52% of LGBT+ people had experienced depression in the past year, while 61% had experienced anxiety.[70] LGBT+ people are 2.2 times more likely to self-harm than their heterosexual peers, while transgender people face up to a five times higher risk than cisgender people of long-term mental health conditions.[71]

Many LGBT+ people also experience significantly increased risk of suicide and suicidal ideation. Gay and bisexual men are four times more likely to attempt suicide across their lifetime than the rest of the population, 46% of transgender people have thought of ending their life in the previous year, and lesbian and bisexual women have higher rates of suicidal thoughts than the general population.[72]

LGBT+ people are more open to accessing counselling and psychotherapy than those outside the community. Findings from BACP's latest Public Perceptions Survey, published in 2026, found:

> LGBTQ+ people are less likely to describe their mental health as good or very good compared with non-LGBTQ+ people (47% vs 59%).

> Nearly half (47%) say they would turn to a counsellor or psychotherapist if they needed support, compared with 28% of non-LGBTQ+ people.

> More than a quarter (26%) have considered having counselling or psychotherapy, compared with 18% of non-LGBTQ+ people.[73]

In June 2026, the PCPB, working alongside the British Psychological Society (BPS) and the Association of Child Psychotherapists (ACP), began a programme of work to develop a definition of conversion practices and a set of good practice principles for working with gender, sexuality and relationship diversity (GSRD). This is particularly relevant given the publication of a draft Bill to ban conversion therapy in June 2026.[74] Members of the LGBT+ community are also more likely to be the target of hate crime, with gay men, young LGBT+ people, and global majority LGBT+ people being at further risk.[75]

Socioeconomic factors

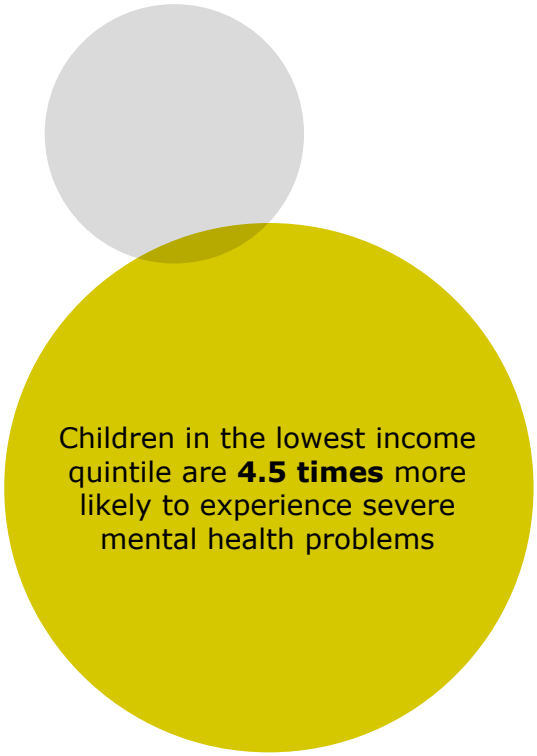
Socioeconomic factors shape the likelihood of poor mental health and exposure to systemic, contributing factors described elsewhere in this section. Data analysis from the Millenium Cohort Study 'found children in the lowest income quintile to be 4.5 times more likely to experience severe mental health problems than those in the highest.'[76] The analysis also found the 'income gradient' demonstrated among young people with poor mental health had notably worsened, signalling increasing inequality.[77]

Material and socioeconomic factors linked to poorer mental health include:

- Unemployment, precarious employment and underemployment
- Housing insecurity, relying on housing benefit, and homelessness
- Food insecurity
- Digital exclusion, including a lack of access to technology and the internet, and
- Social isolation and loneliness. [78]

Notably, the relationship between these factors is often multi-directional, and some factors, such as homelessness and food insecurity, are both a cause and consequence of poor mental health. People with lower incomes or in poverty have less options for accessing mental health interventions. For instance, they are often unable to afford private counselling and psychotherapy, while financial pressures are increasingly resulting in reductions in services and, in some cases, organisational closure for critical third sector services.[79]

The counselling and psychotherapy profession has been described as predominantly or disproportionately middle class, and social class is increasingly recognised as an important but under-researched dimension of diversity within counselling and psychotherapy.[80] In practice, there is a risk that therapists may inadvertently reproduce systemic biases and lack insight into socioeconomic challenges affecting those they seek to help.[81] Access to the profession for potential practitioners from a working-class background can be limited by the significant cost and time barriers associated with training.[82]





Towanroath Engine House, Wheal Coates, Cornwall, UK

Regional inequalities

The prevalence of mental health conditions, access to treatment, and mental health outcomes vary regionally and across the four nations. As health is a devolved matter in Scotland, Wales, and Northern Ireland, further exploration for each of those contexts is set out in the nation specific chapters, later in this report. In England, the prevalence of mental health conditions ranges from 24.6% in the North East and East Midlands to 16.3% in the South East.[83] Prevalence is also higher in more deprived areas, ranging from 26.2% for the most deprived fifth of areas to 16% in the least deprived fifth. Differences in funding, commissioning, and the political priorities of local authorities across regions also lead to a 'postcode lottery' for services.

People in rural and coastal communities experience different factors that influence their mental health compared to their urban and inland peers. This is driven by a range of factors including geographical isolation, economic deprivation, and sector-specific challenges in areas such as agriculture, hospitality, and tourism.

Coastal communities show a higher burden of mental ill-health than those inland. Rates of self-harm among 10 to 24-year olds have also been found to be higher among coastal populations.[84] Young people living in deprived coastal areas also have an excess risk of undiagnosed mental distress, though older people in those areas have a lower risk.[85]

Meanwhile, a 2023 UK government report found that 'rural communities' needs are not fully reflected in mental health policy and services and national NHS planning'.[86] Geographical isolation, the centralisation of services in cities and towns, a lack of granularity in monitoring data, poor public transport and limited digital connectivity were all further cited factors driving poor rural mental health.

How counselling and psychotherapy help

The need to improve the nation's mental health is clear and widely acknowledged.[87] We have demonstrated that the current challenges are profound. There is a growing body of research that demonstrates the effectiveness of counselling and psychotherapy[88] in reducing symptoms of depression[89] and anxiety, improving quality of life and interpersonal functioning, and supporting recovery and participation, including in employment.[90] This supports the value of offering a range of evidence-based therapeutic approaches matched to individual need.

A 2021 randomised-control trial of PCET (Person-Centred Experiential Therapy) demonstrated that PCET was 'non-inferior' to CBT in depression outcomes, six months after randomisation.[91] A 2017 study of adults presenting to IAPT (Improving Access to Psychological Therapies – now called NHS Talking Therapies) services with depression found 46.6% of service users who accessed counselling experienced a 'reliable and clinically significant' improvement in symptoms.[92] Psychodynamic psychotherapy can be beneficial for treatment-resistant depression in adults, with some of the strongest differences emerging during longer-term follow-up with patients.[93]

Evidence also suggests short-term counselling provision in primary care has greater clinical effectiveness than routine General Practitioner (GP) care.[94] In university settings, counselling has been found to lead to reliable change (an improvement which is not attributable to measurement error) in 67% of cases, and clinically significant change (a change which means a person moves from scores within a 'clinical range' to a 'healthy range') in 40% of cases.[95]

Evidence shows that counselling can be effective for older people experiencing anxiety and depression,[96] while a range of counselling and psychotherapeutic approaches can lead to meaningful improvements in outcomes including depression, anxiety, quality of life and coping for people with dementia and their caregivers.[97] Psychotherapy for clients with intellectual disabilities is found to be 'at least moderately effective',[98] and ADHD-specific group psychotherapy is shown to outperform unspecific management (measured through clients' subjective ratings) post-treatment.[99]

There is a clear economic incentive to invest in increased mental health treatment. According to the 2026 Prevention That Pays report by the Children's Society and PBE (formerly known as Pro Bono Economics), it would take £4.1 billion to fill the gap between capacity and demand for children and young people's mental health services, although for every £1 spent, there would be a £14 return on investment.[100] Deloitte estimates that evidence-based workplace mental health interventions can generate an average return of around £5 for every £1 invested through reduced absence, presenteeism and staff turnover.[101]
The Health Economics And Relational Disorder (HEARD) study followed a new psychotherapy treatment pathway in Devon for people with severe and complex mental and physical health needs. The study found that the new service 'significantly reduced the number and duration of hospital admissions both locally and out of area, reduced emergency service attendance, and provided a better experience for service users and their families'.[102]

The counselling and psychotherapy workforce

Across the six PCPB organisations there are approximately 105,000 members. Of these, 82,000 are qualified, trained, and registered on at least one of the six organisations' Professional Standards Authority (PSA) Accredited Registers, who we describe as 'registrants' to show this distinction. Members may work across multiple sectors and split their time between paid and voluntary work. Members also include those who provide training and supervisory services to other practitioners. Our call for evidence gave an indication as to where PCPB members work, with a breakdown available in Appendix B.

We received 3,320 responses to our call for evidence from individual members of the PCPB partner organisations. 2,932 responses came from registrants who are fully qualified to practise.

When looking at the respondents qualified to practise, they told us that they have significant additional capacity to deliver services. Just under three quarters of qualified respondents to our call for evidence (74.4.%) say they have capacity, and would like, to take on additional paid weekly client hours. Just over one in six practitioners (17.9%) said they would like to take on five additional weekly paid client hours, while nearly one in five practitioners (18.8%) said they would like to take on 10 or more hours a week.

Extrapolating these figures across the estimated total PCPB registrants of 82,000, this would mean approximately 61,000 qualified practitioners (61,008) have capacity for additional paid work. The total number of additional hours capacity this represents is 370,394 hours per week or 14,815,760 hours per year, by conservative estimates. Appendices D and E provide further information as to how we arrived at this figure.

By our calculations, each year these 14.8 million hours of extra capacity from trained, qualified, registered practitioners are not being used to address the nation's poor mental health. Given the significant return-on-investment that evidenced mental health interventions provide, including counselling and psychotherapy, this is a tremendous, missed opportunity, and it is essential that this is addressed.

Volunteering

Volunteering has a central, albeit complicated, role within the profession. Placements, often voluntary, are an essential component of practitioner training. Trainees will acquire at least 100 hours of experience on the journey to achieving their level four qualification, which is the widely accepted minimum professional standard to practise as a counsellor. In practice, trainees may acquire far more voluntary hours before landing a paid role, and many qualified practitioners continue to work in a voluntary capacity. Importantly though, not every practitioner in the VCFSE (Voluntary, Community, Faith and Social Enterprise) sector is a volunteer, and not every volunteer works in the VCFSE sector.

Where counsellors and psychotherapists have impact

Volunteering plays a crucial role in the sector, with many VCFSE services being dependent on volunteer labour to run. Volunteers often gain personal development, experience, and confidence through their contributions and find the opportunity to help those who otherwise cannot access therapeutic provision deeply meaningful. Commissioners highlighted that nobody becomes a counsellor or psychotherapist to make money, they do so because they want to help others improve their lives and wellbeing. Counselling and psychotherapy are seen by many as more of a vocation than a job alone and so practitioners may well be motivated to go 'the extra mile'.

With paid roles few and far between, qualified practitioners often feel pressured to undertake further voluntary work to gain additional experience that distinguishes them from their peers. Unfortunately, the willingness and charitability of practitioners to provide voluntary labour can be overly relied upon, or at worst, outright exploited.



Private practice

Private practice is the most common work setting for UK counsellors and psychotherapists. Recent workforce surveys found that nearly 70% of BACP members [103] and 75.5% of UKCP members worked in private or independent practice,[104] although many practitioners work across multiple settings and may combine private practice with employment in the NHS, voluntary sector, education or workplace counselling. Over four-fifths (81.5%) of our call for evidence respondents work in private practice. Practitioners typically are self-employed, offering short- and long-term therapy in person, online or in hybrid formats, and many combine private practice with roles in the NHS, charities, education or employee assistance programmes (EAPs). Private practitioners may be able to offer modalities that are not available through the NHS.

Private practitioners can often also offer flexibility in appointment times, therapeutic approaches and session length, enabling clients to access treatment without NHS waiting lists. However, these many benefits of private practice are only accessible to clients who can afford them. This results in a two-tier system where those with means have greater choice, flexibility and variety in their care, and can access treatment for longer.

Running a private practice also requires counsellors and psychotherapists to manage business responsibilities such as marketing, insurance, data protection, clinical governance, tax, accountancy, and ongoing supervision. As demand for mental health provision has increased, private practice has become an increasingly core component of the UK's wider psychological therapy landscape, complementing statutory and third-sector services while expanding access and client choice, for those who can access and afford it.

Schools, colleges and universities

There is government funding for school-based counselling in Wales, Scotland, and Northern Ireland, although provision, governance and commissioning structures differ between them. England is unusual in this regard, and despite the Government's commitment to roll out Mental Health Support Teams (MHSTs) in every school and college by 2029/30,[105] there is no specific requirement to include counselling or psychotherapy within this provision.



Embedding professionally qualified counsellors within schools provides an accessible, non-stigmatising form of care that can improve mental wellbeing, attendance, resilience, relationships and educational engagement, while also addressing the 'missing middle' of children whose needs exceed pastoral support but do not meet thresholds for specialist Child and Adolescent Mental Health Services (CAMHS). A 2024 independent economic analysis commissioned by BACP estimated that universal school counselling would generate approximately £8 in fiscal benefits for every £1 invested in secondary schools and colleges, and around £10 for every £1 invested in primary schools, with the costs of provision recovered through reduced demand on public services and improved long-term outcomes.[106]

In Wales, local authorities are required, by statute, to make provision for independent counselling for children and young people at the site of every secondary school, as well as for year 6 pupils in primary.[107] In Northern Ireland, counselling is available for young people during 'difficult and vulnerable periods in their lives' in the post-primary stage of education, and school-based counselling and psychotherapy are available for those on the waiting list for CAMHS.[108] In Scotland, school-based counselling is universally available in all secondary schools, fully funded by the Scottish Government. Between July and December 2022, 13,150 children and young people were recorded to have accessed secondary school counselling services.[109]

Counsellors and psychotherapists are a vital part of student support services across UK universities and colleges, providing confidential therapeutic support for a wide range of psychological, emotional and academic challenges. Embedded counselling services help students manage anxiety, depression, relationship difficulties, bereavement, trauma and the pressures associated with transitioning into and completing further and higher education, while also supporting retention, academic engagement and wellbeing. Evidence from the Student Counselling Outcomes Research and Evaluation (SCORE) programme shows that counselling significantly reduces psychological distress, with around 75% of students showing reliable improvement or recovery. Research involving more than 5,500 students across 65 UK universities and further education colleges found counselling and psychotherapy helped:

> **81%** remain in education
> **79%** improve their academic work
> **83%** enhance their overall student experience, and
> **78%** develop employability skills.[110]

79% of students who received counselling and psychotherapy reported it improved their academic work

Employee Assistance Programmes (EAPs)

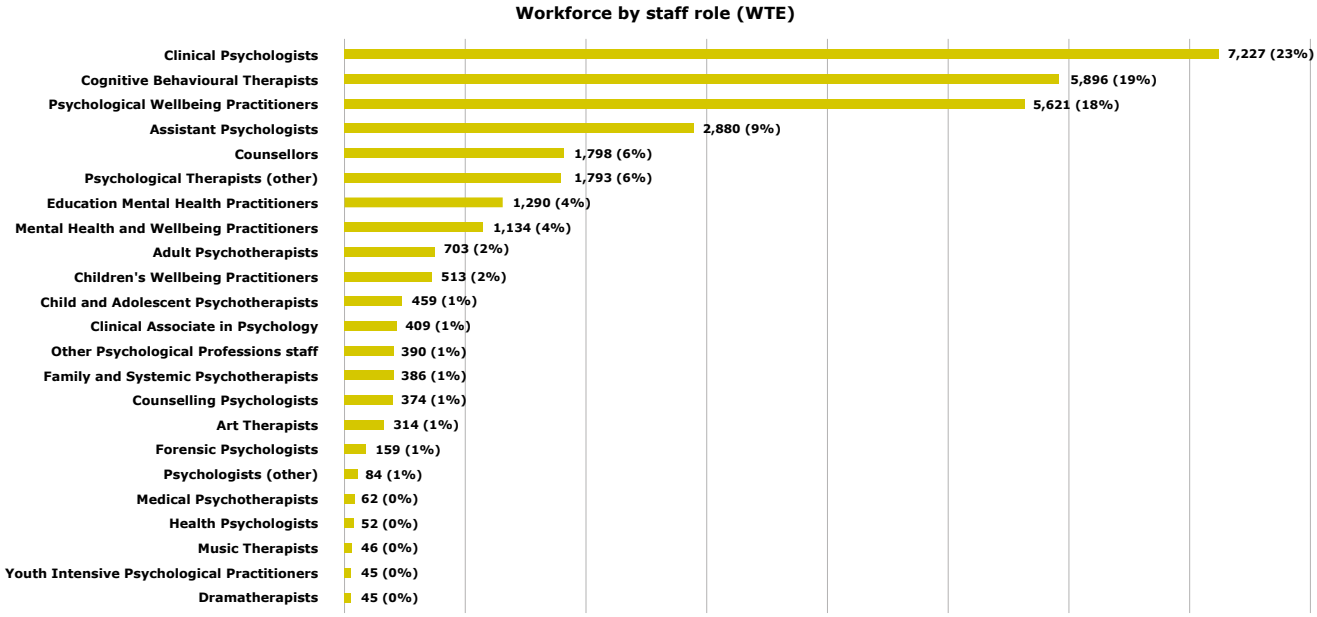
Workplace counselling and psychotherapy play a central role in supporting employee mental health in the UK, most commonly through Employee Assistance Programmes (EAPs). EAPs typically provide rapid access to confidential, short-term counselling alongside practical interventions for issues such as stress, anxiety, bereavement, financial concerns and relationship difficulties. They also act as an early intervention, helping employees access treatment before problems escalate.

Evidence suggests EAPs have become a major component of UK mental health provision. The UK Employee Assistance Professionals Association (EAPA) reported that EAPs now support more than half of the UK workforce, with over 623,000 employees accessing services in the previous year.[111] Recent reports also show that EAPs are increasingly functioning as broader wellbeing services rather than simply telephone helplines.

Research commissioned by BACP and EAPA found workplace counselling is associated with improved wellbeing, reduced sickness absence, lower presenteeism and better job retention when embedded within a wider organisational wellbeing strategy.[112] For employers, investing in workplace mental health interventions is associated with strong economic returns.[113]

The National Health Service

The Psychological Professions National Workforce census[114] and NHS Talking Therapies for Anxiety and Depression National Workforce Census[115] provide an indication as to the number of counsellors and psychotherapists employed in the NHS in England, across mental health services and specifically within NHS Talking Therapies services. Figures from the census published in 2025 (covering data from April 2023-March 2024) show that 36% of the NHS's psychological professional workforce comprises psychological therapists.[116] From a 32,017 total whole time equivalent (WTE) headcount recorded across adult and children and young people (CYP) services on the electronic staff record (ESR), counselling and psychotherapy roles were represented as follows:



[117] Data from 2025 Psychological Professions National Workforce census.

Unfortunately, the census report acknowledges that Adult Psychotherapists are 'known' to not be properly recorded on the ESR. This is driven by a reliance on legacy coding that uses primary clinical backgrounds (such as nursing and psychology) to describe staff, inconsistent data entry in free-text fields, and a lack of title protection removing one motivation to use consistent job titles. Details of employment in the NHS across the other nations of the UK are provided in the relevant sections below.

The National Institute for Health and Care Excellence (NICE) sets guidance for the health service and wider health and care sector to commission effective, quality, cost-effective interventions.[118] The NICE guideline for depression in adults was updated in 2022. The revised guideline for depression in adults recommended a wider range of psychological therapies, including counselling and psychotherapy, as first line interventions, improving patient choice.

The third sector (voluntary, community, faith and social enterprise organisations)

Counsellors and psychotherapists make a significant contribution to mental health provision across the UK voluntary, community, faith and social enterprise (VCFSE) sector, delivering services through charities, community organisations, faith-based organisations, social enterprises and specialist providers. These services often reach people who experience barriers to accessing statutory mental health provision, including those affected by poverty, domestic abuse, bereavement, homelessness, discrimination, trauma, long-term physical health conditions and social exclusion. Many VCFSE organisations also provide culturally responsive and community-led services tailored to the needs of under-served populations, including global majority communities, LGBTQ+ people, refugees and asylum seekers,[119] [120] unpaid carers and young people.

The treatment provided ranges from one-to-one counselling and psychotherapy to group interventions, family support, peer-led programmes and integrated wellbeing services. As part of a wider system of care, VCFSE organisations frequently offer practical advice, social prescribing, advocacy and community connections alongside therapeutic interventions, recognising the social determinants of mental health.

Evidence suggests that counselling and psychotherapy delivered through the VCFSE sector can produce meaningful improvements in psychological distress, wellbeing and quality of life while reducing social isolation and supporting recovery. The sector also contributes to relieving pressure on NHS mental health services by providing accessible early intervention and treatment for people whose needs do not meet statutory thresholds or who are waiting for specialist care.

Investment in mental health promotion, prevention and community-based support can generate substantial social and economic returns, including through reduced demand on health and social care services and wider benefits to employment, welfare and society.[121] [122] [123] The VCFSE sector is increasingly recognised as an essential partner in delivering mental health care across the UK.[124]

Many **VCFSE** organisations provide culturally responsive, community-led services tailored to underserved populations



"'At a time when depression and other mental health issues are a too-common challenge for mothers in the UK, policymakers should look to successful programmes like this to help shape future plans for support." [125]

Case study: Supporting mothers through perinatal depression: How MumsAid counselling delivered lasting mental health and social value

MumsAid provides specialist perinatal counselling for pregnant women and mothers with children up to two years old experiencing depression and other maternal mental health challenges. Analysis published in December 2024 by PBE reviewed outcomes for 300 mothers who received counselling between 2019 and 2024, many of whom faced barriers accessing timely or appropriate NHS mental health services, particularly women from minority and marginalised communities. Up to one in five new and expectant mothers experience perinatal depression, yet many remain undiagnosed or face lengthy waiting times for specialist support. Untreated depression can have lasting consequences for maternal wellbeing, mother-infant bonding, child development and family outcomes. Many women supported by MumsAid had limited access to tailored, culturally responsive mental health services and required specialist intervention during the critical perinatal period.

Total benefits exceeded **£3.1 million** compared with programme costs of **£424,000**

MumsAid delivered a specialist 12-session one-to-one counselling programme, complemented by follow-up sessions at three and six months, alongside therapeutic group work and advocacy where appropriate. Counselling was specifically designed for the perinatal period, providing personalised psychological support to help mothers manage depression, strengthen emotional wellbeing, improve confidence, reduce stress and enhance attachment with their babies. The evaluation found that 76% of mothers showed a clinically reliable improvement in their mental health, while 56% recovered from depression by the end of counselling. After accounting for expected relapse, 101 mothers (34%) achieved sustained recovery over one year. The programme generated an estimated economic benefit of more than £10,500 per mother supported, with total benefits exceeding £3.1 million compared with programme costs of approximately £424,000.

Analysis concluded that the service delivers excellent value for money, with only one in seven recoveries needing to be directly attributable to MumsAid counselling for the programme's benefits to outweigh its costs. Previous evaluations also found improvements in mothers' confidence, reduced stress and stronger parent–infant bonding, demonstrating both immediate and long-term benefits for families.

Other key contexts

Counselling and psychotherapy can be offered in a range of contexts to support people facing a broad variety of challenges. It would be impossible within the confines of this report to do true justice to the depth and value of practice in every setting that it occurs. This subsection highlights some of these additional areas of practice, noting they all merit further understanding and consideration in the development of policy and funding decisions, in addition to recommendations arising from this report.



Hospice and palliative care

Counsellors and psychotherapists working in hospices and palliative care support patients, families and carers as they navigate serious illness, grief, anticipatory loss and bereavement. Counselling and psychotherapy are increasingly recognised as an essential component of holistic end-of-life care, helping individuals manage anxiety, depression, existential distress and adjustment to life-limiting illness. Access to treatment from qualified practitioners can form part of comprehensive palliative care services.

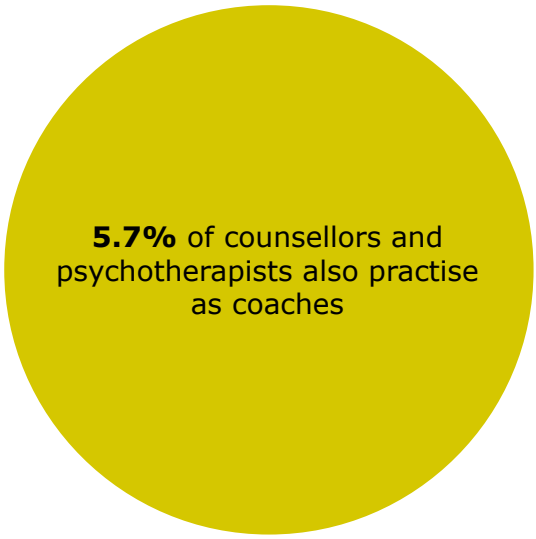
Youth services

Counsellors and psychotherapists play a significant role in UK youth services, working in schools, colleges, community organisations and Youth Information, Advice and Counselling Services (YIACS). They support young people experiencing anxiety, depression, self-harm, trauma, family difficulties and other emotional challenges. Research from BACP and Youth Access[126] has demonstrated that counselling delivered through voluntary-sector youth services leads to significant improvements in psychological distress and wellbeing, highlighting its value as an early intervention that can reduce pressure on statutory mental health services.[127]



The justice system and prisons

Counsellors and psychotherapists work across prisons, probation services, youth justice and rehabilitation programmes, supporting individuals with complex trauma, substance misuse, personality difficulties and severe mental health needs. Therapeutic interventions contribute to emotional wellbeing, rehabilitation and reducing the impact of adverse childhood experiences, while also supporting staff exposed to challenging environments. Psychological therapies within the justice system could also provide specialist interventions for jurors and other justice professionals.



Coaching

According to our call for evidence, 5.7% of counsellors and psychotherapists also practise as coaches, integrating therapeutic understanding with goal-focused coaching to support leadership, career development, resilience and wellbeing. Practitioners with dual training are well placed to help clients address both performance goals and underlying psychological processes while maintaining clear ethical boundaries between coaching and therapy. This integrative approach is increasingly used in organisational, educational and private practice settings.

Spirituality and chaplaincy care

Counsellors and psychotherapists contribute to spiritual and chaplaincy care in hospitals, hospices, universities, prisons and faith-based organisations, often working alongside chaplains as part of multidisciplinary teams. Their work recognises that psychological wellbeing, spirituality, meaning and identity are often closely connected, particularly during periods of illness, bereavement or major life transitions. Some practitioners hold dual qualifications in counselling and chaplaincy, enabling them to integrate psychological and pastoral care while respecting diverse beliefs and values.

Registration and accreditation

The voluntary registration system

In the UK there is no statutory register for counsellors or psychotherapists. The lack of a statutory register for counsellors and psychotherapists contrasts with other relevant professions, such as art therapists, clinical psychologists, youth workers, and social workers. Instead, practitioners can opt to register voluntarily with a professional body, such as one of the PCPB partners. The six PCPB partners all maintain Professional Standards Authority (PSA) accredited registers, which are discussed in further detail below.

Similarly, neither 'counsellor', 'therapist' nor 'psychotherapist' are legally protected titles. This means that any person may market themselves as such and practise regardless of qualification, registration, training, or experience. Almost half (48%) of the public believe these titles are protected.[128] This is one of several manifestations of the understanding and familiarity gap between practitioners and the public. The benefits and drawbacks of the current system are explored further in the next section of this report.

The regulation of counselling and psychotherapy differs around the world, with statutory regulation of both professions on a state/provincial basis in the USA and Canada,[129] statutory regulation of psychotherapy in Italy and Germany, to the voluntary registration approach to both professions taken in UK, Australia[130] and currently in operation in Ireland.

Given its proximity and the similar roots of the profession to the UK, Ireland is an example which has been moving towards full statutory regulation since 2016. It is the first country in the world to establish distinct regulatory standards for entry to both professions, with requirements separate and specific to counselling and psychotherapy. This process is being led by Ireland's multi-profession health register, CORU (not an acronym but derived from the Irish word *cóir'*, meaning fair, just, and proper). CORU is responsible for setting new national standards where the titles 'counsellor' and 'psychotherapist' would become protected under Ireland's Health and Social Care professionals Act 2005.

In July 2025, a significant milestone was reached with the Counsellors and Psychotherapists Registration Board publishing its pre-registration education and training requirements for entry to the registers for counsellors and psychotherapists. The process has generated considerable debate. Several professional bodies in Ireland, and some in the UK, have expressed significant concerns regarding proposed changes to the scope of practice for counsellors, and insufficient consultation with the profession.[131] [132]

The Commission received evidence from one of main professional bodies for counselling and psychotherapy in Ireland, who reaffirmed that these proposals risk exacerbating waiting lists, excluding vulnerable communities from affordable care, and place an unfair burden on smaller counselling services. A central concern is that many of these negative elements were not included within the initial consultation draft, which had support from 91% of public respondents. Political figures have called on the Minister for Health to pause the regulatory process until professional representative groups are granted the opportunity to engage in 'meaningful consultation'. A key learning point for the UK is that any future proposals to strengthen regulation must draw on expertise from the UK's counselling and psychotherapy professional bodies and sector and be informed by the views of experts by experience.

SCoPEd framework

Launched in January 2022, the Scope of Practice and Education for Counselling and Psychotherapy (SCoPEd) framework outlines the core training, practice and competency requirements for counsellors and psychotherapists working with adults[133] It has since had minor revisions in 2025 and is due for a comprehensive review every five years, the first coming in 2027. All six PCPB partners have aligned their registration and accreditation criteria with the SCoPEd columns, ensuring consistent minimum standards across the partners.

Professional Standards Authority accredited register scheme

The Professional Standards Authority (PSA) Accredited Registers programme provides independent oversight of registers for health and care professionals, including counsellors and psychotherapists. Registers awarded PSA accreditation must meet rigorous standards relating to governance, education, complaints' processes, professional conduct and public protection.[134] Through regular review, the PSA helps ensure these standards continue to be met, promoting confidence among clients, employers and the wider public.[135] Counsellors and psychotherapists who are registered with a PSA-accredited register demonstrate their commitment to practising safely, ethically and professionally. Although the accreditation applies to the register rather than individual practitioners, it provides reassurance that registrants are supported by a robust framework designed to maintain high standards of practice and safeguard the public.

Challenges for the profession

Public understanding of the profession

Public understanding of counselling and psychotherapy is broadly limited and misconceptions about the profession are common. Counselling and psychotherapy are part of a vast mental health care landscape, operating alongside psychology and psychiatry, as well as associated professions such as mental health nursing and mental health social work. There are two particularly consequential ways this lack of understanding unfolds. First, misconceptions about how counselling and psychotherapy work may be off-putting to people who would otherwise benefit from accessing treatment. The technical language used to discuss specific aspects, practices, and modalities of counselling and psychotherapy with precision is useful for practitioners but often daunting and confusing to clients. This can create a disconnect between practitioners and the people they wish to support.

Second, due to the way in which the profession describes itself, it becomes hard for people seeking help to determine who is a genuine, qualified and registered practitioner, and who is not. The counselling and psychotherapy landscape is complicated to navigate and places the onus to identify the appropriate treatment option on individual clients, unless they are already in some sort of support pathway (such as through NHS primary care or schools). Familiarity with the Accredited Registers and any of the six PCPB partner bodies is low. Increasingly, practitioners market themselves directly to clients on social media, which reduces the role of directory services and registers as gatekeepers.

The responsibility for public understanding of the profession and straightforward access to the profession lies with professional bodies, service providers, policymakers, practitioners, and the PSA. Accessing treatment often requires self-motivation, a minimum level of knowledge, and trial-and-error from people seeking help. Meanwhile, these same people are often in mental distress, are more likely to be in vulnerable circumstances, and may lack the knowledge to discern which treatment offering is credible. It is unreasonable to expect somebody in such difficulty to reliably and successfully navigate the complicated mental health care landscape. Public awareness campaigns by PCPB partners seek to raise understanding, but this work is clearly not yet finished.

Political de-prioritisation and undervaluing

Counselling and psychotherapy are not the only mental health professions experiencing a gap between rising demand and workforce capacity. Psychiatry, clinical psychology, mental health nursing and mental health social work are also facing significant recruitment and retention challenges within NHS services.[136] [137] These pressures reflect wider workforce planning challenges across health and social care, where growth in training numbers has not always been matched by available employment, training or progression opportunities.[138] For example, increasing numbers of medical graduates have placed pressure on the capacity of the Foundation Programme to provide sufficient training places. Similar workforce pressures are evident across other regulated health professions, highlighting the need for sustainable workforce planning, investment and commissioning approaches that align workforce supply with population need.[139]

To justify funding additional counselling and psychotherapy services, return on investment should not only be demonstrated outright but also in comparison to other mental health interventions. Commissioners have the responsibility to fund services which are clinically proven and cost effective, making limited budgets spread as far as possible to meet surging demand. This means they must make difficult decisions based on the evidence before them. How counselling and psychotherapy can be best presented to meet these criteria is explored in the following section of this report.

In recent times, the political climate has not always been favourable towards investing in mental health interventions, and previous policy shifts indicate a reluctance, at times, to recognise and respond to the extent of the challenge. This is particularly significant in the context of wider economic difficulty which sees other aspects of health and social care, and indeed other sectors, under considerable financial strain. In March 2025, former Secretary of State for Health and Social Care Wes Streeting referred to an 'overdiagnosis' of mental illnesses,[140] prompting criticism from leading mental health organisations[141] who described these comments as stigmatising and dismissive of the extent and depth of the UK's mental health crisis.[142] Subsequently, the complexity of these issues was acknowledged,[143] while the report of the independent review into mental health, autism and attention deficit hyperactivity disorder (ADHD) did not conclude these conditions were overdiagnosed.[144] Sustaining confidence in mental health policy will require that governments recognise the complexity of need and demonstrate a long-term commitment to accessible, evidence-based treatment.

The Government led by Andy Burnham MP has placed an emphasis on prevention, early intervention and community-based mental health provision. In his first speech in July 2026, the Prime Minister committed to providing young people with more mental health support, a commitment he reaffirmed in his Party Conference speech in September 2026. He described his broader ambition as building a more preventative state, with investment directed towards enabling people to live well rather than responding only once problems have escalated.[145] This approach has been reflected in the Government's announcement of £343 million for up to 159 new NHS mental health centres across England, intended to provide earlier support closer to people's homes and dedicated crisis care outside A&E.[146]

The Government's approach remains at an early stage which offers an opportunity for counselling and psychotherapy to make the case to play a key role in narrowing the treatment gap. The key policy challenge will consequently be whether the emphasis on prevention is matched by the capacity, funding and evidence-based provision required to meet existing and anticipated levels of need.

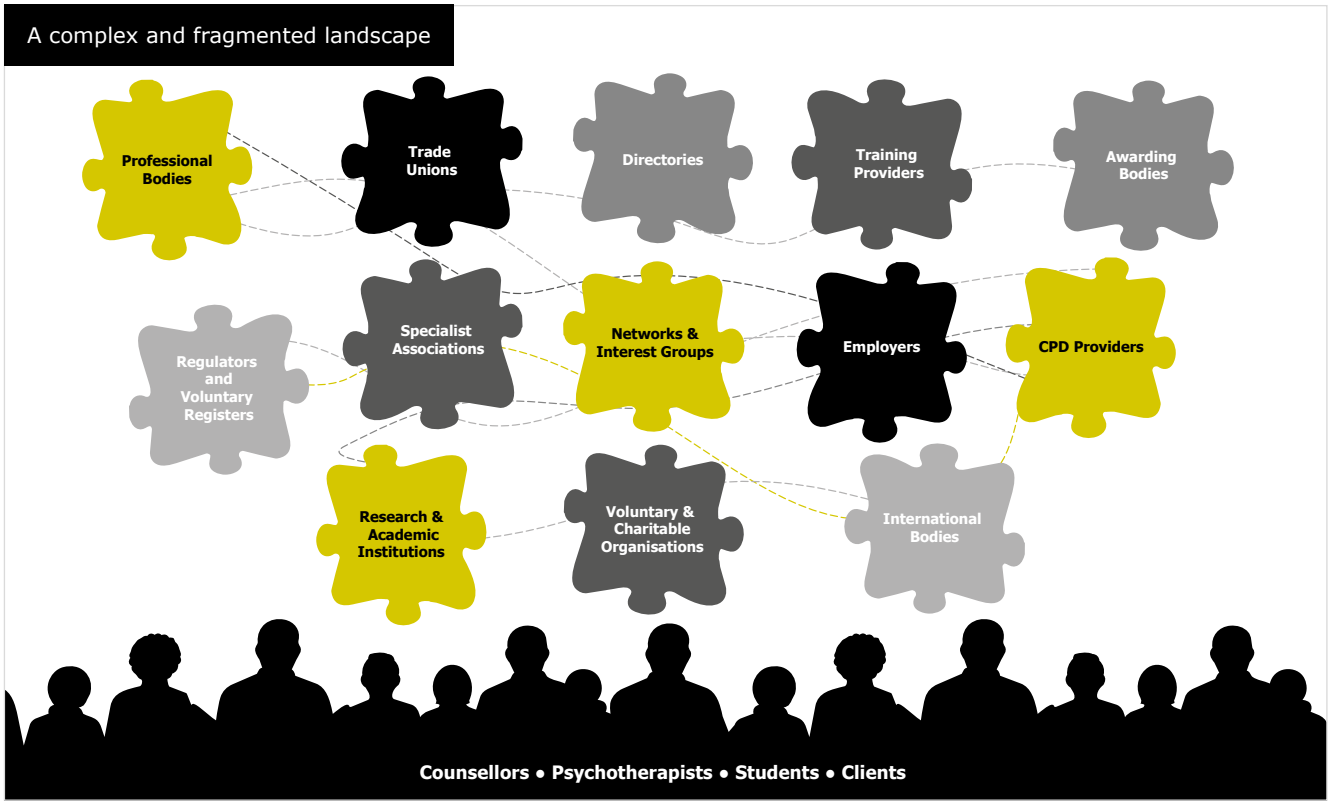
"We'll help more young people by changing the education system and giving them more mental health support"

Prime Minister Rt Hon Andy Burnham, MP
20 July 2026

Fragmentation of the sector

The professional landscape for counselling and psychotherapy is complex and fragmented. There are numerous professional bodies, trade unions, directories, training providers, and awarding bodies, with overlapping remits and memberships. Many are similarly branded, while one Commissioner described the 'acronym soup' of organisations that makes navigating the landscape confusing for professionals, let alone clients.

A complex and fragmented landscape



Much of this is the consequence of the organic growth of the profession over time with different bodies forming to meet different needs. Having a selection of, for instance, membership bodies or training providers, may allow practitioners to choose the organisation which best suits their needs, values and practice. Membership bodies are free to be responsive to the needs of their own members and are answerable to them through democratic processes. This means they can pursue different objectives, adopt different stances, and serve a different segment of the profession.

However, this fragmentation also serves as an obstacle that prevents the profession from speaking with a unified voice. There is duplication of effort across the PCPB partners in areas such as external communications, awareness campaigns, public affairs, and research. Internally, there is overlap in areas such as best practice guidance and professional conduct proceedings. This leads to a considerable duplication of efforts, particularly given the specific, limited scope of the PCPB. Membership organisations risk seeing each other as competition, rather than embracing a collaborative approach to better support their collective membership.

With the considerable challenges facing the profession, bodies within and beyond the PCPB would do well to embrace areas of common ground, pooling efforts and resources to present a unified front to their shared audiences and those they want to influence, engage and educate.

Diversity, equity, inclusion and belonging

The counselling and psychotherapy workforce is not demographically representative of the general population nor the people most likely to experience or seek help for mental ill-health. For practitioners and clients, this leads to difficulties and missed opportunities through every step of their journey. A sustained commitment to anti-oppressive, anti-racist, and trauma-informed approaches across training, research, policy, and practice is essential for the future of counselling and psychotherapy,[147] enabling the profession to challenge systemic inequalities, respond more effectively to diverse lived experiences, and promote greater equity, inclusion, and social justice.[148]

First, we focus on the experience of clients. A lack of diversity or even perceived lack within the workforce deters some people from seeking help, particularly if it creates the impression that counselling and psychotherapy are not for people of their background. BACP has highlighted that cultural stigma, alienation from clinical settings and experiences of racism can act as barriers to accessing mental health support,[149] while NHS England recommends culturally responsive practice and a workforce that better reflects the communities it serves.[150]

Accessing treatment is only the first step. A lack of cultural competency from practitioners can be alienating to people from the global majority. This can get in the way of the development of a functioning therapeutic alliance (the rapport, collaboration and trust between practitioner and client). A strong therapeutic alliance is foundational to success in counselling and psychotherapy. At the same time, a culturally competent practitioner can make clients from all backgrounds feel accepted and at ease, paving the way for relational depth and understanding.

Second, we focus on the experience of practitioners. When we asked call for evidence respondents 'what, if any, do you feel are the barriers to increasing diversity in the counselling and psychotherapy workforce?', we found:

> 59.3% said unclear or insecure career pathways, including difficulties in maintaining a sustainable income

> 38.3% said structural limitations of training and placements (e.g. limited providers, narrow curricula, rigid requirements)

> 35.7% said a lack of flexibility or accessibility within training requirements (e.g. online training/placement opportunities and required hours)

> 34.3% said an exclusionary or discriminatory culture within the training and the profession (e.g. lack of representation, stigma, pressure to conform).

These findings suggest that barriers to workforce diversity are rooted not only in individual circumstances but also in the structure and culture of the counselling and psychotherapy profession. The predominance of concerns about insecure career pathways and sustainable income reflects the financial realities of a workforce in which many practitioners are self-employed, early career roles are often poorly remunerated, and progression pathways can be unclear. Structural limitations within training and placements may further restrict entry by concentrating opportunities among a relatively small number of providers, requiring substantial unpaid placement hours, and offering curricula or modes of delivery that do not adequately accommodate diverse learning needs, accessibility needs, or professional backgrounds.

Inflexibility concerning placement hours, attendance, and location can disproportionately affect individuals with caring responsibilities, disabilities, or other employment commitments. Finally, reports of exclusionary or discriminatory cultures highlight the importance of representation, inclusive learning environments, and equitable access to professional networks. Increasing diversity in the counselling and psychotherapy workforce will require systemic changes that address financial, structural, and cultural barriers across the training and career pipeline, rather than focusing solely on recruitment initiatives.

Demonstrating effectiveness to decision-makers

Forty-four point two per cent of respondents to our call for evidence identified 'commissioning and regulatory models that prioritise efficiency and measurable outcomes over relational care' as one of the most significant challenges facing the profession, ranking second only to digital therapy and AI. Across respondents, our commissioners, and witnesses, there was a strong perception that the manualised, readily quantifiable, and often short-term model of interventions such as CBT, as delivered through NHS Talking Therapies, is more attractive to service commissioners because of its perceived ease of measurement and evaluation.

Our Commissioners discussed how this creates a vicious cycle. An intervention which more readily lends itself to quantitative evaluation, for example CBT, becomes the preferred choice for service commissioners, is then commissioned, and consequently evaluated. These evaluations then increase the evidence base for CBT, furthering the argument it is 'better evidenced'. Despite this, the fact there may be a larger body of evidence concerning manualised approaches, such as CBT, does not inherently prove they are more effective, only more thoroughly evaluated.

Rich nuance about the impact and value of counselling and psychotherapy is often difficult to convey through quantitative approaches alone.[151] In the context of children's counselling and psychotherapy, for instance, therapy is child-led, and does not follow a generalisable, easily replicable or extrapolated structure. The use of more qualitative data would also support a broader evidence base. This, in turn, could be used to inform new applications of counselling and psychotherapy, to better understand the value for clients and practitioners, and capture elements of the experience of accessing therapy that are not so easily quantified.

Further challenges relate to the generalisability of studies (both qualitative and quantitative) for wider applications. While randomised-control trials (RCTs) are seen as a gold standard of evidence, they are still susceptible to bias and may be less objective than broadly understood.[152] Trials of counselling and psychotherapy interventions also cannot be 'double-blind',[153] and the small sample size of patients with specific conditions and unique experiences lower confidence that their experiences are reflective of their population. Studies concerning depression and anxiety tend to recruit participants with 'limited psychosocial stressors',[154] yet in practice, most clients experience these stressors, lending doubt to the generalisability of these findings.

None of this is to diminish the effectiveness of manualised approaches or deny their value as mental health interventions. There is also a need for pragmatism and to present proof of the effectiveness of counselling and psychotherapy in the terms that decision-makers are looking for, in addition to making the case for the greater recognition of qualitative evidence. NICE's Real World Evidence Framework is a valuable resource to make more effective use of case studies, service evaluations, and other 'real world' data, specifically by:

> [Identifying] when real-world data can be used to reduce uncertainties and improve guidance

> [Clearly] describing best practices for planning, conducting and reporting real-world evidence studies to improve the quality and transparency of evidence.[155]

A plurality of evidence-based interventions, alongside meaningful patient choice between treatment options, is consistent with NICE's approach to shared decision-making and its recommendations that commissioners ensure access to a range of appropriate treatments.[156]

Marketisation and commercial competition

Responses to our call for evidence clearly demonstrate there is significantly greater capacity to deliver counselling and psychotherapy than there is funding to pay for it, both in terms of weekly client hours and jobs. This issue of hidden capacity is driven in part by the limited provision of paid counselling and psychotherapy services across the NHS, schools, youth and community services, and other settings, as discussed earlier in the report.

In our call for evidence, through written submissions and formal evidence sessions of the Commission, we heard how some early-career practitioners are driven into private practice with limited organisational or professional experience; often against their preference and without the chance to find their feet, professionally, and without the necessary organisational safeguards in place that are part and parcel of working within a service.

Unlike some health and social care professions where training and degree places are constrained by public funding, such as clinical psychology, there is no set upper limit for the number of people training to become counsellors and psychotherapists. With limited job opportunities in the public sector and redundancies and service closures in the VCFSE sector, there seems to be a flow of qualified counsellors and psychotherapists into private practice without a proper workforce development plan to use this capacity effectively. Such a plan, underpinned by robust analysis of need across the population, could be instrumental in redeploying counsellors and psychotherapists to narrow the mental health treatment gap. Moreover, in the context of the current cost-of-living crisis, private counselling and psychotherapy are becoming increasingly unaffordable for many people who might benefit from these treatments.

Digital therapy platforms and artificial intelligence (AI)

Fifty-two point nine per cent of our call for evidence respondents identified 'increased use of digital therapy platforms and artificial intelligence in mental health support and practice' as one of the biggest challenges facing the profession, more than any other option. 'Digital therapy platforms' here refers to digital apps and websites which provide a range of services, such as connecting clients to therapists, mood tracking and journalling, dialectical behaviour therapy (DBT) skills, CBT, and chatbots.

Some digital platforms are based abroad, operating outside established NHS care pathways, and as such may not provide the continuity of care, multidisciplinary working or safeguarding arrangements expected within UK mental health services. Concerns remain regarding the management of higher-risk presentations, transparency around therapist regulation across jurisdictions, governance of sensitive personal data, and the conditions under which practitioners work. This means that clients in the UK who access practitioners based abroad may have limited recourse should something go wrong. We also heard concerns about the economic impact of clients being diverted from the UK market to practitioners based overseas.

At the same time, digital platforms can improve access by reducing geographical barriers, offering greater flexibility, and connecting people who might otherwise struggle to engage with therapy, particularly in underserved areas or outside normal working hours. They also allow practitioners a greater reach by helping them reach clients from further afield. Highly specialised practitioners can support clients in need of their expertise regardless of where they live, and for some disabled clients, digital (or otherwise remote) therapy is the only form of therapy accessible to them.

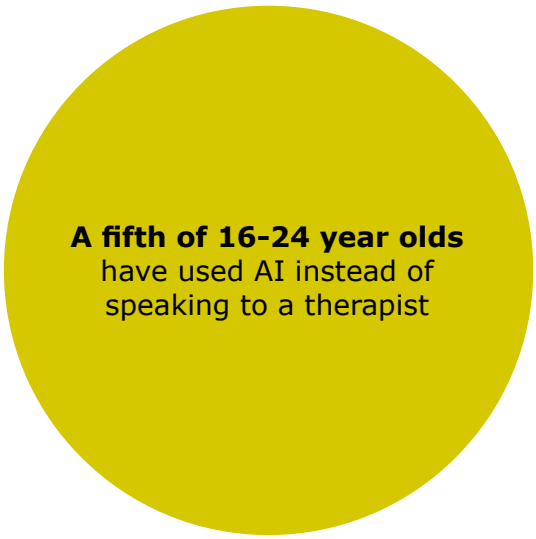
The use of AI is now commonplace in everyday life and for mental health support-seeking. 2026 evidence from BACP found that, of 16 to 24-year-old respondents:

> 'Almost half (46%) have used AI instead of reaching out to a real person
> Nearly a third (31%) have used AI instead of talking to a friend
> A fifth (20%) have used AI instead of speaking to a therapist
> 70% say loneliness negatively affects their mental health and 18% say it has a serious impact
> A quarter (25%) say AI has made them feel less lonely when reflecting on their mental health.'

AI-enabled triage and assessment products have already been deployed by the NHS.[157] These systems are intended to support administrative processes such as collecting information, prioritising referrals and reducing waiting times, allowing clinicians to spend more time on direct patient care rather than replacing clinical judgment. Early evaluations suggest AI-supported assessment can improve efficiency and patient experience in some settings,[158] while the body of evidence evaluating longer-term clinical outcomes is still developing.

We know the use of AI for mental health support, in the broadest sense, is commonplace. For instance, one study indicates that 31% of users of large language models (LLMs) report using them for personal and emotional support.[159] Appropriately designed, clinically governed AI tools may have a role in psychoeducation, symptom monitoring, administrative support and between-session exercises[160] when used as additional support alongside human care, rather than as a replacement.[161] [162] At the same time, high-profile reports of people experiencing harmful interactions with AI systems illustrate the risks, particularly for clients in vulnerable circumstances.[163]

Less well understood are the more common situations in which people may receive mental health advice from systems without the clinical governance, professional accountability and established safeguarding procedures that underpin established mental health services.[164] AI models may provide immediate, short-term relief from anxiety or distress while inadvertently reinforcing avoidance and reassurance-seeking. This is particularly consequential, for instance, for people who are experiencing Obsessive-Compulsive Disorder (OCD), anxiety disorders, or other conditions where rumination and an intolerance of uncertainty are a feature.[165] In this way, without the oversight and judgment that human counsellors and psychotherapists exercise, people using AI in this way may actually make their own condition worse in the long-term.



The question is no longer whether AI will be used by clients seeking mental health support but how we can make sure its use is safe, ethical, and appropriate, with clear parameters and boundaries. One of the core strengths of counselling and psychotherapy is that they provide human connection, building a therapeutic relationship between people, broadly underpinned by positive regard.[166] [167] In this respect, AI cannot truly replace counselling and psychotherapy delivered by human beings. However, the profession would do itself a disservice not to adapt to the changing mental health support landscape. In practice, the PCPB partners should seek to demonstrate what continues to make human counselling and psychotherapy so valuable as a core offering, and how practitioners may ethically use AI to minimise administrative work,[168] freeing them up to do what they do best.

Wider ethical, environmental and socioeconomic questions surrounding AI remain unresolved, including in relation to mental health care. Evidence shows that climate change and environmental damage are harmful to mental health. Generative AI expends significant energy and water to run. The question of how to accommodate the growing adoption of AI for mental health care while preventing further environmental damage is beyond the scope of this Commission, although one for cross-departmental government specialists to address. Certainly, it is important that health interventions do not create such environmental damage that they inadvertently worsen health outcomes.

The adoption of AI tools to support mental health in any capacity should be co-led by practitioners and people with lived experience, rather than being driven primarily by technology developers whose commercial interests may not always align with the best interests of the public.[169] The World Health Organization (WHO)[170] explicitly recommends these tools are co-designed with mental health experts and people with lived experience. NCPS' 'Principles for relational safeguards in AI mental health tools' provides a framework for assessing AI mental health tools against key ethical considerations.[171]



Maximising impact

Lived experience

In counselling and psychotherapy, lived experience provides insight into aspects of care that clinical measures may not capture, including whether therapy feels safe, accessible, culturally competent and genuinely collaborative. NICE states that people who use mental health services can become 'experts through experience' and should contribute to the planning, commissioning, delivery, monitoring and review of services.[172] Experts by experience (EBE) can, for example, identify barriers to accessing interventions, such as referral processes, waiting times, language, stigma or previous negative experiences of services.

Lived experience should be recognised and valued as a distinct form of expertise alongside the knowledge of counsellors, psychotherapists, researchers and service managers. This does not replace professional knowledge; rather, it complements it, providing a different perspective that can strengthen clinical and organisational decision-making. The Health Research Authority, the NHS, the Social Care Institute for Excellence,[173] and NICE provide resources which set out best practice for co-production with EBEs to utilise lived experience as effectively as possible.

Co-production is the process of involving people with lived experience as equal partners from the beginning of service design through to evaluation. For example, EBE can work with therapists to redesign an NHS talking-therapy pathway, develop accessible patient information, contribute to outcome-measure selection, or review anonymised service-user feedback to identify improvements.[174] The Health Research Authority also emphasises involving people early, sufficiently and in ways that influence research design and outcomes.[175]

There is no one-size-fits-all approach to successful co-production, however principles of best practice provide an underlying framework to build upon. Co-production is an ongoing process and is never 'complete', which means it should be sustainably resourced and integrated into service planning, monitoring and evaluation, research, strategy, policy development, and senior decision-making.[176] There are also additional barriers to working ethically and effectively with some EBEs, such as children, EBEs from marginalised backgrounds and those in vulnerable circumstances. Importantly, practitioners themselves can also be EBEs, whether through their own lived experience of poor mental health, or when they are the subject of a process such as training, accreditation, supervision, or service evaluation.[177]

Embedding lived experience is a question of giving clients and people with poor mental health a stake in the profession that serves them. Throughout the remainder of this section of the report and its recommendations, EBEs should be valued participants throughout any process of change and improvement.

Evidencing impact

The misconception that counselling and psychotherapy are not evidence-backed approaches does a great disservice to clients and practitioners alike. This manifests in public distrust, a lack of public understanding, and the devaluing of the work of practitioners by the public, commissioners, policymakers, public sector leaders, and even other health and social care professionals.

There is also a lack of confidence interpreting research among practitioners. Relevant research is also, all-too-often 'paywalled' by academic journals or requires literature search skills to identify. This sense of inaccessibility is created in part because research methods and skills are not a substantial component of practitioner training until level seven, which is equivalent to a postgraduate degree. Some practitioners will not undertake study at level seven throughout their career and may never access formal research training.

The SCoPEd framework does already identify the use of audit and evaluation tools as a competency:

> 4.15.A: Ability to understand the use of audit and evaluation tools to review own counselling work

> 4.15.B: Ability to utilise audit and evaluation tools to monitor and maintain standards within practice settings

> 4.15.C: Ability to utilise audit and evaluation methodologies to contribute to improving the process and outcomes of therapy.[178]

However, specific metrics, outcome measures, and evaluation approaches are not universal and are not always accessible to practitioners. Going further, professional bodies do not have the infrastructure to accommodate the collation and analysis of these data. 'Universal' outcome measures may not capture the nuances of every case but enable consistent comparison and evaluation on a large scale, with a greater sample size and more reliable extrapolation to the profession as a whole. Experts by experience, practitioners, professional bodies and researchers could recognise the potential of this uncaptured dataset by developing accessible, user-friendly, transparent facilities to submit and access case studies and evaluation data.

Finally, and especially for private practitioners who are paid hourly, many of our participants throughout the commission expressed an enthusiasm for taking part in research efforts but said they simply did not have the capacity. PCPB partners may seek to better facilitate these efforts by subsidising or funding research participation by private practitioners, though this should be supported by a thought-out research ethics and participation framework.

Not every practitioner wants to, or is able to, be a researcher. With a crowded training curriculum (with more areas to add, as we discuss below), we must be realistic about which skills are the most important for any practising counsellor or psychotherapist. Indeed, if we are serious about diversifying the profession, adding criteria for qualification which are already indicators of socioeconomic advantage (such as degree-level education in research methods) will likely run contrary to that mission.

Diversifying who leads, participates in, and evaluates research, is another important goal. However, as far as training is concerned, a practical approach may be to embed research skills earlier in the curriculum as a voluntary component of training, in addition to existing level seven provision. The University of Warwick's annual Counselling and Psychotherapy Student Research Conference[179] and the national Student Mental Health Research Network (SMaRteN) Conference are two examples of student-led research activity that encourage collaboration, communication and student ownership of research, enabling the meaningful development of research skills for those early in their careers.[180]

Training

Commissioners, witnesses, and call for evidence respondents provided topics that they would like to see given further attention whether as part of core training, optional training, or CPD. The most raised topics included:

- **Neurodiversity:** This includes working with clients with ADHD, autism and other neurodiverse conditions; succeeding as a neurodiverse practitioner; understanding the structural issues faced by neurodiverse people; exploring modalities and interventions that suit the needs of neurodiverse people; neurodiversity in children and young people

- **Trauma:** Exploring the benefits of the development and implementation of a trauma-informed 'baseline' of knowledge. Not everyone needs to be a specialist, but all professionals should be able to recognise trauma impact, manage disclosure safely and collaboratively, and avoid re-traumatisation

- **Serious and severe mental health conditions:** This could include understanding bipolar disorder, schizophrenia, and psychosis; understanding and working with eating disorders; understanding and working with personality disorders; safeguarding vulnerable adults, and more broadly working with people with medicalised and pathologised backgrounds, including as part of a multi-disciplinary team

- **Self-injury and suicidality:** Many of the core skills counsellors and psychotherapists develop equip them to navigate sensitive conversations around suicide and self-injury. Despite this, we heard clearly from Commissioners that they would benefit from more training to deal with increasingly complex presentations, particularly in the context of a system where clients may have had negative experiences with the mental health care system

- **Diversity, social justice, decolonisation, and cultural competency:** All practitioners benefit from a core foundation of cultural competency, awareness of systemic and structural issues that affect their clients and learning how to talk about diversity and marginalisation appropriately and in a way that strengthens, not threatens, the therapeutic alliance. A large portion of this learning will arise from reflective practice and supervision. Commissioners also discussed decolonising the curriculum. In practice, this would mean embedding education about practices and theories from the global majority

- **Self-employment and private practice:** This may include the basics of establishing practitioners' own business, policies and procedures, marketing, insurance and indemnity, and other key considerations for private practice. Given the large majority of our call for evidence respondents were working in private practice, it is important they are set up for success

- **Working within the public sector:** Trainees should be taught how to navigate health and social care systems, such as the NHS and partnership services, both to maximise their employment prospects and allow them to best support clients from inside those systems

- **Research:** We believe it is in the best interests of clients for the latest research to be available to practitioners, and for practitioners to feel confident embedding findings in their practice. Specific goals of further, research-specific training could include understanding and interpreting counselling and psychotherapy research, how to access research and assess its quality, metrics for assessing improvement and client outcomes, research ethics, and how to get involved in research.

Our commissioners, witnesses, and call for evidence respondents widely described existing training requirements as unnecessarily rigid particularly with mind to logistics and the mode of delivery. Witnesses raised the benefits of online instruction, which is currently underused by many training programmes, given the standard is in-person instruction. This need not mean that compromises must be made in terms of training quality and standards, only that where such logistical barriers exist, they should be justified. Group work, face-to-face communication, and open discussion and exploration are foundational blocks of counselling and psychotherapy training.

Similarly, 'asynchronous' instruction, which allows learners to study at their own pace, rather than attending sessions at set times, is not widely available, creating additional barriers to access. For trainees with fixed work commitments, caring or parenting responsibilities, who live in remote and rural areas, or have other accessibility requirements, these barriers may put training out of reach. One model of a different approach is the 'flipped classroom', under which learners engage with learning content at home and the classroom is reserved for active and interactive learning, such as problem solving, discussions and triads (an exercise used in therapist training, where three students take turns acting as the counsellor, the client, and an observer).

We have heard from Commissioners, witnesses, and call for evidence respondents how the existing training requirements for practitioners to become qualified may disadvantage otherwise capable trainees. Suggested factors include, but are likely not limited to, excessive mandatory volunteering hours, limited curricula, stringent in-person attendance requirements, and narrow assessment criteria. When trainees are disabled and their accessibility requirements are not met, this not only raises questions of inclusivity but could see training providers falling foul of the Equality Act 2010. Education and training providers have a duty to provide reasonable adjustments under the Act.[181]

PCPB partners have a responsibility to ensure their members provide high quality, ethical, interventions. Further dialogue between trainees, experts by experience, qualified practitioners, training providers, and PCPB partners could help identify how these concerns may be addressed without compromising minimum standards and trust in the profession.

More broadly, there was a common perception that creativity in pedagogy, instruction, and assessment is discouraged. Again, while standardisation through the SCoPEd framework provides an assurance of minimum standards, this should not have to compromise creativity, novelty and innovation throughout the profession, including training. Unnecessary rigidity also compromises the cultural diversity of the curriculum, meaning trainees from underserved backgrounds may find their training does not reflect their lived experience nor how mental health is understood in their communities. Addressing this will be key to building a profession as diverse and representative as the people who need it most.

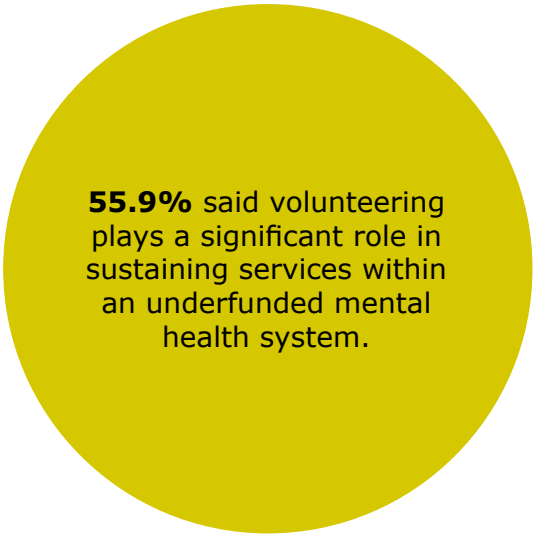
Volunteering

Responses to our call for evidence revealed that:

- 67.7% of respondents said volunteering is often expected or pressured as a route into training or early career progression
- 66.3% said reliance on volunteering undermines fair pay, working conditions and workforce stability
- 63.9% said volunteering allows practitioners to support individuals and communities who might otherwise be unable to access counselling and psychotherapy
- 63.6% said volunteering can be personally meaningful, support skills development and self-confidence
- 55.9% said volunteering plays a significant role in sustaining services within an underfunded mental health system.

The current reliance on volunteering within the profession is not sustainable. Some qualified practitioners freely choose to volunteer, and this should not be discouraged. However, the current system reinforces the undervaluing of counselling and psychotherapy and reduces access to the profession for those from less privileged backgrounds, which in turn risks entrenching the lack of diversity within the workforce.[182] The challenge for policymakers and commissioners therefore is to find a sustainable solution that reconciles qualified practitioners' right to fair remuneration with the significant funding constraints faced by VCFSE organisations. There is also a clear case for a wholesale review of the role of volunteering within counselling and psychotherapy services.

Striking this balance will require careful collaboration between VCFSE services, commissioners, policymakers, practitioners, experts by experience, and professional bodies. Our commissioners and witnesses outlined potential areas for improvement. For instance, established services with long records of delivering effective support, evidenced through evaluations, case studies and outcomes data, could benefit from priority access to longer-term funding arrangements through a streamlined bidding process.[183] This would enable better continuity of care, financial stability, and secure working conditions. Revised commissioning approaches and local authority funding models could also reflect the essential part these services play in the mental health landscape, acknowledging their function as de facto public services within health and social care pathways.[184]



Public affairs and advocacy

This report has already explored the body of evidence demonstrating the cost-effectiveness of counselling and psychotherapy, and mental health treatment more widely. It has also touched on the existing evidence supporting counselling and psychotherapy as well as the need to better draw upon what data is already available. So long as counselling and psychotherapy are not best used to address worsening mental health across the UK, there remains a need for a coordinated, data-backed, public affairs approach.

Key to this will be the tackling the 'acronym soup' – the overcomplicated, confusing, landscape of professional bodies, training providers, accrediting bodies, and other interested organisations. As discussed, this need not mean that these various organisations – many of which have sprung up to respond to a specific need or interest – must cease to exist. Instead, a federation of existing counselling and psychotherapy bodies, particularly membership organisations, could deepen the existing partnership work done by the PCPB. The collective power and resources of these organisations surely outstrip that of one and this also avoids the needless duplication of efforts.

Such a federation could also, in time, be a vehicle for collaboration, streamlining and the standardisation of other workstreams. This need not mean that individual member organisations should abandon their individual agendas when their membership has a particular interest, and in seeking better coordination, it is important that onerous bureaucratic structures do not restrict the ability of organisations to respond to the shifting political landscape quickly and appropriately. However, a wider shift from competition to collaboration, within public affairs and beyond, will help to address fragmentation in the sector.

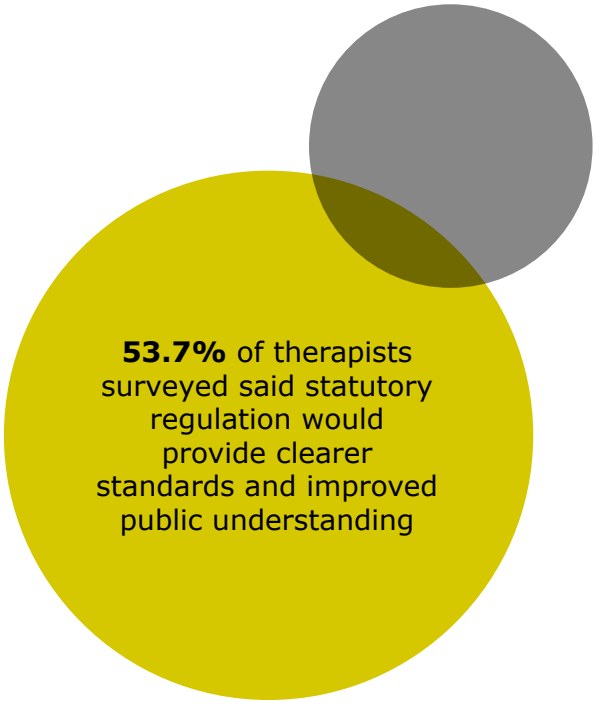
Much has been made throughout this report of the under-utilisation of the evidence base for counselling and psychotherapy. To elevate the status of the field in line with other psychological professions, addressing the idea that counselling and psychotherapy do not have the evidenced impact of CBT and other interventions is key. Service evaluation data, case studies, and routine outcome monitoring are common outputs of individual practice and service delivery. This impact data is rarely used beyond its first-order purpose, despite providing powerful evidence of how counselling and psychotherapy make a difference. An improved, collaborative approach should therefore make more deliberate and considered use of this giant dataset, with the specific goal of proving the impact of counselling and psychotherapy and raising the status of the profession in the eyes of politicians and decision-makers.

Public confidence, protection and regulation

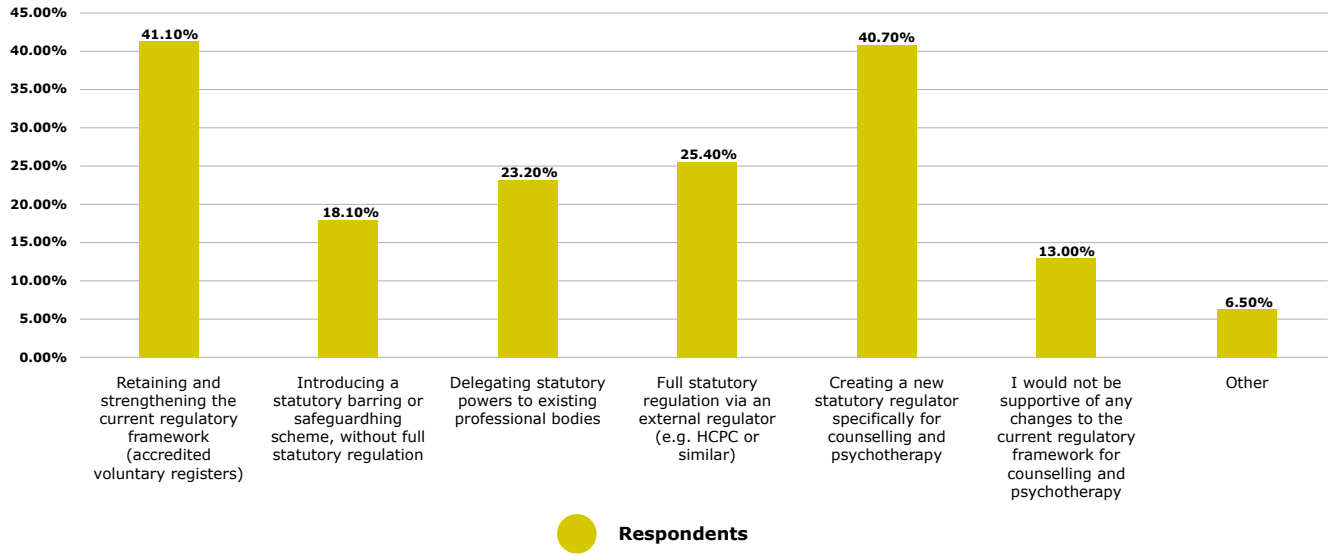
Public safety must ultimately be the guiding principle which determines our response to the question of regulation. Undertaking counselling or psychotherapy can ask for significant vulnerability and trust from clients, and just as there is capacity for this to have a positively transformative impact, there is room for harm and abuse. Knowing that the consequences of malpractice can be life-changing, it is only right that as many assurances as possible are provided and that clients are not put at unnecessary risk.

We have also already explored how the lack of public understanding of the profession and the regulatory landscape, compounded by fragmentation and an abundance of jargon, is a barrier to identifying highly competent, qualified and registered practitioners. It is unreasonable to expect clients who are potentially in extreme mental distress to navigate the complex, fragmented, and jargon-laid landscape of services, modalities, and organisations. For comparison, somebody experiencing serious physical illness would not be expected to understand the physiology, pharmacology, and diagnostic assessment processes behind their condition to determine their treatment plan. The onus must be on professional bodies, practitioners, health services, and policymakers to make accessing counselling and psychotherapy as safe, straightforward, and streamlined as possible.

This Commission heard powerful testimony from Ella Janneh, a survivor of sexual abuse by a self-described therapist Mike Lousada,[185] who detailed the devastating, ongoing impact that this had on her life. Ella was ruled by a judge to have suffered Complex Post-Traumatic Stress Disorder as a result of Lousada's actions and was initially awarded damages of over £200,000 through a civil claim, after the Crown Prosecution Service refused to pursue her case in 2018.[186] This ruling came at tremendous personal cost to Ella, who waived anonymity and shared that she had committed, at the time of her testimony to the Commission, nine years of her life to introduce statutory regulation for therapists and protect others from going through what happened to her.[187] As it stands, Lousada is still able to practise [188] despite the outcome of the civil case. Other high-profile cases further demonstrate the great potential for harm under the current regulatory regime.[189]



Our call for evidence respondents were split concerning changes to the current voluntary registration scheme. We asked respondents to select all that applied when answering the following question: 'If changes to the current regulatory framework for counselling & psychotherapy were considered by the Government, of which approach(es) would you be supportive?'



Only 13% of respondents, approximately one in eight, expressed a clear objection to changing the current regulatory approach. When asked about the advantages and disadvantages of moving to a statutory regulation model, our call for evidence respondents reported the following:

> 53.7% said statutory regulation would provide clearer standards, protected titles, and improved understanding for the public about counselling and psychotherapy

> 52.2% said statutory regulation would provide greater recognition and legitimacy for the profession among governments, commissioners and the public

> 46.7% said statutory regulation would improve public protection, accountability and public trust.

However:

> 49.7% said they had concerns about how statutory regulation would be implemented and its unintended consequences

> 31.1% said statutory regulation risks reducing professional autonomy and flexibility of practice

> 30.2% said statutory regulation would increase bureaucracy, costs, and state involvement with limited benefit.

The current voluntary regulation regime already submits practitioners to considerable scrutiny and, to be clear, any recommendation to strengthen regulation does not come as a criticism of the vast majority of registered practitioners, who are competent, ethical, and highly professional in their work. A statutory approach to regulation is not inherently punitive; for comparison, less than 1% of Nursing and Midwifery Council members have been through fitness to practise proceedings each year.[190] We understand that further regulation could very easily translate to more bureaucracy if not done correctly, becoming burdensome and time-consuming.

Any changes should also be co-developed with practitioners, professional bodies, and experts by experience to ensure there are no loopholes or 'cracks' in approach which inadvertently penalise qualified counsellors and psychotherapists or allow rogue practitioners to continue to work. However, for the protection of the public and qualified practitioners alike, we believe that some form of enhanced, statutory regulation is necessary. While ministers have previously shown little appetite for statutory regulation,[191] the need and desire for the current system to be improved is clear.

Professionalisation

Professionalisation here can be taken to mean the process by which a socially important occupation becomes regulated, publicly recognised, and awarded a high status within society. Counselling and psychotherapy are partway through this process. The development of registers accredited by the Professional Standards Authority (PSA), the work of membership bodies and trade unions, and the standardisation of the SCoPEd framework, are all factors which drive professionalisation.

One of the key benefits of professionalisation is that it grants an occupation prestige, recognition and trust from the public.[192] [193] As identified in this report, at times a lack of public confidence in counselling and psychotherapy can lead to their de-prioritisation when commissioning decisions are made. This does a significant disservice to qualified counsellors and psychotherapists, who are highly trained and capable, and to the meaningful impact they have in the lives of the people they help. Professionalisation is also associated with higher rates of pay and the reduced acceptance of an overreliance on volunteering.[194]

There are also reasons to be sceptical of any professionalisation process. Overreach from policymakers who do not fully understand counselling and psychotherapy could lead to regulations and statutory requirements that are not fit for purpose. There is a risk that systemic issues within the profession, and indeed beyond it, are reproduced and entrenched through the professionalisation process.[195] This may include, for example, cultural bias, a lack of diversity within the workforce, outdated training methods and the improper use of the evidence base to update practice.

52.2% of our call for evidence respondents said statutory regulation would provide greater recognition and legitimacy with governments, commissioners and the public

There is a tension between the aim for the profession to be perceived in parity of esteem with other psychological professions and the resistance to further professionalisation and regulation. Counselling and psychotherapy are anomalies in the health and social care landscape precisely because they are not statutorily regulated. The present regime allows anybody to call themselves, market themselves, and practise as a counsellor or psychotherapist regardless of training, experience, ethics, scrutiny, and accountability. This means that highly trained, ethical, and capable practitioners may be let down by an unknown number who are not, as high-profile cases of malpractice by people who label themselves 'counsellors', 'therapists', and 'psychotherapists' undermine public confidence.

In professions subject to statutory regulation, registered practitioners are subject to mandatory ongoing scrutiny and accountability when concerns arise. For example, the General Medical Council (GMC) maintains a statutory register of doctors, sets standards of professional conduct, investigates concerns about fitness to practise and can remove practitioners from the register where necessary to protect the public.[196] It should be noted that statutory regulation is not an infallible safeguard against malpractice. Nevertheless, registration and title protection create enforceable standards and barriers to practice for those who do not meet them, providing commissioners and the public with an additional mechanism of assurance and accountability.

We have already identified some of the risks attached to professionalisation, and arguably some of counselling and psychotherapy's greatest strengths are that they are flexible and adaptable to the unique needs of every person. We have discussed how counselling and psychotherapy are misunderstood by policymakers. Any move toward regulation must therefore be informed by knowledgeable practitioners and experts by experience, alongside professional bodies, and supported by a greater public awareness and perceptions effort. Lessons from the SCoPEd framework development process must also be taken on board. It must also be based on a clear assessment of risk to the public.

Commissioning and funding

Underfunding and funding instability are commonly the root of the challenges we have explored in this report. They manifest in the inability to recruit and retain qualified, capable practitioners, to provide continuity of care for clients, and to create services that are sustainable in the long term. Numerous economic analyses show that investment in mental health services leads to long-term savings, with significant returns on investment that far outstrip initial costs. Beyond this, early-stage interventions are typically cheaper, leading to greater savings and reduced suffering for those who need mental health interventions. Greater investment into earlier-stage interventions, including counselling and psychotherapy, would be in line with one of the three shifts from 'sickness to prevention' as detailed in *Fit for the Future*.[197]

Evidence on the effectiveness of counselling and psychotherapy provided to commissioners is not always collated or presented in ways that align with NICE guidelines. Interventions that are highly standardised, manualised and readily measured using predefined outcomes may be more straightforward to evaluate against established evidence standards, whereas the relational and individualised nature of many counselling and psychotherapy approaches can present additional methodological challenges.[198] This presents an opportunity for the profession to strengthen the way evidence is generated, synthesised and communicated, including through high-quality service evaluations and outcomes research that demonstrate effectiveness, patient experience and value in forms that support commissioning decisions. Sustainable funding could be facilitated through longer-term commissioning arrangements that enable services to recruit and retain skilled practitioners, rather than relying predominantly on short-term contracts and fragmented provision.[199] Sustainable NHS services require approaches that address workforce pressures, improve service integration and move beyond reactive models of care.[200]

Numerous economic analyses show that investment leads to longterm savings, with significant returns on investment that far outstrip initial costs



Tower Bridge. London, England.

In context: England

Mental health demand in England

Like the rest of the UK, England is experiencing an unprecedented rise in demand for mental health support. Over the past decade, increasing public awareness of mental health, reduced stigma, demographic change, economic uncertainty and the lasting effects of the COVID-19 pandemic have fundamentally changed both the scale and nature of psychological need. While successive governments have invested significantly in mental health, particularly through NHS Talking Therapies and expanded children's mental health services, demand continues to outstrip supply. This has resulted in growing waiting times in many areas, increased pressure on primary care and specialist services, and greater reliance on voluntary and community organisations to provide accessible emotional support.

The Adult Psychiatric Morbidity Survey, commissioned by NHS England, estimates that approximately one in six adults experiences a common mental disorder such as anxiety or depression in any given week, representing a substantial increase over previous decades. Women, younger adults and people living in areas of higher deprivation continue to experience the highest prevalence of common mental health conditions.[201] The Report from the Review into Mental Health Conditions, ADHD and Autism[202] also found that demand has increased.

Children and young people have experienced particularly significant increases in emotional distress. The Mental Health of Children and Young People in England Survey found that around 20% of children and young people aged 8-25 years now have a probable mental health condition, almost doubling compared with 2017. Referrals to Child and Adolescent Mental Health Services (CAMHS) have increased substantially over the past five years.[203]

Mental ill health has also become one of the principal drivers of economic inactivity. The Office for National Statistics estimates that more than 2.8 million people are economically inactive because of long-term sickness, with mental health conditions representing one of the leading causes.[204] The Commission also found that employers across England are experiencing rising levels of sickness absence linked to stress, anxiety and depression. According to the Health and Safety Executive (HSE), work-related stress, depression and anxiety accounted for an estimated 22.1 million working days lost during 2024/25, making them the largest contributor to work-related ill health in Great Britain.[205] This has encouraged growing investment in workplace wellbeing, employee assistance programmes and occupational mental health services, creating new opportunities for counsellors and psychotherapists to contribute to prevention and early intervention.

The Commission believes that England has reached a critical point in the evolution of its mental health system. The challenge is no longer simply expanding specialist mental health services but developing a broader and more integrated model of psychological support that reflects the realities of modern mental health need. Prevention, early intervention, continuity of care and community-based support are becoming central principles of mental health policy. Counsellors and psychotherapists, working alongside the wider mental health workforce, have an increasingly important role to play in helping the NHS and wider public services meet this growing demand.

The mental health response in England

One of the most significant developments in English mental health policy over the past two decades has been the expansion of NHS Talking Therapies for anxiety and depression (formerly Improving Access to Psychological Therapies – IAPT). The programme has transformed access to evidence-based treatment for common mental health conditions, with more than 1.8 million referrals each year and hundreds of thousands of people completing treatment annually.[206] The programme has established routine outcome measurement, increased investment in psychological therapies and demonstrated the value of early intervention within primary care.

England is currently undergoing possibly the most significant reform of health and mental health services for a generation. Across Government and the NHS there is increasing recognition that mental health support must move closer to where people live, become easier to access and intervene much earlier before difficulties escalate into crisis. The Commission considers that this shift presents one of the greatest opportunities in a generation to better utilise the counselling and psychotherapy workforce.

The publication of the NHS 10-Year Health Plan[207] provided a fundamental shift in the organisation of health services in England. The Plan sets out three major transitions that will shape future NHS delivery: moving care from hospitals into communities, shifting from analogue to digital services, and placing much greater emphasis on prevention rather than treatment.

Central to the NHS reforms is the development of Neighbourhood Health Services,[208] bringing together primary care, community health services, social care, voluntary organisations and local government around populations of approximately 30,000 to 50,000 people.[209] A further significant development has been the establishment of 24/7 Neighbourhood Mental Health Centres.[210] These provide care through multidisciplinary teams capable of responding to changing levels of need, reducing fragmentation between crisis services, community mental health teams and primary care. The initial programme comprises six national demonstration sites alongside 16 associate sites that are testing different aspects of the model prior to wider national implementation.[211] A more recent policy change was the welcome announcement of 159 new NHS Community Mental Health Centres which offer walk-in support with no referral needed and no long wait.[212] As these neighbourhood and community services develop, there is an important opportunity to embed counsellors and psychotherapists to increase workforce capacity, improve access to psychological support and strengthen delivery of the NHS's broader prevention agenda.

Another key recent development has been for mental health policy in England to increasingly extend beyond the health system. The Government's Get Britain Working White Paper,[213] together with the Keep Britain Working Review, led by Sir Charlie Mayfield,[214] and the Youth Employment and Mental Health Review led by Sir Alan Milburn,[215] reflect growing recognition that good mental health is fundamental to labour market participation and economic growth. The Commission welcomes this broader understanding of mental health. Counsellors and psychotherapists already support thousands of people through occupational health services, employee assistance programmes, vocational rehabilitation, primary care and independent practice. Their expertise has significant potential to contribute to the Government's wider ambitions for reducing economic inactivity and improving workforce participation.



Case study: Supporting survivors of sexual violence and abuse: How Survive delivers life-changing trauma-informed support and lasting mental health outcomes

Survive is the only specialist sexual violence support service in York and North Yorkshire, helping adult survivors of child sexual abuse, rape and sexual assault to heal, rebuild and thrive. Established in 1990, Survive provides free specialist support work, stabilisation counselling, trauma therapy and EMDR psychotherapy.

Experiencing child sexual abuse, rape or sexual assault can have profound and lifelong consequences for physical health, mental wellbeing, relationships and employment. Survivors frequently experience anxiety, depression, trauma symptoms, self-harm, suicidal thoughts and substance misuse, yet many face significant barriers to seeking help, including shame, fear of not being believed and difficulties accessing specialist support. Generic services do not always meet the complex needs of survivors, while growing demand continues to place pressure on specialist organisations, like Survive. Many people accessing Survive arrive with severe and enduring trauma that affects almost every aspect of daily life.

Survive delivers a specialist trauma-informed pathway tailored to survivors of sexual violence and abuse. Following an initial assessment, clients are triaged into either support work or up to 10 sessions of stabilisation counselling designed to help them develop coping strategies, improve emotional regulation, build resilience and prepare for longer-term recovery. Where appropriate, clients can progress to trauma therapy or EMDR psychotherapy. The service focuses on creating a safe, compassionate environment where survivors feel heard, respected and empowered, while providing support that is specifically designed around the impacts of sexual trauma.

An independent evaluation published in May 2026 by researchers at the University of York[216] reviewed outcomes for more than 400 clients supported during 2023/24 and 2024/25, including an NHS-funded pilot programme. The analysis examined the impact of Survive's trauma-informed counselling on psychological distress, trauma symptoms and use of NHS mental health services.

The evaluation found significant reductions in both psychological distress and trauma symptoms among survivors accessing Survive's services.

Across 260 clients, average psychological distress scores reduced from 20.8 to 12.7, while trauma scores among 138 clients fell from 53.3 to 31.6 following support. Improvements were consistent across genders and age groups. Among NHS pilot participants, 90% reported being better able to manage their mental health and wellbeing, 85% felt better able to care for themselves and 77% reported improved ability to cope with everyday life. The service also reduced pressure on NHS mental health provision, with 82% of pilot participants reporting that their use of NHS mental health services had either stopped or reduced following support.

Client feedback highlights increased self-esteem, stronger relationships, improved coping strategies and greater hope for the future, demonstrating Survive's role in helping survivors recover from the long-term impacts of sexual trauma and living healthier, happier lives.

The pilot reduced pressure on NHS services, with **82%** of participants reporting that their use of NHS mental health services had either stopped or reduced following support

The contribution of counsellors and psychotherapists in England

The PCPB estimates they have approximately 71,000 registrants across England making an important, yet often underrecognised contribution to England's mental health system. Every day they support people experiencing anxiety, depression, trauma, bereavement, relationship difficulties, addiction, workplace stress, psychological distress associated with long-term physical illness and many of the wider social challenges that affect emotional wellbeing. Their work extends far beyond mental health services and reflects the NHS's growing emphasis on prevention, early intervention and community-based care.

Counsellors and psychotherapists work throughout NHS England, delivering psychological assessment and therapy across primary, secondary and specialist services. They are employed within NHS Mental Health Trusts, acute hospitals, community health services, GP practices, specialist psychological therapy teams, cancer services, pain management, perinatal mental health, palliative care, sexual health services, rehabilitation programmes and integrated care services. Within NHS Talking Therapies, counsellors are a vital part of the workforce delivering evidence-based interventions for people experiencing anxiety and depression. Counsellors contribute across assessment, low- and high-intensity interventions and recovery-focused treatment pathways.[217] However, Talking Therapies provision is largely skewed toward providing short-term interventions such as CBT, restricting the choice for those seeking support and described by the Nuffield Trust as at times being 'overly distressing or invalidating to those who prefer other modalities of help'.[218] Talking Therapies are also known to be less effective for 16 to 24-year olds[219] and suffer significant attrition.

The development of Neighbourhood Health Services and 24/7 Neighbourhood Mental Health Centres provide a major opportunity to strengthen psychological support within primary care. Counsellors already work alongside GPs through Primary Care Networks, integrated care teams and community mental health services, providing timely interventions that reduce pressure on general practice and improve access to non-pharmacological treatment. The Commission believes that the neighbourhood model should make far greater use of counsellors and psychotherapists. Their expertise in assessment, relational therapy, trauma-informed practice and continuity of care aligns closely with the objectives of neighbourhood multidisciplinary teams.

Research commissioned by the Talking Therapies Taskforce, including the HEARD study, has found that people with the most complex mental health difficulties, who are often inappropriately routed through services designed for mild-to-moderate presentations, account for a disproportionate share of health and social care costs, including expensive and often traumatic out-of-area hospital placements. Evidence from a specialist psychotherapeutic pathway in Devon suggests that intensive, tailored community-based psychotherapy can reduce reliance on such placements while improving outcomes, indicating a clear case for investment in specialist, longer-term therapeutic provision for this group.[220]

Counsellors and psychotherapists play an increasingly important role in supporting the emotional wellbeing of children and young people providing vital therapeutic support across a range of settings. England is the only nation within the UK to not have a fully funded school counselling programme.

It is estimated that a 'Missing middle' of 730,000 children per year fall between the provision offered by Mental Health Support Teams (MHSTs) and Child and Adolescent Mental Health Services (CAMHS). The Commission believes that MHST provision needs to include a route to funded counselling or psychotherapy provision with trained children and young people's therapists working as part of wider, multi-disciplinary team. Young Futures Hubs can also play a crucial role. There's an underutilised workforce of qualified therapists who can deliver this support, which can be led by the child or young person to respond to their specific needs.

The voluntary sector represents one of the largest employers of counsellors and psychotherapists in England, providing vital support. Counselling delivered within trusted community organisations is often more accessible than statutory services and reaches groups who might otherwise receive little or no psychological support. Throughout our review the Commission consistently heard concerns regarding the sustainability of community counselling services. Many rely upon short-term grant funding, annual commissioning cycles and charitable fundraising, limiting their ability to retain experienced practitioners or expand provision despite increasing demand.[221]

Workforce, education and sustainability

The Commission found growing concerns regarding workforce sustainability. Most training programmes require extensive supervised clinical placements, yet placement opportunities have become increasingly difficult to secure. Many rely upon voluntary organisations already experiencing severe financial pressures. The Commission heard that this creates a bottleneck within the workforce pipeline at precisely the time when England requires greater therapeutic capacity.

Unlike other mental health professions, the vast majority of therapists pay for their own training. The profession also faces inconsistent career pathways, variable NHS grading, limited opportunities for progression and continued dependence on unpaid or low-paid placements during training. These issues risk constraining future workforce growth despite rising demand for psychological support.

A 'Missing middle' of **730,000 children per year** fall between the provision offered by Mental Health Support Teams (MHSTs) and Child and Adolescent Mental Health Services (CAMHS)



The Forth rail bridge from North Queensferry, Scotland

In context: Scotland

Mental health demand in Scotland

Scotland faces significant and complex mental health challenges. While progress has been made in reducing stigma and increasing public understanding of mental health, the scale of need remains substantial.

The Scottish Health Survey provides important insight into the prevalence of mental health difficulties across the population. In 2023, this showed that almost one in five adults recorded a score on the General Health Questionnaire (GHQ-12) indicating a possible psychiatric disorder and demonstrating the extent of psychological distress within the nation's population.

The relationship between deprivation and mental health is particularly significant. People living in Scotland's most disadvantaged communities experience higher levels of exposure to factors that can affect emotional wellbeing, including financial insecurity, unemployment, poor housing, adverse childhood experiences and reduced access to protective factors such as stable employment, community connection and social support. This means that improving mental health cannot be achieved through clinical services alone. It requires a broader approach that recognises the social circumstances that shape people's lives.

Scotland's geography also creates particular challenges with rural and island communities experiencing barriers to accessing mental health support, including workforce shortages, travel distances and limited availability of specialist services. Flexible approaches, including community-based counselling and digital delivery, provide opportunities to improve access and ensure that support is available across Scotland's diverse communities.

These pressures reflect wider challenges within mental health services. Increasing demand, workforce shortages and growing complexity of need have placed significant pressure on existing models of provision.

There is also an economic imperative for getting this right. The Mental Health Foundation reported that poor mental health cost the Scottish economy £8.8 billion in 2019 with 72 per cent accounted for by the lost productivity of people living with mental health conditions and costs incurred by unpaid informal carers.[222] Audit Scotland has indicated that this is likely to be a significant underestimate because of a lack of data.[223] They note the figure does not include costs associated with the impact of poor mental health on areas including the criminal justice system, housing, and addictions services.

The mental health response in Scotland

Mental health services in Scotland have primarily been funded through the NHS and delivered primarily by 14 territorial NHS Boards, working in partnership with local authorities through Health and Social Care Partnerships (HSCPs). Scotland has progressively integrated health and social care commissioning, with mental health services often planned and funded jointly through local Integration Joint Boards (IJBs). In September 2026, Scottish Government announced they are to consult on radical plans to reshape Scotland's existing health architecture.[224] This proposes replacing Scotland's 14 territorial NHS boards with two Strategic Health Boards alongside significant local government reorganisation.

Under the proposals, the existing 32 councils would be replaced by between 6–10 strategic regional authorities, as well as the potential establishment of 120–160 smaller 'community authorities' who will be responsible for much more local decision-making and commissioning. If they go ahead, these proposed reforms could have major implications for counselling services in Scotland, because they would change both who commissions services and the geographic level at which decisions are made. Total mental health spending in Scotland exceeds £1.5 billion annually. This encompasses local NHS Board budgets, direct Scottish Government programme budgets, and dedicated funds for specialist services like Child and Adolescent Mental Health Services (CAMHS).

The current strategic direction is set by the Scottish Government's Mental Health and Wellbeing Strategy (2023 onwards), which emphasises prevention, population wellbeing, early intervention, community support, and reducing inequalities.[225] The most recent iteration, published in September 2026, includes an important and radical commitment to redesign Scotland's mental health system through the development of a new 'Mental Health and Wellbeing Blueprint'. This will be designed in partnership with the mental health sector and lived experience and published by Autumn 2027. The Blueprint will define how services should provide stepped and matched care across the spectrum of need, integrating community-based, primary and secondary care alongside commissioned services. This has the potential to expand access, increase choice and make better use of the existing counselling and psychotherapy workforce.

Scotland has long recognised the importance of improving access to psychological therapies through its national commitment that people should receive timely support following referral. The Psychological Therapies Waiting Times Standard sets out an ambition that 90% of people referred for psychological therapy should begin treatment within 18 weeks. However, achieving this ambition remains challenging.

Public Health Scotland data has shown that performance continues to fall below the national standard for adults, with a significant proportion of people waiting longer than 18 weeks before beginning therapy. Some 79.4% of people started psychological therapy-based treatment within 18 weeks of referral in the quarter ending March 2026.[226] The situation for children and young people has seen good recent improvement where 91.2% started treatment with specialist Child and Adolescent Mental Health services in the same timescale.[227] The latest data show that the children and young people's target has now been met over six consecutive quarters, since December 2024.

The Scottish Government's Mental Health and Wellbeing Workforce Action Plan 2023-2025, developed in partnership with COSLA, aims to support, retain, and grow the health and social care workforce.[228] It followed on from the National Workforce Strategy for Health and Social Care (NWSHSC), produced in March 2022, which focused upon the Government's vision of 'a sustainable, skilled workforce with attractive career choices where all are respected and valued for the work they do'. Rather than specifying the numbers and types of roles required across the system to meet demand, the Workforce plan provides a series of proposed actions to address. We expect the proposed Mental Health Services Blueprint, will be followed by an updated Workforce Plan in 2027.


Glasgow Arc Bridge over the River Clyde, Scotland

Case Study: Prevention and early intervention in action: How Lifelink brings accessible, relational counselling and psychotherapy closer to communities across Scotland

Founded in Glasgow in 1992, Lifelink was built from a belief that people experiencing poor mental health, adversity or distress deserved accessible, relational support as an alternative to medication alone. Today, they continue to provide this support wherever people live, work or learn across the UK. Lifelink's services now include wellbeing education, distress interventions, counselling in community, school, prison, healthcare and workplace settings, reflective practice and a growing Training Academy. In 2025/26, they supported over 23,000 people.

Lifelink currently work with eight Scottish local authorities delivering counselling across primary, secondary and additional support needs schools. They support pupils, families and staff, with practitioners specifically qualified to work with children and young people through their BACP and Qualifications Scotland jointly awarded training.

Partnerships with Scottish Health and Social Care Partnerships and the NHS connect community counselling to wider pathways of care. Flexible referral routes offer access to time-bound counselling in community, healthcare or digital settings. Lifelink's social enterprise model extends this approach to workplaces and organisations further afield, offering counselling, wellbeing education, neurodivergence support and reflective practice.

Scale and innovation matter to remain sustainable, but relationships remain at the heart of Lifelink's impact. Responsive delivery and relational partnerships enable them to operate as a cohesive part of the system. For individuals, this means access to better support, sooner, and for commissioners, a trusted, practical way to extend prevention and early intervention.

The Contribution of Counsellors and Psychotherapists in Scotland

Counsellors and psychotherapists already make a substantial contribution to Scotland's mental health system. We estimate around 6,000-7,000 counsellors and psychotherapists are working to support people across a range of settings in Scotland, including Health and Social Care, schools, universities, charities, community organisations, justice settings, workplaces and in private practice.[229]

Within NHS Scotland, counsellors and psychotherapists contribute to primary care mental health teams, community mental health services, psychological therapies services, specialist trauma services, cancer care, pain management, palliative care, rehabilitation and perinatal mental health services. This contribution is recognised in the Mental Health Strategy, which identifies counsellors and psychotherapists as part of the core mental health workforce in Scotland.

A lack of published workforce data by NHS Scotland means it is difficult to understand their full contribution. This prevents the counselling professions being adequately reflected within workforce planning, commissioning arrangements or strategic frameworks. A further barrier to NHS recruitment has been the status of counselling and psychotherapy within the Psychological Therapies 'Matrix'.[230]

This is designed to be used by commissioners and managers to support evidence-based decision- making for service planning, and we believe it underestimates the important contribution that counselling and psychotherapy could make to address the treatment gap within psychological therapies.

In education, counsellors are working across a range of settings and have benefited from additional Government investment since 2018. In September 2018, the Scottish Government's Programme for Government pledged to: *'invest over £60 million in additional school counselling services across all of Scotland to create around 350 counsellors in school education across Scotland ensuring that every secondary school has counselling services'*.[231] This commitment was extended in September 2020 to provide access to 'high quality and effective counselling support through schools for children aged 10 and over'. The most recent evaluation report on this investment showed that 591 counsellors were employed on this programme, supporting 17,621 children and young people between July 2023 and March 2024, and resulting in 8,636 children and young people showing improved outcomes.[232] One of the concerns raised during our roundtable discussions in Scotland was that the funding for school-based counselling had remained at the same level since the programme commenced in 2020, despite increased cost-of-living pressures. This creates a risk to the sustainability of service provision.

The 2018 Programme for Government (PfG) also included a commitment for the Scottish Government to 'provide more than 80 additional counsellors in Further and Higher Education over the next four years', with an investment of £20 million.[233] For the final year of the four-year PfG commitment, at least 19,940 students accessed counsellors. Institutions reported that this aided the retention, attainment and wellbeing of students accessing the service and has resulted in improved life chances for a significant number of students.[234] This funding ended in 2024-25 and since then there has been a reduction in services and several institutions have been forced to make their therapists redundant. The Commission would like to see this funding restored.

The third sector plays a fundamental role in Scotland's mental health system with community-based counselling services providing complementary support to NHS services. They frequently work with people experiencing complex social and emotional challenges, including trauma, bereavement, domestic abuse, addiction, loneliness and financial hardship. Their contribution is particularly important in supporting people earlier and reducing pressure on more intensive services.

However, the sustainability of this contribution is hugely affected by funding arrangements. Many third-sector organisations continue to operate through short-term grants or contracts, creating uncertainty for services, staff and clients. As well as contracts from Local Authorities, Health Boards and local Integration Joint Boards, some services have secured grants from the Scottish Government's Communities Mental Health and Wellbeing Fund for Adults, which has provided over £66 million in funding across the third sector since 2021. The Commission have heard how this 'hand to mouth' existence makes it difficult to retain experienced practitioners, for services to invest in workforce development or build long-term therapeutic relationships. It also creates a climate of uncertainty and fear. In the past 12 months alone, funding pressures faced by local Integration Joint Boards have sadly led to counselling service closures in Edinburgh, Glasgow and Aberdeen, leaving vulnerable clients without much needed support.

The Commission considers that where third-sector organisations are delivering essential mental health support aligned with national priorities, funding models should enable sustainability rather than simply support short-term delivery. A preventative mental health system requires much more stable community-based services.

Workforce, training and sustainability

The Commission heard concerns that many counsellors and psychotherapists in Scotland experience insecure employment conditions, particularly in the early stages of their careers. While some practitioners establish independent practices, others rely on sessional work, short-term contracts or roles dependent on temporary funding streams. This creates challenges for both practitioners and services. For practitioners, insecure employment can make it difficult to plan financially, access professional development opportunities or remain within the profession. For employers, particularly within the third sector, workforce instability can affect continuity of care and the ability to retain experienced clinicians.

If Scotland is to expand access to psychological support, it must ensure that qualified practitioners have meaningful opportunities to use their skills. The Commission considers that workforce planning must therefore look beyond recruitment and training numbers. It must also consider retention, career progression and the creation of sustainable employment pathways. This includes exploring how counselling and psychotherapy roles can be better integrated into NHS services, community mental health provision, including the proposed community mental health hubs and other preventative approaches across statutory services.



Llandudno Pier, Clwyd, Wales

In context: Wales

Mental health demand in Wales

Mental health has become one of the defining public health challenges facing Wales and has the largest single spend of any programme of care in NHS Wales, 'accounting for £1.1 billion (or 11.4%) of total expenditure in 2023-24, an increase of £108 million (or 10.6%) from 2022-23.'[235]

The National Survey for Wales has consistently found that approximately one in six adults report low mental wellbeing.[236] Levels of wellbeing are significantly lower among people living in deprivation, those who are economically inactive, unpaid carers and people with long-term health conditions. Public Health Wales has concluded that mental wellbeing follows a clear social gradient, with poorer outcomes closely linked to socioeconomic disadvantage rather than individual circumstances alone.[237]

Children and young people have experienced particularly marked increases in emotional distress over recent years. Schools, colleges and universities report growing concerns relating to anxiety, depression, self-harm, neurodiversity, exam pressures and the psychological impact of social media and financial insecurity. Demand for Child and Adolescent Mental Health Services (CAMHS) has increased substantially since the COVID-19 pandemic, despite continued investment in children's mental health services.

The economic consequences of poor mental health are equally significant. Mental ill health remains one of the leading causes of economic inactivity across Wales, contributing to sickness absence, reduced productivity and increased demand for health and social care services. Welsh Government analysis has recognised that improving mental wellbeing is essential not only for improving individual health outcomes but also for supporting economic participation, reducing health inequalities and strengthening community resilience.[238] As Wales seeks to improve economic growth and tackle long-term inactivity, supporting people's mental health will become increasingly important.

The mental health response in Wales

Mental health services in Wales are publicly funded through the NHS and delivered through seven local health boards,[239] working alongside local authorities and third sector organisations. The system is shaped by Welsh Government policy and legislation, particularly the Mental Health (Wales) Measure 2010, which emphasises early intervention, access to primary mental health support, care coordination, and recovery-focused services.

The Measure represented a significant innovation within the UK by creating a legal duty on Local Health Boards to provide Local Primary Mental Health Support Services (LPMHSS). The legislation recognised that many people require timely psychological support rather than specialist psychiatric care and sought to embed early intervention within primary care. These services provide evidence-based interventions including counselling, in addition to Cognitive Behavioural Therapy (CBT), family interventions, and other structured psychological therapies.

Since 2023, national direction has been provided by the NHS Wales Strategic Programme for Mental Health,[240] which aims to reduce variation between regions, improve quality and outcomes, and implement national mental health strategy priorities.

The Mental Health and Wellbeing Strategy 2025–2035 sets out an ambitious 10-year vision for transforming mental health across Wales.[241] The Strategy places prevention, early intervention and tackling inequalities at its centre, while emphasising that people should receive support earlier, closer to home and in ways that reflect their individual circumstances and preferences. It also acknowledges the importance of trauma-informed practice, community resilience and reducing the wider social factors that contribute to poor mental health.

Children and young people's mental health has become a particular policy priority and Government funded school-based counselling has been a key feature of the mental health architecture since 2007. Through the more recent NEST (Nyth) Framework, Wales has adopted a whole-system approach that seeks to ensure children receive the right support, at the right time, from the right people.[242] The Welsh Government has also strengthened partnership working through the Social Services and Wellbeing (Wales) Act 2014, which established Regional Partnership Boards to improve collaboration between health boards, local authorities and the voluntary sector.[243] These partnerships have become increasingly important in commissioning community-based mental health support and recognising that many people benefit from integrated services that address housing, employment, social isolation and emotional wellbeing together.

Since taking office following the 2026 Senedd election, the Plaid Cymru-led Welsh Government has reaffirmed its commitment to reducing health inequalities, improving access to community-based healthcare and strengthening the 'no wrong door' approach to preventative support. While implementation priorities will inevitably evolve over the course of the Senedd, the overall policy direction remains consistent with the preventative ambitions established in the Mental Health and Wellbeing Strategy.



Case Study: Bringing mental health support closer to communities: How Platfform delivers person-centred counselling and early intervention to improve outcomes and wellbeing in Wales

Platfform is a Welsh charity for mental health and social justice with more than 35 years' experience of supporting people, communities and organisations. Counselling, therapy and workplace wellbeing is a core part of their offer. Their approach is rooted in relational and trauma-informed practice, recognising the impact that life experiences, inequalities and trauma can have on mental health and wellbeing.

They work with local authorities, health boards, schools, colleges, charities and employers across Wales, delivering counselling and wellbeing support through commissioned services, workplace wellbeing programmes and self-referral pathways. Services are provided in community, education, workplace and online settings, enabling people to access support close to home and in ways that best meet their needs.

Many people accessing Platfform's services are experiencing anxiety, depression, bereavement, trauma, relationship difficulties, workplace stress or other life challenges that affect their wellbeing. Their service provides a safe, compassionate space where people can feel heard, understood and supported to develop greater resilience and make meaningful change.

In 2025/26, Platfform provided counselling and therapy services to 1,237 clients. Through this provision, average CORE-10 scores reduced from 19.75 at the start of therapy to 11.50 at completion, representing a 41.77% reduction in psychological distress.

Client feedback consistently highlights feeling heard, understood and empowered to move forward. Their BACP-Accredited service combines clinical expertise with compassionate, person-centred support, helping individuals improve their wellbeing while providing commissioners and partner organisations with an effective, evidence-based approach to prevention and early intervention.

The contribution of counsellors and psychotherapists in Wales

The Commission found that counsellors and psychotherapists make a substantial, though often under-recognised, contribution to the mental health and wellbeing of the people of Wales. Their work extends far beyond traditional mental health services and reflects the Welsh Government's ambition to provide support earlier, closer to people's homes and within the communities where they live, learn and work.

Counsellors and psychotherapists are employed across NHS Wales, working within community mental health teams, specialist psychological therapy services and multidisciplinary teams supporting people with long-term physical and mental health conditions. Counsellors and psychotherapists also contribute to specialist NHS services including cancer care, palliative care, chronic pain management, rehabilitation, perinatal mental health, trauma services and support for people living with long-term health conditions. Despite this contribution, there is not a comprehensive national dataset describing the counselling and psychotherapy workforce, where they are employed or the specialist skills they possess. Without reliable data, it is difficult for policymakers to understand the full contribution of the profession, plan future workforce requirements or commission services that make best use of the available expertise across NHS services.

The Commission also heard that there is considerable variation between Health Boards in how counselling roles are commissioned and utilised. Greater consistency would enable services to make better use of existing expertise while improving access to evidence-based psychological interventions across primary, community and specialist care.

Counsellors have become an established part of educational provision across Wales since funded school-based counselling was introduced in 2007. Evidence from Welsh Government evaluations has consistently demonstrated high levels of satisfaction among young people using school counselling services, with improvements reported in emotional wellbeing, resilience, school attendance and engagement with learning. Counsellors also work extensively within further and higher education settings across Wales, supporting wider objectives relating to retention, achievement and equality of opportunity.

The voluntary and community sector represents one of the largest employers of counsellors and psychotherapists in Wales. The Commission heard compelling evidence that the third sector plays a crucial role in extending access to psychological support, particularly for people who may be reluctant to engage with statutory services. Despite its importance, much of this provision continues to rely upon short-term funding arrangements that create uncertainty for both organisations and the workforce.

Greater recognition within workforce strategies would strengthen recruitment and retention and enable the profession to fully contribute to mental heath strategy implementation



Workforce, training and sustainability

Although the profession makes a substantial contribution across Wales, the Commission found growing concerns regarding workforce sustainability, career progression and professional recognition. While counsellors work across many statutory and community settings, opportunities for progression remain inconsistent. Furthermore, counselling is not always recognised as a distinct professional group within workforce planning for psychological therapies, despite making a significant contribution to service delivery. Greater recognition within workforce strategies would strengthen recruitment, improve retention and ensure that the profession is able to contribute fully to the implementation of the Welsh Government's Mental Health and Wellbeing Strategy.



Peace Bridge, Derry, Northern Ireland

In context: Northern Ireland

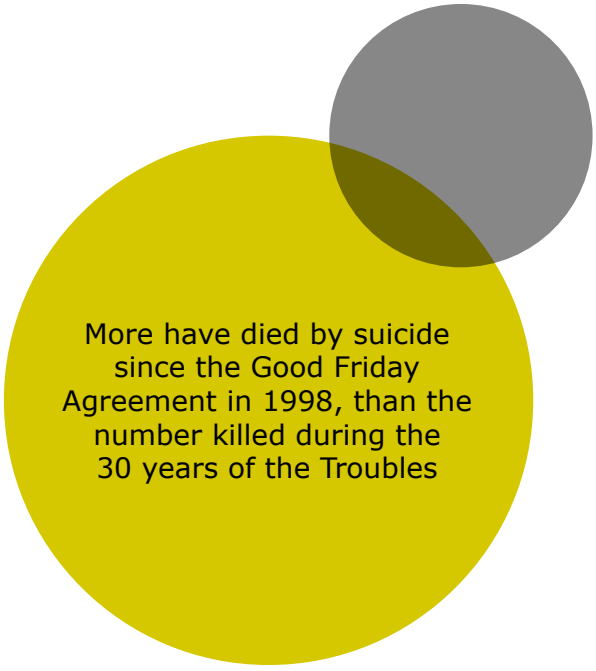
Mental health demand in Northern Ireland

Northern Ireland's mental health needs cannot be fully understood without recognising and understanding the longstanding impact of the Troubles, where over 3,500 people were killed and tens of thousands injured between 1968 and 1998.[244] As a result, communities experienced prolonged exposure to violence, fear, bereavement, displacement, imprisonment, intimidation and social division. Unlike single traumatic events, the Troubles represented decades of repeated exposure to adversity across generations.

In March 2024, the Northern Ireland-related Terrorism Threat level was reduced from 'severe' to 'substantial'. Despite this there remains ongoing violence and paramilitary activity in Northern Ireland.[245] Multiple studies have demonstrated the continuing impact of this experience on mental health.[246] The Northern Ireland Study of Health and Stress, undertaken as part of the World Mental Health Survey Initiative, found that 39% of adults had experienced a conflict-related traumatic event, while lifetime prevalence of post-traumatic stress disorder (PTSD) was estimated at 8.8% – among the highest recorded in the international study. The research also showed that exposure to Troubles-related trauma was associated with substantially higher rates of depression, anxiety disorders and other mental health difficulties.
Post peace deal suicides have increased, with more people dying by suicide in Northern Ireland since the 1998 Good Friday Agreement, than the number of people killed during the 30 years of the Troubles.[247]

The legacy of trauma is not confined to those who experienced violence directly. Increasing attention has been given to the concept of intergenerational trauma, recognising that the effects of conflict can be transmitted through family relationships, disrupted attachment, unresolved grief, parental mental ill health and social disadvantage. Children and young people growing up in communities affected by conflict continue to experience the consequences of trauma even when they were not themselves exposed to the violence.

Mental ill health also creates a significant economic challenge. The Mental Health Foundation estimates that poor mental health costs Northern Ireland more than £3.4 billion each year, through lost productivity, sickness absence, unemployment, healthcare costs and wider social impacts.[248] This reinforces that improving mental wellbeing is not only a health priority but also an economic and societal imperative.



The result of historic poor investment is longer waiting times. The latest available waiting time data show that 983 people were waiting longer than the target of 13 weeks to access mental health services. A total of 16,000 were on waiting lists for any period of time.[249] Meanwhile, the Northern Ireland Mental Health Champion, Professor Siobhan O'Neill, reported that 'the number of young people waiting more than nine weeks for access to the Child and Adolescent Mental Health Service (CAMHS) more than tripled from 364 in December 2018 to 1,269 in December 2022.'[250] The Department of Health's Mental Health Services Workforce Review 2022–2032 identifies the expansion of children's mental health provision as a priority and highlights the need for earlier intervention.

These pressures demonstrate the limitations of a system focused primarily on responding once difficulties have become severe. A sustainable mental health system requires accessible support earlier in the pathway, including accessible community-based provision. Counselling and psychotherapy services are particularly well placed to contribute to this approach. They provide opportunities for early intervention, helping people address difficulties before they escalate and supporting recovery from trauma, loss and adversity.

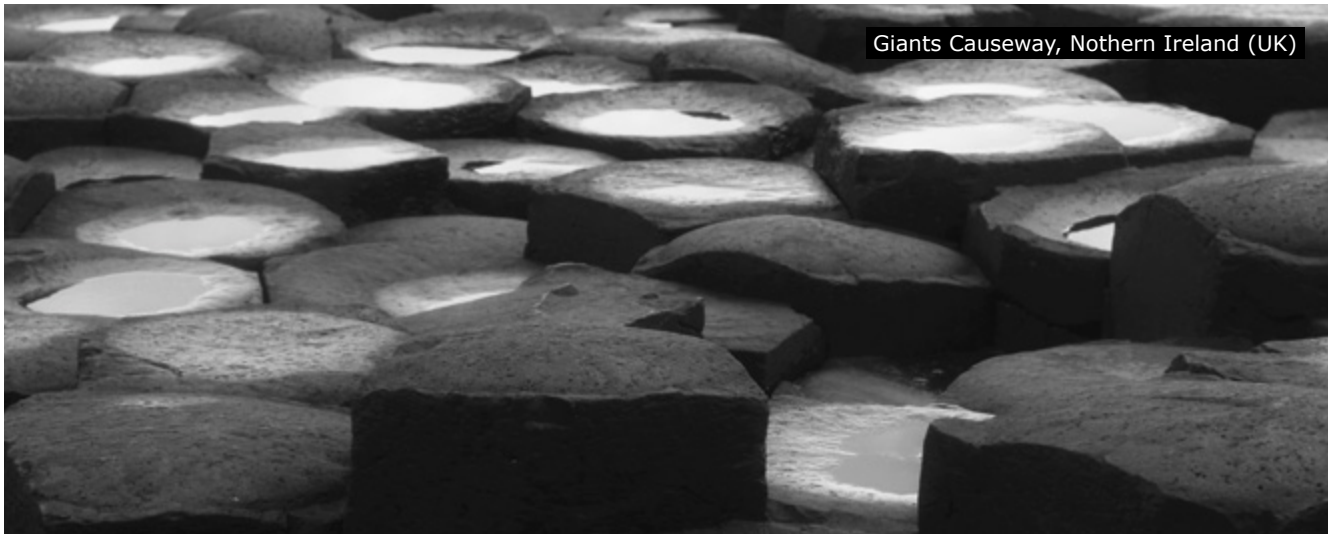
The mental health response in Northern Ireland

Northern Ireland's health and social care services have been structurally integrated since 1973, meaning that healthcare and social care are commissioned and delivered through a single system rather than separate organisations. The system is overseen by the Northern Ireland Department of Health. Mental health policy is currently guided by the 10-Year Mental Health Strategy 2021–2031, which aims to improve prevention, early intervention, access, recovery, and service quality. Mental health care is coordinated regionally across five Health and Social Care (HSC) Trusts, with much face-to-face support provided through Community and Voluntary sector partners under contract.



Whilst Northern Ireland consistently reports some of the highest rates of poor mental health in the UK, it has the lowest per capita spend on mental health services of the four nations at £220 (compared to £234 in Scotland, £256 in Wales and £264 in England).[251] While the full implementation of the 10-Year Mental Health Strategy is expected to require an estimated £1.2 billion spend, drastic underfunding has stalled implementation, leaving nearly 80% of its programme sidelined by resource shortages.[252] The Department of Health's Health and Social Care Reset plan [253] sought to set out a framework to stabilise, reform and deliver a more sustainable, community-centred health and social care system as well as setting out an ambition for a Neighbourhood Model of Care. This focus is also reflected in the latest Mental Health Strategy Delivery Plan, published in October 2026, which reaffirmed important commitments to strengthen the mental health workforce. This included actions to harness the contribution of the community and voluntary sectors in Northern Ireland, where so many therapists are undertaking life saving work.[254]

Drastic underfunding has stalled implementation of the Mental Health Strategy, leaving nearly **80%** of its programme sidelined


Giants Causeway, Nothern Ireland (UK)

Case Study: Making early intervention work in primary care: How Links community counselling provides accessible support and helps prevent escalation to more intensive services across Northern Ireland

Links Counselling operates eight counselling centres across Northern Ireland, strategically located in areas of social and economic deprivation to maximise accessibility. While Links delivers services across several Health and Social Care Trust areas, commissioned Primary Care counselling has, over the past decade, only been available within the Northern Trust through the Northern Emotional Wellbeing Service (NEWS). Introduced in 2019, NEWS enables GPs to refer patients directly for talking therapy, providing early intervention for people experiencing mild to moderate mental health difficulties before they require more intensive services.

Within the Northern Trust, NEWS has demonstrated significant demand for accessible community-based counselling, yet waiting lists continue to grow. There are currently 1,741 people waiting for support, with delays of between six and nine months depending on location.

Through NEWS, GPs can refer patients directly to qualified counsellors delivering evidence-based talking therapy within local community settings. The service delivers an average of 585 sessions of counselling per month, supporting 267 clients each month. Since its introduction in 2019, the service has provided 49,000 counselling sessions to 18,039 clients, offering timely psychological support designed to improve emotional wellbeing, reduce distress and prevent the escalation of mental health difficulties. The service works in close partnership with primary care, social care and community mental health teams to ensure people receive appropriate support as early as possible.

Over its first seven years, NEWS has consistently delivered strong clinical outcomes. Average CORE-OM scores fell from 20 before counselling to 12 following treatment, demonstrating significant improvements in clients' psychological wellbeing. The service has supported more than 18,000 people through almost 50,000 counselling sessions, helping many avoid deterioration in their mental health.

Professionals across the Northern Trust consistently highlight the value of the service:

"We appreciate all you do. It is great to have an option in the town for directing people who are in need to." **— GP, Coleraine**

"Ballymena is in desperation for organisations to be able to provide support – it is wonderful to know you are here." **— Social Worker**

"It is a great service, and we see the benefits of having a counselling service available for our patients." **— Community Mental Health Team**

Clients also describe the profound difference counselling has made to their lives:

"You have made such a difference to my day. I haven't spoken to another human being in six days and you have been so understanding."

"I don't have the words to express how important you are and what you do is, and the difference it makes to so many."

"They gave me hope when I was hopeless and help when I felt helpless."

"I entered counselling thinking, 'What's the point?' I am leaving today feeling empowered and strengthened."

"These sessions have given me light at the end of the tunnel. I feel like I have a future now."

These outcomes demonstrate that accessible, community-based counselling is an essential component of primary mental healthcare, delivering measurable clinical improvements while providing life-changing support to individuals experiencing emotional distress.



The contribution of counsellors and psychotherapists in Northern Ireland

Counsellors and psychotherapists already make a substantial contribution to Northern Ireland's mental health system. We estimate around 5,000 counsellors and psychotherapists are working to support people across the lifespan in a wide range of settings, including Health and Social Care, schools, universities, charities, community organisations, justice settings, workplaces and independent practice.

Within Health and Social Care, counsellors and psychotherapists contribute to services including primary care talking therapies, community mental health teams, CAMHS, trauma services, addictions, cancer care, palliative care and support for people experiencing significant life challenges. They work alongside psychologists, psychiatrists, nurses, occupational therapists and social workers, providing specialist therapeutic interventions as part of multidisciplinary teams. The profession has particular expertise in relational approaches to mental health. This is especially valuable in Northern Ireland, where many individuals present with difficulties rooted in trauma, loss, identity, relationships and social circumstances rather than a single mental health diagnosis.

The voluntary and community sector is another area where counsellors and psychotherapists play a vital role. Many organisations developed in response to the needs created by the Troubles and have built significant expertise in trauma-informed practice, victim support, suicide prevention, domestic abuse, addiction and community wellbeing. These organisations often provide support that complements statutory services and reaches people who may face barriers accessing traditional healthcare settings. Their work demonstrates the value of community-based therapeutic support in improving resilience and reducing escalation to crisis services. An example is the Regional Trauma Network, established to better address the long-term consequences of the Troubles on the mental health of the population in Northern Ireland.

Counsellors also make an increasingly important contribution in education settings. Northern Ireland was the first nation within the UK to fund and provide school-based counselling in post primary settings, provided through a grant system since 2007. This has led to significant reductions in psychological distress. For children and young people, early access to therapeutic support has been shown to improve educational engagement, relationships and long-term outcomes. An evaluation of the programme in 2020 showed that 88% of children and young people who completed an average of five counselling sessions did not require onward referral to specialist help and 85% of all respondents felt more able to cope as a result of the support they received.[255]

The Northern Ireland Mental Health Services Workforce Review identifies counselling and psychological therapies as an essential component of future mental health service delivery and recommends significant workforce expansion to meet growing demand.[256] Counselling and psychotherapy are also recognised psychological professions, represented in the Psychological Professions Forum NI. Despite this and the significant contribution it makes, the profession remains poorly represented in official workforce planning. Unlike medicine, nursing, psychology and social work, there is no comprehensive dataset identifying how many counsellors and psychotherapists work in Northern Ireland, where they are employed or how workforce capacity is changing. The Commission considers this lack of workforce intelligence to be one of the most significant barriers to recognising and maximising the contribution of counselling and psychotherapy.

Workforce, training and sustainability

A central challenge is the absence of comprehensive workforce planning for counselling and psychotherapy. While the Department of Health's Mental Health Services Workforce Review 2022–2032 provides important analysis of future mental health staffing needs, counselling and psychotherapy remain insufficiently visible within workforce modelling.[257] This reflects a wider issue across the UK, where the profession does not have the same workforce recognition or data infrastructure as some other health professions.

The consequence is that workforce supply and demand cannot be accurately assessed in terms of the number of practising counsellors and psychotherapists, the settings in which they work, the specialist skills available, geographical distribution or future workforce requirements. The Commission considers that improving workforce intelligence should be an immediate priority. Without reliable differentiated data and accurate professional categorisation, it is impossible to plan effectively for the expansion of psychological therapies required to meet population need.

Northern Ireland has a strong tradition of counselling education. Training is provided through universities, further education colleges and independent providers, creating multiple routes into the profession. Concerns were raised in our Northern Ireland roundtable about the lack of postgraduate training in Northern Ireland.

Clinical placements represent one of the most important elements of professional training. They provide students with supervised experience of therapeutic practice and are essential for maintaining standards of public protection, but the availability of placement opportunities is increasingly becoming a constraint. The Commission heard during our Northern Ireland roundtable that many students rely on voluntary and community organisations to provide placement settings. These organisations make an essential contribution but often operate with limited funding and supervision capacity. As demand for placements increases, organisations can struggle to provide sufficient opportunities while maintaining quality assurance. The Commission were told that this additionally reduces paid employment opportunities, as services facing huge funding pressures utilise trainees on placement as a workforce.

The Commission also heard concerns about the transition from qualification into employment. Many newly qualified counsellors experience difficulty securing stable, salaried employment despite evidence of growing demand for psychological support. Some enter sessional work, short-term contracts or self-employment, while others continue within voluntary sector roles where they completed placements. While these routes can provide valuable experience, they do not always provide the stability, career progression or professional development opportunities associated with other mental health professions. Increasing numbers of graduates are entering private practice, including immediately post-qualification, with limited professional experience.

A further related challenge, specific to Northern Ireland, is that the contracting rules for statutory services indicate that they will employ only therapists who are accredited or working towards accreditation. The Commission have been told that this perpetuates a market of unpaid or low paid employment as those working towards accreditation are often undertaking unpaid work to meet the required practice hours required to achieve accreditation status.

The Mental Health Workforce Review reflected this challenge of therapists securing paid employment, highlighting that while training capacity is relatively strong, transition into paid employment remains problematic due to limited commissioned posts and widespread dependence on unpaid placements. This creates a paradox: Northern Ireland trains skilled counsellors and psychotherapists while simultaneously struggling to create enough sustainable employment opportunities to retain them. The Commission believes that addressing this gap should be central to future workforce planning in Northern Ireland.

Funding, commissioning and the future of services in Northern Ireland

The Mental Health Strategy 2021–2031 provides Northern Ireland with a clear framework for reform. It sets out an ambitious vision based on prevention, early intervention, community support, trauma-informed practice and improved access to psychological therapies. However, implementation has been significantly constrained by severe financial pressures. The Department committed to reviewing the overall deliverability of the Mental Health Strategy, as recommended by the Public Accounts Committee in its Report on Mental Health Services in Northern Ireland.[258] This review highlighted the substantial funding shortfall against the Strategy's estimated £1.2 billion cost and that difficult prioritisation decisions were required.[259]

For counselling and psychotherapy, this challenging funding environment has had consequences. Many services, especially those delivered through the voluntary and community sector, operate through short-term contracts or grant funding. While these organisations provide essential services and employ highly skilled practitioners, uncertainty over funding makes workforce planning difficult. Short-term funding arrangements can lead to difficulty retaining experienced therapists, uncertainty for staff and service users, challenges investing in supervision and development and reduced ability to plan for future demand.

The Commission heard repeatedly that the voluntary and community sector should not be viewed simply as an additional resource but as an essential component of Northern Ireland's mental health infrastructure. This is particularly important given the region's experience of conflict. Many community organisations have developed specialist expertise in trauma recovery and supporting individuals affected by violence, bereavement and social division.

Action 17 of the Mental Health Strategy reinforced the importance of third sector organisations as strategic partners in delivering mental health reform. However, it also highlighted the need for stronger integration, longer-term funding and more consistent commissioning arrangements. A failure to fund the strategy has meant that this remains an undeliverable ambition.

The Commission believes that a sustainable mental health system requires a different approach: one that recognises prevention and early intervention as investments rather than costs. Counselling and psychotherapy have an important role in this shift. By supporting people earlier, they can help reduce escalation, improve recovery and potentially reduce pressure on more intensive services.

An important opportunity to utilise the counselling professions to address need is the proposed holistic model of primary care and early intervention, set out in the Health and Social Care NI Reset Plan.[260] This focuses on providing enlarged and empowered Neighbourhood population healthcare management which brings together a range of specialisms in community settings to address need.

Appendix A:
About the Commission

The Commission for the Future of Counselling and Psychotherapy was launched in October 2025 to examine the current and future landscape of the professions and the key issues affecting the sector, professionals, services and clients, drawing on expert and lived experience, alongside input from the wider Partnership of Counselling and Psychotherapy Bodies (PCPB) memberships.

Independently chaired by Phil Hope, former Minister of State for Care Services and Andrea Sutcliffe, an influential leader and specialist in health service delivery and regulation, the commission brought together counselling and psychotherapy professional bodies, key providers and clinical experts, decision-makers and those with lived experience to explore and discuss four key topics. Each topic was explored in a session where expert witnesses gave evidence, followed by a wider discussion among Commissioners.

The four sessions were as follows:

> Counselling and psychotherapy, the state of the sector

> Counselling and psychotherapy, is there a case for statutory regulation?

> Counselling and psychotherapy, the evidence base

> Counselling and psychotherapy, the future of the professions.

To ensure we captured the unique contexts in Northern Ireland, Scotland and Wales we held dedicated panel meetings in each nation. These provided an important forum to hear from relevant experts and sector representatives.

Each PCPB partner nominated a representative to the Commission. They are:

> Dr Heather Churchill, Association of Christians in Counselling and Linked Professions (ACC)

> Professor Lynne Gabriel OBE, President, British Association for Counselling and Psychotherapy (BACP)

> Lee Smith, Chair, British Psychoanalytic Council (BPC)

> Graeme Layzell, Director, Human Givens Institute (HGI)

> Lindsay Cooper, National Counselling and Psychotherapy Society (NCPS)

> Pippa Donovan, Chair, United Kingdom Council for Psychotherapy (UKCP).

The appointed Commissioners are:

- Andy Bell – CEO, Centre for Mental Health
- Professor Divine Charura MBE – York St John University
- Kate Day – NCPS Children and Young People Ambassador
- Emma Davies – director, The Exchange
- Chris Frederick – expert by experience
- Julian Harrison – expert by experience
- Myira Khan – award-winning counsellor and author, Myira Khan Counselling
- Professor Alessandra Lemma – University College London
- Professor John McLeod – Abertay University
- Anjula Mutanda – broadcaster, author, columnist and relationship therapist
- Mat Pronger – Psychotherapy and Counselling Union
- Sebastian Rees – The Institute for Public Policy Research
- Professor Andrew Reeves – University of Chester
- Dr Alistair Ross – University of Oxford
- Mark Rowland – CEO, Mental Health Foundation
- Dr Caryl Sibbett – psychotherapist, supervisor, art psychotherapist and trainer, Kairos Counselling.

For clarity, the work of this Commission and its members is referred to with capitalisation to reflect their specific title, while the work of service commissioners (such as within the context of the NHS) is referred to in lowercase.

Appendix B:
Our call for evidence

In support of the creation of this report, we invited all PCPB members and interested organisations to contribute to our call for evidence. The call for evidence had two components: the survey, which gathered individual member responses, and a call for written submissions from organisations and services. The call for evidence was open from January until March 2026. The individual survey yielded 3,320 responses across all six PCPB partners, and over 4,000 responses when including submissions from services and organisations. Of the individual respondents, 92.3% were fully qualified to practise.

At present, the PCPB partners do not share a standardised approach to monitoring membership data, including membership demographics. On this basis, it is hard to know with certainty that our respondents are completely representative of the wider PCPB membership. In addition to informing the work of the Commission, the survey insights into our respondent base are a step in the right direction to garner a better understanding of the PCPB membership composition.

Question: Which PCPB professional body, or bodies, are you a member of? Select all that apply

> Association of Christians in Counselling and Linked Professions (ACC) – 4.7%
> British Association for Counselling and Psychotherapy – 53.2%
> British Psychoanalytic Council – 2.8%
> Human Givens Institute – 1.8%
> National Counselling and Psychotherapy Society – 41.6%
> United Kingdom Council for Psychotherapy – 21.2%.

Question: How long have you been a member of a counselling and psychotherapy professional body, including as a student?

> 0-2 years – 8.3%
> 2-3 years – 5.5%
> 3-5 years – 14.7%
> 5-10 years – 24.2%
> 10 years + - 47.3%.

Question: Which country or countries do you live and work? Select all that apply

> England – 89.9%
> Northern Ireland – 5.7%
> Scotland – 9.7%
> Wales – 8.3%
> Other UK location – 2.3%
> Outside the UK – 7.2%.

Appendix C:
Abbreviations and acronyms

- **ACC** – Association of Christians in Counselling and Linked Professions
- **BACP** – The British Association for Counselling and Psychotherapy
- **BPC** – British Psychoanalytic Council
- **BPS** – British Psychological Society
- **CAMHS** – Child and Adolescent Mental Health Services
- **CBT** – Cognitive Behavioural Therapy
- **COSCA** – Confederation of Scottish Counselling Agencies
  (now uses the long title 'Counselling & Psychotherapy in Scotland' but retains the acronym)
- **DBT** – Dialectical Behavioural Therapy
- **EBE** – Expert(s) By Experience
- **HEIW** – Health Education and Improvement Wales
- **HGI** – Human Givens Institute
- **ICB** – Integrated Care Board
- **ICS** – Integrated Care System
- **IJB** – Integration Joint Board
- **MHSTs** – Mental Health Support Teams in Schools
- **NHS** – National Health Service
- **NICE** – National Institute for Health and Care Excellence
- **PBE** – Pro Bono Economics
- **PCPB** – Partnership of Counselling and Psychotherapy Bodies
- **NCPS** – National Counselling and Psychotherapy Society
- **PSA** – Professional Standards Authority
- **SCORE** – Student Counselling Outcomes Research and Evaluation consortium
- **SCoPEd** – Scope of Practice and Education
- **TT** – Talking Therapies
- **UKCP** – United Kingdom Council for Psychotherapy
- **VCFSE** – Voluntary, Community, Faith and Social Enterprise
- **WHO** – World Health Organization
- **WTE** – Whole Time Equivalent
- **YIACS** – Youth Information, Advice and Counselling Services

Appendix D: Workforce capacity estimates and unmet need

Across the PCPB organisations there are 105,000 members; with 82,000 of these members Registrants on a PSA Register – indicating that they're qualified to practise.[261]

On behalf of the Commission the PCPB organisations undertook a collective membership survey[262] in January 2026. There was a total of 3,320 responses to the survey, with 92.3% of respondents indicating that they're fully qualified to practise.

We asked respondents to indicate what capacity they had to take on additional paid hours' work each week. For the purposes of this work one hour of work is equal to one session of therapy. To ascertain the capacity of the qualified practitioners to undertake additional paid work we excluded those respondents who indicated that they weren't yet qualified to practise and on a Register.

Our findings indicate that there is an estimated minimum of 14,815,760 additional hours capacity within the existing counselling workforce, and when converted to Whole Time Equivalent posts, the capacity is equal to 18,520 additional practitioners. *[see table 1 (Page19)]*. We calculate that this number of sessions annually would enable the delivery of counselling and psychotherapy to between 1.2 and 1.75 million people a year based on the average number of sessions in a course of treatment *[see table 2]*.

It is estimated that there are 1.8 million people on a waiting list for mental health services in England.[263] There aren't similar data published for Northern Ireland, Scotland and Wales but the Mental Health Foundation estimates the level of mental health need across the UK to be just short of 14,000,000 people[264] *[see table 3]*. The capacity in the counselling professions workforce can make a huge impact on the level of unmet need.

Caveats

- The survey conducted by PCPB on behalf of the Commission asked respondents to indicate which country they live and work in. Respondents were able to select more than one option. Therefore, we are unable to confidently produce nation-specific estimates for capacity and we have instead a UK-wide estimate.
- The additional hours question clustered all capacity from 10 hours a week upwards in one group. Therefore, we have been conservative in our assumptions and attributed only 10 hours a week per respondent in that group – however it is extremely likely that a proportion of the 10+ hours group would have significantly more than 10 hours' capacity and therefore the estimates of capacity would be an underestimate.

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Table 2: Unused Capacity Across Qualified PCPB Members (UK Wide) [265]

Hours Capacity Indicated Per Week in Commission Survey	Percentage of Qualified Repondents Indicating Capacity Across Survey Capacity Options	Extrapolated Number of Qualified Members from PCPB Total Registrant Count Jan 2026 (82,000)	Weekly Hours capacity across cohort (1hour = 1 session)	Annual hours capacity across cohort (42.1 week annual working pattern)	Equivalent number of FTE posts to deliver this capacity (annual sessions/ (42.1 weeks worked*20 sessions per WTE per week)
0	25.60%	20,992	-	-	-
1	2.00%	1,640	1,640	67,893	81
2	6.10%	5,002	10,004	414,147	492
3	6.30%	5,166	15,498	641,589	762
4	7.80%	6,396	25,584	1,059,131	1,258
5	17.90%	14,678	73,390	3,038,212	3,608
6	6.10%	5,002	30,012	1,242,442	1,475
7	3.20%	2,624	18,368	760,402	903
8	4.90%	4,018	32,144	1,330,703	1,580
9	1.30%	1,066	9,594	397,174	472
10+	18.80%	15,416	154,160	6,381,942	7,579
Total	100.00%	82,000	370,394	15,333,635	18,210
	Total number of members with any capacity:	61,008			

10+ calculations rounded down to 10, so represents a minimum of the capacity within this group i.e. total number could be significantly increased

Table 3: Estimate of mental health need across the UK in 2023-24 [266]

Nation	% of population	Number of people
England	25%	11,700,000
Northern Ireland	24%	370,000
Scotland	25%	1,100,000
Wales	27%	720,000
	Total	13,890,000

Table 4: Employment costs of practitioners by AfC banding (England only)

	FTE salary (2026-27) [267]	Local payroll pension contributions 14.38%	NHS England funded pension contributions 9.4%	Employer NI (15% above £5000 earnings threshold)	Apprenticeships levy (0.5%)	Total local payroll annual cost	Total payroll annual cost inc. local and national costs
Band 6 (< 2 years exp)	£39,959.00	£5,746.10	£3,756.15	£5,243.85	£199.80	£51,148.75	£54,904.90
Band 6 (2-4 years exp)	£42,170.00	£6,064.05	£3,963.98	£5,575.50	£210.85	£54,020.40	£57,984.38
Band 6 (5+ years exp)	£48,117.00	£6,919.22	£4,523.00	£6,467.55	£240.59	£61,744.36	£66,267.36
Band 7 (<2 years exp)	£49,387.00	£7,101.85	£4,642.38	£6,658.05	£246.94	£63,393.84	£68,036.21
Band 7 (2-4 years exp)	£51,932.00	£7,467.82	£4,881.61	£7,039.80	£259.66	£66,699.28	£71,580.89
Band 7 (5+ years exp)	£56,515.00	£8,126.86	£5,312.41	£7,727.25	£282.58	£72,651.68	£77,964.09

Table 5: Census UK population estimates by nation [268]

	ONS estimated UK population (mid-2024)	Nation share of total UK population
England	58,620,101	84.61%
Northern Ireland	1,927,855	2.78%
Scotland	5,546,900	8.01%
Wales	3,186,581	4.60%
Total population	69,281,437	

Table 6: NHS FTE role (no deductions to working time)

	NHS FTE hours (daily)	NHS FTE hours (weekly)	NHS FTE days (annually)	NHS FTE (weeks/ annually)
England [269]	7.5	37.5	260	52
Northern Ireland [270]	7.5	37.5	260	52
Scotland [271]	7.2	36	260	52
Wales [272]	7.5	37.5	260	52

Table 7: Annual leave and bank holiday entitlements by nation

	Annual leave and bank holiday entitlements						NHS FTE role (post annual leave and bank holiday entitlements)	
	Bank holiday (days)	On appointment in role (days)	After 5 years (days)	After 10 years (days)	Avg. leave across entitlements (days)	Avg. across entitlements (weeks)	NHS FTE (days/ annually)	NHS FTE (weeks/ annually)
England [273]	8	27	29	33	37.67	7.53	222.33	
Northern Ireland [274]	10	27	29	33	39.67	7.93	220.33	
Scotland [275]	8	27	29	33	37.67	7.53	222.33	
Wales [276]	8	28	30	34	38.67	7.73	221.33	

Table 8: Sickness absence average for WTE by nation

	Sickness absence average for WTE														
	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	12 month average sickness	12 month average sickness (days)	12 month average sickness (weeks)
England [277]	4.90%	5.10%	5.10%	5.30%	5.70%	5.60%	5.90%	5.70%	5.40%	5.10%	5.00%	5.00%	5.32%	11.82	2.36
Northern Ireland													8.34%	18.38	3.68
Belfast Trust [278]	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.33%		
Northern Trust [279]	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.65%		
South Eastern Trust [280]	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.38%		
Southern Trust [281]	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.93%		
Western Trust [282]	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.68%		
NI Ambulance Service Trust [283]	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	10.07%		
Scotland [284]	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.40%	14.23	2.85
Wales [285]	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.30%	13.94	2.79

Table 9: NHS FTE role (AL, bank holiday and sickness absence)

	NHS FTE role (AL, bank holiday and sickness absence)		
	Days worked annually	**Weeks worked annually**	**FTE annual sessions deliverable per nation (weeks worked * 20 clients per week)**
England	210.51	42.10	842.05
Northern Ireland	201.96	40.39	807.83
Scotland	208.10	41.62	832.42
Wales	207.39	41.48	829.56
Unweighted UK Aver-age	206.99	41.40	827.96

Table 10: Total employment costs by banding and nation

England										
Agenda for Change Band	FTE Salary 2026-27 286	NHS Employer Pension Cost (14.38%)	National pension Cost (9.4%)	Employer NICs (15% above £5000 earnings threshold) 287	Apprenticeships Levy (0.5%)	Total FTE Cost	Sessional Cost 288	10 sessions Course of Treatment Cost	Cost of Delivering Population Weighted Share of 150,000 courses of therapy (10 session course of treatment)	Number of Courses of Therapy Delivered for Cost
Band 6 (< 2 years exp)	£39,959.00	£5,746.10	£3,756.15	£5,243.85	£199.80	£54,904.90	£65.20	£652.04	£82,754,856.43	126,917.21
Band 6 (2-4 years exp)	£42,170.00	£6,064.05	£3,963.98	£5,575.50	£210.85	£57,984.38	£68.86	£688.61	£87,396,373.20	126,917.21
Band 6 (5+ years exp)	£48,117.00	£6,919.22	£4,523.00	£6,467.55	£240.59	£66,267.36	£78.70	£786.98	£99,880,814.72	126,917.21
Band 7 (<2 years exp)	£49,387.00	£7,101.85	£4,642.38	£6,658.05	£246.94	£68,036.21	£80.80	£807.98	£102,546,905.30	126,917.21
Band 7 (2-4 years exp)	£51,932.00	£7,467.82	£4,881.61	£7,039.80	£259.66	£71,580.89	£85.01	£850.08	£107,889,582.90	126,917.21
Band 7 (5+ years exp)	£56,515.00	£8,126.86	£5,312.41	£7,727.25	£282.58	£77,964.09	£92.59	£925.88	£117,510,601.14	126,917.21

Table 10 continues on page 110 >

Table 10 continued: Total employment costs by banding and nation

Northern Ireland

Agenda for Change Band	FTE Salary 2026-27 289	NHS Employer Pension Cost (23.2%) 290	National pension Cost (0%)	Employer NICs (15% above £5000 earnings threshold) 291	Apprenticeships Levy (0.5%)	Total FTE Cost	Session Cost 292	10 sessions Course of Treatment Cost	Cost of Delivering Population Weighted Share of 150,000 courses of therapy (10 session course of treatment)	Number of Courses of Therapy Delivered for Cost
Band 6 (< 2 years exp)	£38,682.00	£8,974.22	£-	£5,052.30	£193.41	£52,901.93	£65.49	£654.86	£2,733,442.74	4,174.06
Band 6 (2-4 years exp)	£40,823.00	£9,470.94	£-	£5,373.45	£204.12	£55,871.50	£69.16	£691.62	£2,886,880.26	4,174.06
Band 6 (5+ years exp)	£46,580.00	£10,806.56	£-	£6,237.00	£232.90	£63,856.46	£79.05	£790.47	£3,299,463.06	4,174.06
Band 7 (<2 years exp)	£47,810.00	£11,091.92	£-	£6,421.50	£239.05	£65,562.47	£81.16	£811.59	£3,387,612.59	4,174.06
Band 7 (2-4 years exp)	£50,273.00	£11,663.34	£-	£6,790.95	£251.37	£68,978.65	£85.39	£853.88	£3,564,126.65	4,174.06
Band 7 (5+ years exp)	£54,710.00	£12,692.72	£-	£7,456.50	£273.55	£75,132.77	£93.01	£930.06	£3,882,109.96	4,174.06

Scotland

Agenda for Change Band	FTE Salary 2026-27 293	NHS Employer Pension Cost (22.5%) 294	National pension Cost (0%)	Employer NICs (15% above £5000 earnings threshold) 295	Apprenticeships Levy (0.5%)	Total FTE Cost	Session Cost 296	10 sessions Course of Treatment Cost	Cost of Delivering Population Weighted Share of 150,000 courses of therapy (10 session course of treatment)	Number of Courses of Therapy Delivered for Cost
Band 6 (point 1)	£43,231.00	£9,726.98	£-	£5,734.65	£216.16	£58,908.78	£70.77	£707.68	£8,498,923.55	12,009.48
Band 6 (point 2)	£45,135.00	£10,155.38	£-	£6,020.25	£225.68	£61,536.30	£73.92	£739.25	£8,878,002.73	12,009.48
Band 6 (point 3)	£52,679.00	£11,852.78	£-	£7,151.85	£263.40	£71,947.02	£86.43	£864.32	£10,379,984.49	12,009.48
Band 7 (point 1)	£52,845.00	£11,890.13	£-	£7,176.75	£264.23	£72,176.10	£86.71	£867.07	£10,413,034.46	12,009.48
Band 7 (point 2)	£54,863.00	£12,344.18	£-	£7,479.45	£274.32	£74,960.94	£90.05	£900.52	£10,814,810.60	12,009.48
Band 7 (point 3)	£61,466.00	£13,829.85	£-	£8,469.90	£307.33	£84,073.08	£101.00	£1,009.99	£12,129,442.84	12,009.48

Wales

Agenda for Change Band	FTE Salary 2026-27 297	NHS Employer Pension Cost (14.38%) 298	National pension Cost (9.4%)	Employer NICs (15% above £5000 earnings threshold) 299	Apprenticeships Levy (0.5%)	Total FTE Cost	Session Cost 300	10 sessions Course of Treatment Cost	Cost of Delivering Population Weighted Share of 150,000 courses of therapy (10 session course of treatment)	Number of Courses of Therapy Delivered for Cost
Band 6 (< 2 years exp)	£40,559.00	£5,832.38	£3,812.55	£5,333.85	£202.80	£55,740.58	£67.19	£671.93	£4,635,820.03	6,899.24
Band 6 (2-4 years exp)	£42,805.00	£6,155.36	£4,023.67	£5,670.75	£214.03	£58,868.80	£70.96	£709.64	£4,895,987.89	6,899.24
Band 6 (5+ years exp)	£48,841.00	£7,023.34	£4,591.05	£6,576.15	£244.21	£67,275.74	£81.10	£810.98	£5,595,174.51	6,899.24
Band 7 (<2 years exp)	£50,129.00	£7,208.55	£4,712.13	£6,769.35	£250.65	£69,069.67	£83.26	£832.61	£5,744,371.39	6,899.24
Band 7 (2-4 years exp)	£52,712.00	£7,579.99	£4,954.93	£7,156.80	£263.56	£72,667.27	£87.60	£875.98	£6,043,576.01	6,899.24
Band 7 (5+ years exp)	£57,365.00	£8,249.09	£5,392.31	£7,854.75	£286.83	£79,147.97	£95.41	£954.10	£6,582,561.32	6,899.24

Table 11: Proportion of each national mental health budget our 10% capacity proposals represent				
	Proportion of each national mental health budget our 10% capacity proposals represent			
Nation	**Mental health budget**	**Percentage of health expenditure**	**What percentage of budget is the 10% capacity usage**	
England [301]	£18.99 bn	9.36%	0.54%	2024-25
Northern Ireland [302]	£0.39 bn	7%	0.87%	2023-24
Scotland [303]	£1.50 bn	9.00%	0.69%	2023-24
Wales [304]	£1.10 bn	11.40%	0.52%	2023-24
UK total:	£21.98 bn		0.56%	

References

[1] Department of Health and Social Care. (2026). *Independent review into mental health conditions, ADHD and autism: Final report*. GOV.UK. https://www.gov.uk/government/publications/independent-review-into-mental-health-conditions-adhd-and-autism-final-report

[2] Department of Health and Social Care. (2026). Major expansion of community mental health support across England. GOV.UK.

[3] Rethink (2025) *Right Treatment, Right Time.* https://www.rethink.org/media/hpapzday/right-treatment-right-time-2025-report.pdf *[accessed 8th September 2026]*

[4] Mental Health Foundation (2026) *The Foundation Reports: The State of Mental Health Inequality in the UK* https://reports.mentalhealth.org.uk/foundation-reports/june-2026/report *[accessed 8th September 2026]*

[5] Pro Bono Economics. (2026). *Prevention that pays: The economic case for early support for young people's mental health and wellbeing.* https://pbe.co.uk/wp-content/uploads/2026/06/Prevention-that-pays_The-economic-case-for-early-support-for-young-peoples-mental-health-and-wellbeing.pdf

[6] *Mental health and employers: The case for employers to invest in supporting working parents and a mentally healthy workplace.* Deloitte. https://www.deloitte.com/uk/en/services/consulting/research/mental-health-and-employers-the-case-for-employers-to-invest-in-supporting-working-parents-and-a-mentally-health-workplace.html

[7] NHS England, Evidence base for NHS Talking Therapies for anxiety and depression available from https://www.england.nhs.uk/mental-health/adults/nhs-talking-therapies

[8] Rethink (2025) *Right Treatment, Right Time.* https://www.rethink.org/media/hpapzday/right-treatment-right-time-2025-report.pdf *[accessed 8 September 2026]*

[9] Mental Health Foundation (2026) *The Foundation Reports: The State of Mental Health Inequality in the UK* https://reports.mentalhealth.org.uk/foundation-reports/june-2026/report/) [accessed 8 September 2026]

[10] PCPB Shared Membership Data, January 2026

[11] Pro Bono Economics. (2026). *Prevention that pays: The economic case for early support for young people's mental health and wellbeing.* https://pbe.co.uk/wp-content/uploads/2026/06/Prevention-that-pays_The-economic-case-for-early-support-for-young-peoples-mental-health-and-wellbeing.pdf

[12] Mental health and employers: *The case for employers to invest in supporting working parents and a mentally healthy workplace.* Deloitte. https://www.deloitte.com/uk/en/services/consulting/research/mental-health-and-employers-the-case-for-employers-to-invest-in-supporting-working-parents-and-a-mentally-health-workplace.html

[13] NHS England, Evidence base for NHS Talking Therapies for anxiety and depression available from https://www.england.nhs.uk/mental-health/adults/nhs-talking-therapies

[14] Department of Health and Social Care. (2026). *Independent review into mental health conditions, ADHD and autism: Interim report.* https://www.gov.uk/government/publications/independent-review-into-mental-health-conditions-adhd-and-autism-interim-report

[15] Collyer Merritt, E. (2026). Mental health conditions: Prevalence, impacts and government action. House of Lords Library. https://lordslibrary.parliament.uk/mental-health-conditions-prevalence-impacts-and-government-action/

[16] Cardoso, F., & McHayle, Z. (2024). *The economic and social costs of mental ill health. Centre for Mental Health.* https://www.centreformentalhealth.org.uk/publications/the-economic-and-social-costs-of-mental-ill-health/

[17] House of Commons Health and Social Care Committee. (2025). *Community mental health services: Fourth report of session 2024–26. UK Parliament.* https://committees.parliament.uk/publications/50484/documents/274145/default/

[18] Department of Health and Social Care. (2026). *Independent review into mental health conditions, ADHD and autism: Interim report.* https://www.gov.uk/government/publications/independent-review-into-mental-health-conditions-adhd-and-autism-interim-report

[19] Darzi, A. (2024). *Summary letter from Lord Darzi to the Secretary of State for Health and Social Care.* GOV.UK. https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england/summary-letter-from-lord-darzi-to-the-secretary-of-state-for-health-and-social-care

[20] Department of Health and Social Care. (2026). *Independent review into mental health conditions, ADHD and autism: Interim report. GOV.UK*. https://www.gov.uk/government/publications/independent-review-into-mental-health-conditions-adhd-and-autism-interim-report/independent-review-into-mental-health-conditions-adhd-and-autism-interim-report

[21] Office for Statistics Regulation. (2026). *Review of mental health statistics in Wales*. https://osr.statisticsauthority.gov.uk/publication/review-of-mental-health-statistics-in-wales/pages/2/

[22] Scottish Government. (2025). *The Scottish Health Survey 2024 – Volume 1: Main report: 1. Mental health and wellbeing.* https://www.gov.scot/publications/scottish-health-survey-2024-volume-1-main-report/pages/1--mental-health-and-wellbeing/

[23] Northern Ireland Statistics and Research Agency. (2025). *Two-fifths of adults report mental health concerns.* https://www.nisra.gov.uk/news/two-fifths-adults-report-mental-health-concerns

[24] Royal College of Psychiatrists. (2017). *Postcode lottery for psychiatric care.* https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2017/09/11/postcode-lottery-for-psychiatric-care

[25] UK Health Security Agency. (2026). *Estimated prevalence of severe mental illness in England. GOV.UK.* https://www.gov.uk/government/statistics/adult-mental-health-and-wellbeing-profile-april-2026-update/estimated-prevalence-of-severe-mental-illness-in-england-report

[26] Mental Health Foundation. (2023). *Mental health in Northern Ireland: Fundamental Facts 2023.* https://www.mentalhealth.org.uk/sites/default/files/2023-10/Northern%20Ireland%20Fundamental%20Facts%20October%202023.pdf

[27] South London and Maudsley NHS Foundation Trust. (2025). *Mortality gap for people with severe mental illness is 'hidden health crisis', study finds.* https://slam.nhs.uk/pressreleases/mortality-gap-for-people-with-severe-mental-illness-is-hidden-health-crisis-study-finds-4890

[28] Office for Health Improvement and Disparities. (2022). *Premature mortality in adults with severe mental illness (SMI). GOV.UK*. https://www.gov.uk/government/publications/premature-mortality-in-adults-with-severe-mental-illness

[29] Collyer Merritt, E. (2026). *Mental health conditions: Prevalence, impacts and government action. House of Lords Library.* https://lordslibrary.parliament.uk/mental-health-conditions-prevalence-impacts-and-government-action/

[30] Scrimgeour, H. (2025). *The big issue: Anxious and absent. British Association for Counselling and Psychotherapy.* https://www.bacp.co.uk/bacp-journals/therapy-today/2025/articles-june/the-big-issue/

[31] The Health Foundation. (2025). *Inequalities in absences by mental health status.* https://www.health.org.uk/resources-and-toolkits/data-tools/evidence-hub/inequalities-in-absences-by-mental-health-status

[32] Department for Education. (2026). *Attendance: Why it matters, key data and guidance.* GOV.UK. https://www.gov.uk/government/publications/improving-the-attendance-of-children-with-a-social-worker/attendance-why-it-matters-key-data-and-guidance

[33] Department for Education. (2025). *The impact of school absence on lifetime earnings.* Department for Education. https://assets.publishing.service.gov.uk/media/67d2cf8f4702aacd2251cbae/The_impact_of_school_absence_on_lifetime_earnings.pdf

[34] Department for Work and Pensions. (2026). *Young people and work: Interim report.* GOV.UK. https://www.gov.uk/government/publications/young-people-and-work-interim-report/young-people-and-work-interim-report

[35] Centre for Mental Health. (2024). *The economic and social costs of mental ill health: Parliamentary briefing.* https://www.centreformentalhealth.org.uk/wp-content/uploads/2024/03/ParliamentaryBriefing_EconomicSocialCostsReport-briefing_March24-1.pdf

[36] McDaid, D., Park, A.-L., Davidson, G., John, A., Knifton, L., McDaid, S., Morton, A., Thorpe, L., & Wilson, N. (2022). *The economic case for investing in the prevention of mental health conditions in the UK: Summary. Mental Health Foundation*. https://www.mentalhealth.org.uk/sites/default/files/2022-06/MHF-Investing-in-Prevention-Report-Summary.pdf

[37] Duagi, D., Bell, A., & Obateru, A. (2024). *Covid-19 and the nation's mental health: A review of the evidence published so far.* Centre for Mental Health.

[38] Office for Health Improvement and Disparities. (2022). *COVID-19: Mental health and wellbeing surveillance report.* GOV.UK.

[39] Wang, Y., Su, B., Xie, J., Garcia-Rizo, C., & Prieto-Alhambra, D. (2024). *Long-term risk of psychiatric disorder and psychotropic prescription after SARS-CoV-2 infection among UK general population.* Nature Human Behaviour. https://doi.org/10.1038/s41562-024-01853-4

[40] Henseke, G., & Schoon, I. (2025). *Revisiting the mental health impact of COVID-19 on young adults in the UK: Long-term trends, temporary setbacks, and recovery.* Social Indicators Research. https://doi.org/10.1007/s11205-025-03616-8

[41] Royal College of Psychiatrists. (2021). *Pandemic impact on mental health backlog catastrophic, says Royal College of Psychiatrists.* https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2021/09/19/pandemic-impact-on-mental-health-backlog-catastrophic-says-royal-college-of-psychiatrists

[42] Welsh Government (2021), *Health and care services pandemic recovery plan.* March 2021. Available at https://www.gov.wales/health-and-care-services-pandemic-recovery-plan-published

[43] Northern Ireland Audit Office (2023), *Tackling Waiting Lists*, October 2023. Available at https://www.niauditoffice.gov.uk/publications/html-document/tackling-waiting-lists

[44] Scottish Government and NHS Scotland (2021), *NHS Recovery Plan* 2012-2026, August 2021 https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2021/08/nhs-recovery-plan/documents/nhs-recovery-plan-2021-2026/nhs-recovery-plan-2021-2026/govscot:document/nhs-recovery-plan-2021-2026.pdf

[45] Mahase, E. (2024). Covid-19: *NHS staff still struggling with "traumatic memories" of pandemic, report finds.* The BMJ, 386, q1969. https://doi.org/10.1136/bmj.q1969

[46] Wilson, C., & Bunn, S. (2020). *Mental health impacts of COVID-19 on NHS staff (POSTnote No. 634). Parliamentary Office of Science and Technology.* https://researchbriefings.files.parliament.uk/documents/POST-PN-0634/POST-PN-0634.pdf

[47] Buckingham, N. (2025). *NHS workforce in a nutshell.* The King's Fund. https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/nhs-workforce-nutshell

[48] Mishra, R., Guyatt, A. L., Medisauskaite, A., Martin, C. A., Musuka, S., Katikireddi, S. V., Woolf, K., Pareek, M., & I-CARE Study Collaborative Group. (2026). *Intentions and actions towards leaving healthcare work since COVID-19: Group-based trajectory analyses in the UK-REACH cohort.* Journal of the Royal Society of Medicine, 119(3), 73–82. https://doi.org/10.1177/01410768261419581

[49] Nursing and Midwifery Council. (2025). *Professionals who left the NMC register in 2024–2025.* Nursing and Midwifery Council. https://www.nmc.org.uk/globalassets/sitedocuments/data-reports/march-2025/professionals-who-left-the-nmc-register-in-2024-2025.pdf

[50] Nursing and Midwifery Council (2026), *Spotlight on Nursing and Midwifery* 2025

[51] Welsh Government (2026), *NHS workforce: staff directly employed by NHS* Wales, 31 December 2025

[52] Department of Health, Northern Ireland (2026), *Northern Ireland Health and Social Care Active Recruitment Statistics*, *31 March 2026.*

[53] British Medical Association. (2020). *The impact of COVID-19 on mental health in England: Supporting services to go beyond parity of esteem.* https://www.bma.org.uk/media/2750/bma-the-impact-of-covid-19-on-mental-health-in-england.pdf

[54] Pierce, M., Hope, H., Ford, T., Hatch, S., Hotopf, M., John, A., ... & Abel, K. M. (2020). Mental health before and during the COVID-19 pandemic: a longitudinal probability sample survey of the UK population. The Lancet Psychiatry, 7(10), 883-892.

[55] Duagi, D., Bell, A., & Obateru, A. (2024). Covid-19 and the nation's mental health: A review of the evidence published so far. Centre for Mental Health.

[56] UK Covid-19 Inquiry. (2025). Children and young people's voices project: Executive summary.

[57] Race Equality Foundation. (2022). *Mental health and racial disparities report.* https://raceequalityfoundation.org.uk/wp-content/uploads/2022/10/mental-health-report-v5-2.pdf

[58] Office for National Statistics. (2024). *Detentions under the Mental Health Act. Ethnicity facts and figures.* https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/latest/

[59] Mental Health Foundation. (2022). *Inequalities and mental health: Our policy perspective.* https://www.mentalhealth.org.uk/our-work/policy-and-advocacy/inequalities-and-mental-health-our-policy-perspective

[60] Taylor, S., Charura, D., Williams, G., Shaw, M., Allan, J., Cohen, E., Meth, F., & O'Dwyer, L. (2024). Loss, grief, and growth: An interpretative phenomenological analysis of experiences of trauma in asylum seekers and refugees. Traumatology, 30(1), 103-112. https://doi.org/10.1037/trm0000250

[61] O'Brien, C., & Charura, D. (2024). Advancing transculturally informed, humanistic therapeutic practice for refugees and asylum seekers presenting with embodied trauma. Counselling and Psychotherapy Research, 24, 1612-1631. https://doi.org/10.1002/capr.12808

[62] Rethink Mental Illness. (n.d.). *Ethnic minorities and mental health.* https://www.rethink.org/advice-and-information/living-with-mental-illness/underserved-communities-and-mental-health/ethnic-minorities-and-mental-health/

[63] NHS England. (2023). NHS equality, diversity, and inclusion improvement plan.

[64] Brown, A. N., & Hunter, S. C. (2026). *Dismantling barriers: Mental health stigma and support-seeking behavior among Black women in the United Kingdom.* Journal of Black Psychology. https://doi.org/10.1177/00221678261435219

[65] NHS. (2023). *Mental health support if you're lesbian, gay, bisexual or trans (LGBTQ+)*

[66] NHS England. (2023). The mental health nurse's handbook. NHS England

[67] Iskander-Reynolds, A. (2024). *Mental health in later life: Understanding needs, policies and services in England.* Centre for Mental Health. https://www.centreformentalhealth.org.uk/wp-content/uploads/2024/03/CentreforMH_MentalHealthInLaterLife-1.pdf

[68] Mental Health Foundation. (2025). *Older people: Statistics.* https://www.mentalhealth.org.uk/explore-mental-health/statistics/older-people-statistics

[69] Laidlaw, K., Goodman, J., & Age UK. (2024). *NHS Talking Therapies Positive Practice Guide: Older People.* Age UK. https://www.ageuk.org.uk/siteassets/documents/professionals/mental-health-hub/nhs-talking-therapies-older-people-positive-practice-guide-2024.pdf

[70] Mind. (2025). *Mental health facts and statistics.* https://www.mind.org.uk/information-support/types-of-mental-health-problems/mental-health-facts-and-statistics/

[71] Mental Health Matters. (2026). *LGBTQ+ mental health: The facts.* https://www.mhm.org.uk/lgbtq-mental-health-the-facts

[72] Mental Health UK. (2025). *LGBTQIA+ people's mental health.* https://mentalhealth-uk.org/lgbtqia-mental-health/

[73] British Association for Counselling and Psychotherapy. (2026). *BACP public perceptions survey.* https://www.bacp.co.uk/about-us/about-bacp/bacp-public-perceptions-survey/

[74] Office for Equality and Opportunity. (2026). *Draft Conversion Practices Bill. Cabinet Office.* https://www.gov.uk/government/publications/draft-conversion-practices-bill

[75] Mental Health Foundation. (2025). *LGBTIQ+ people: Statistics.* https://www.mentalhealth.org.uk/explore-mental-health/statistics/lgbtiq-people-statistics

[76] Mental Health Foundation. (2025). *Poverty: Statistics.* https://www.mentalhealth.org.uk/explore-mental-health/statistics/poverty-statistics

[77] Gutman, L., Joshi, H., Parsonage, M., & Schoon, I. (2015). *Children of the new century: Mental health findings from the Millennium Cohort Study.* London: Centre for Mental Health.

[78] Mental Health Foundation. (2025). *Poverty: Statistics*. https://www.mentalhealth.org.uk/explore-mental-health/statistics/poverty-statistics

[79] Charity Commission. (2026). *Charity sector risk assessment 2026.* GOV.UK

[80] Ballinger, L., & Wright, J. (2007). *'Does class count?' Social class and counselling. Counselling and Psychotherapy Research,* 7(3), 157–163. https://doi.org/10.1080/14733140701571316

[81] Balmforth, J. (2009). The weight of class: Clients' experiences of how perceived differences in social class between counsellor and client affect the therapeutic relationship. *British Journal of Guidance & Counselling,* 37(3), 375–386. https://doi.org/10.1080/03069880902956942

[82] British Association for Counselling and Psychotherapy. (2026). Research highlights barriers facing trainee counsellors. https://www.bacp.co.uk/news/news-from-bacp/2026/27-august-research-highlights-barriers-facing-trainee-counsellors/

[83] Collyer Merritt, E. (2026). Mental health conditions: Prevalence, impacts and government action. House of Lords Library. https://lordslibrary.parliament.uk/mental-health-conditions-prevalence-impacts-and-government-action/

[84] Department of Health and Social Care. (2021). *Chief Medical Officer's annual report 2021: Health in coastal communities – Summary and recommendations.* GOV.UK. https://assets.publishing.service.gov.uk/media/60f98769e90e0703ba3c9f25/cmo-annual_report-2021-health-in-coastal-communities-summary-and-recommendations-accessible.pdf

[85] Wicks, C., McPherson, S., Booker, C., Trotta, A., Kumari, M., & Murray, E. T. (2025). *Risk of diagnosed and undiagnosed mental distress in coastal and inland English residents: A pooled cross-sectional analysis of adult UKHLS respondents.* Health & Place, 95, 103501.

[86] Environment, Food and Rural Affairs Committee. (2023). *Rural mental health: Report summary. House of Commons.* https://publications.parliament.uk/pa/cm5803/cmselect/cmenvfru/248/summary.html

[87] Department of Health and Social Care. (2026). *Mental health goals.* GOV.UK. https://www.gov.uk/government/publications/life-sciences-healthcare-goals/mental-health-goals

[88] Shedler, J. (2010) The Efficacy of Psychodynamic Psychotherapy. American Psychologist, 65(2): 98-109.

[89] Kolovos, S., Kleiboer, A., & Cuijpers, P. (2016). Effect of psychotherapy for depression on quality of life: Meta-analysis. The British Journal of Psychiatry, 209(6), 460–468. https://doi.org/10.1192/bjp.bp.115.175059

[90] Nieuwenhuijsen, K., Verbeek, J. H. A. M., Neumeyer-Gromen, A., Verhoeven, A. C., Bültmann, U., & Faber, B. (2020). Interventions to improve return to work in depressed people. Cochrane Database of Systematic Reviews, 2020(10), Article CD006237. https://doi.org/10.1002/14651858.CD006237.pub4

[91] Barkham, M., Saxon, D., Hardy, G. E., Bradburn, M., Galloway, D., Wickramasekera, N., ... & Brazier, J. E. (2021). Person-centred experiential therapy versus cognitive behavioural therapy delivered in the English Improving Access to Psychological Therapies service for the treatment of moderate or severe depression (PRaCTICED): a pragmatic, randomised, non-inferiority trial. *The Lancet Psychiatry,* 8(6), 487-499.

[92] 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(1), 215.

[93] Fonagy, et al (2015) https://pubmed.ncbi.nlm.nih.gov/26407787/

[94] Bower, P. J., & Rowland, N. (2006). Effectiveness and cost effectiveness of counselling in primary care. *Cochrane Database of Systematic Reviews,* (3).

[95] McKenzie, K., Murray, K. R., Murray, A. L., & Richelieu, M. (2015). The effectiveness of university counselling for students with academic issues. Counselling and Psychotherapy Research, 15(4), 284-288.

[96] Hill, A., & Brettle, A. (2005). The effectiveness of counselling with older people: Results of a systematic review. Counselling and Psychotherapy Research, 5(4), 265-272.

[97] Shoesmith, E., Griffiths, A. W., Sass, C., & Charura, D. (2022). Effectiveness of counselling and psychotherapeutic interventions for people with dementia and their families: A systematic review. Ageing & Society, 42(4), 962-989.

[98] Prout, H.T., & Browning, B.K. (2011). Psychotherapy with persons with intellectual disabilities: a review of effectiveness research. *Advances in mental health and intellectual disabilities,* 5(5).

[99] Grosse, V., Lücke, C., Graf, E., Lam, A.P., Matthies, S., Borel, P., Sobanski, E., Rosler, M., Retz, W., Jacob, C., Colla M. et al. (2019). *Effectiveness of psychotherapy in adult ADHD: what do patients think? Results of the COMPAS study.* Journal of Attention Disorders, 23(9), 1047-1058.

[100] Pro Bono Economics. (2026). *Prevention that pays: The economic case for early support for young people's mental health and wellbeing.* https://pbe.co.uk/wp-content/uploads/2026/06/Prevention-that-pays_The-economic-case-for-early-support-for-young-peoples-mental-health-and-wellbeing.pdf

[101] Deloitte. (2024). *Mental health and employers: The case for employers to invest in supporting working parents and a mentally healthy workplace.* Deloitte. https://www.deloitte.com/uk/en/services/consulting/research/mental-health-and-employers-the-case-for-employers-to-invest-in-supporting-working-parents-and-a-mentally-health-workplace.html

[102] Mizen, S., Rost, F., & Cardoso, F. (2025). *Improving support for people with complex mental health difficulties. Centre for Mental Health*

[103] British Association for Counselling and Psychotherapy. (2025). *A pathway to private practice.* Private Practice.

[104] United Kingdom Council for Psychotherapy. (2023). 2023 UKCP member survey report.

[105] NHS England. (2025). *Mental health support in schools and colleges.* https://www.england.nhs.uk/mental-health/cyp/trailblazers/

[106] Public First. (2024). The economic case for counselling in schools and colleges. https://www.publicfirst.co.uk/the-economic-case-for-counselling-in-schools-and-colleges

[107] Welsh Government. (2026). *Counselling for children and young people: September 2024 to August 2025.* https://www.gov.wales/counselling-children-and-young-people-september-2024-august-2025-html

[108] Department of Education, Northern Ireland. (2024). *Counselling service in schools.* https://www.education-ni.gov.uk/articles/counselling-service-schools

[109] YouthLink Scotland. (2023). *Access to counsellors in secondary schools and children and young people's community mental health services: Summary reports.* https://www.youthlink.scot/news/access-to-counsellors/

[110] Scruggs, R., Broglia, E., Barkham, M., & Duncan, C. (2023). The impact of psychological distress and university counselling on academic outcomes: Analysis of a routine practice-based dataset. Counselling and Psychotherapy Research, 23(3), 781-789.

[111] Employee Assistance Professionals Association UK. (2025). *Focusing on the job: EAPs and keeping Britain working.* https://www.eapa.org.uk/wp-content/uploads/2025/10/Focusing-on-the-job-EAPs-and-keeping-Britain-working.pdf

[112] Bajorek, Z. (2020). Demonstrating the effectiveness of workplace counselling: Reviewing the evidence for wellbeing and cost-effectiveness outcomes. Institute for Employment Studies.

[113] Deloitte. (2024). Mental health and employers: The case for employers to invest in supporting working parents and a mentally healthy workplace.

[114] NHS England (2025) Psychological Professions National Workforce Census. https://www.england.nhs.uk/publication/psychological-professions-workforce-census/

[115] NHS England (2025) NHS Talking Therapies for Anxiety and Depression National Workforce Census: 1 April 2023-31 March 2024. https://www.england.nhs.uk/wp-content/uploads/2025/05/PRN01890-talking-therapies-for-anxiety-and-depression.docx

[116] https://www.england.nhs.uk/publication/psychological-professions-workforce-census/

[117] NHS England (2025) Psychological Professions National Workforce Census. Page 19. https://www.england.nhs.uk/publication/psychological-professions-workforce-census/

[118] National Institute for Health and Care Excellence. (2026). What NICE does. https://www.nice.org.uk/what-nice-do

[119] O'Brien, C., & Charura, D. (2024). Advancing transculturally informed, humanistic therapeutic practice for refugees and asylum seekers presenting with embodied trauma. Counselling and Psychotherapy Research, 24, 1612-1631. https://doi.org/10.1002/capr.12808

[120] Charura, D. (2024). Therapists' experience of working with refugees and asylum seekers who have been tortured: An interpretative phenomenological analysis. Psychological Trauma: Theory, Research, Practice, and Policy, 16 (Suppl 3), S521-S531. https://doi.org/10.1037/tra0001709

[121] Park, A. L., Rinaldi, M., Brinchmann, B., Killackey, E., Aars, N. A. P., Mykletun, A., & McDaid, D. (2022). Economic analyses of supported employment programmes for people with mental health conditions: A systematic review. European psychiatry: the journal of the Association of European Psychiatrists, 65(1), e51. https://doi.org/10.1192/j.eurpsy.2022.2309

[122] Office for National Statistics. (2026, February 13). The effect of NHS Talking Therapies on monthly employee pay and employment status, England: April 2014 to December 2022. ONS

[123] Southby, K., Bidey, T., Grimes, D., Khor, Z., South, J., & Bagnall, A. (2022). Together through tough times: A qualitative study of community resilience to protect against mental health issues in the UK. Journal of Public Mental Health, 21(4), 279–287.

[124] NHS England. (2019). NHS mental health implementation plan 2019/20–2023/24.

[125] Hughson, H. (2024). *Pregnant then blue? The value of MumsAid counselling for new and expectant mothers.* Pro Bono Economics.

[126] Duncan, C., Rayment, B., Kenrick, J., & Cooper, M. (2020). Counselling for young people and young adults in the voluntary and community sector: An overview of the demographic profile of clients and outcomes. *Psychology and Psychotherapy: Theory, Research and Practice, 93*(1), 36-53.

[127] UK Parliament. (2022). *Written evidence submitted by the British Association for Counselling and Psychotherapy (ELC0073)*. https://committees.parliament.uk/writtenevidence/55424/html/

[128] British Association for Counselling and Psychotherapy. (2026). *BACP public perceptions survey.* https://www.bacp.co.uk/about-us/about-bacp/bacp-public-perceptions-survey/

[129] Canadian Psychological Association. (n.d.). *Licensure (regulation) of the practice of psychology.* https://cpa.ca/practice/practiceregulation/

[130] Australian Health Practitioner Regulation Agency. (2020). Statement on misuse of protected titles. https://www.ahpra.gov.au/News/2020-02-26-statement-on-misuse-of-protected-titles.aspx

[131] Irish Council for Psychotherapy. (2025). *CORU consultation response/position statement.* https://psychotherapy-ireland.com

[132] Irish Association for Counselling and Psychotherapy. (2025). *Response to the Counsellors and Psychotherapists Registration Board education standards.* https://iacp.ie/

[133] Partnership of Counselling and Psychotherapy Bodies. (2025). SCoPEd framework: A shared framework for the scope of practice and education for counselling and psychotherapy with adults (January 2022, amended 2025). https://www.pcpb.org.uk/wp-content/uploads/2025/08/SCoPEd-Framework-January-2022-amended-2025.pdf

[134] Professional Standards Authority. (2025). *About Accredited Registers.* https://www.professionalstandards.org.uk/organisations-we-oversee/our-work-accredited-registers/about-accredited-registers

[135] Professional Standards Authority. (2025). *Our work: Accredited Registers*. https://www.professionalstandards.org.uk/organisations-we-oversee/our-work-accredited-registers

[136] The King's Fund. (2024). *Mental health 360: Workforce*. https://www.kingsfund.org.uk/insight-and-analysis/long-reads/mental-health-360-workforce

[137] Royal College of Psychiatrists. (2020). *Workforce strategy*. https://www.rcpsych.ac.uk/improving-care/workforce/workforce-strategy

[138] NHS England. (2023). *NHS Long Term Workforce Plan.* https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/

[139] The King's Fund. (2024). *NHS workforce in a nutshell.* https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/nhs-workforce-nutshell

[140] BBC News. (2025). *Mental health conditions are overdiagnosed, Streeting says.* BBC News. https://www.bbc.co.uk/news/articles/cd7ejvr3y0zo

[141] Rethink Mental Illness. (2025). *Our response to the Health Secretary's claim that mental illnesses are being "overdiagnosed".* https://www.rethink.org/news-and-stories/news-and-views/2025/our-response-to-the-health-secretary-s-claim-that-mental-illnesses-are-being-overdiagnosed/

[142] Mental Health Foundation. (2025). *Mental Health Foundation responds to Health Secretary's 'overdiagnosis' comment.* https://www.mentalhealth.org.uk/about-us/news/mental-health-foundation-responds-health-secretarys-overdiagnosis-comment

[143] Streeting, W. (2025). *I realise now that my view on mental health overdiagnosis was divisive. We all need better evidence.* The Guardian. https://www.theguardian.com/commentisfree/2025/dec/04/wes-streeting-mental-health-problems-review

[144] Department of Health and Social Care. (2026). *Independent review into mental health conditions, ADHD and autism: Final report.* GOV.UK. https://www.gov.uk/government/publications/independent-review-into-mental-health-conditions-adhd-and-autism-final-report

[145] Prime Minister's Office, 10 Downing Street, & Burnham, A. (2026). Andy Burnham's first speech as Prime Minister: 20 July 2026. GOV.UK.

[146] Department of Health and Social Care. (2026). Major expansion of community mental health support across England. GOV.UK.

[147] Charura, D., & Lago, C. (Eds.). (2016). White therapies, black identities: Teaching, training and practice. Routledge.

[148] Khan, M. (2023). Working within diversity: A reflective guide to anti-oppressive practice in counselling and therapy. Jessica Kingsley Publishers. 12

[149] British Association for Counselling and Psychotherapy. (2024). Bridging the gaps: Exploring the experiences of racialised and ethnically diverse communities in counselling and psychotherapy.

[150] NHS England. (2024). Advancing mental health equalities in NHS Talking Therapies for anxiety and depression

[151] Levitt, H. M., Hamburger, A., Hill, C. E., McLeod, J., Pascual-Leone, A., Timulak, L., Buchholz, M. B., Frommer, J., Fuertes, J., Iwakabe, S., Martínez, C., Morrill, Z., Knox, S., Langer, P., Muran, J. C., Weie Oddli, H., Řiháček, T., Tomicic, A., & Tuval-Mashiach, R. (2025). Broadening the evidentiary basis for clinical practice guidelines: Recommendations from qualitative psychotherapy researchers. The American psychologist, 80(3), 389–410.

[152] Munder, T., Brütsch, O., Leonhart, R., Gerger, H., & Barth, J. (2013). Researcher allegiance in psychotherapy outcome research: an overview of reviews. Clinical psychology review, 33(4), 501-511.

[153] Philips, B., & Falkenström, F. (2021). What Research Evidence Is Valid for Psychotherapy Research? Frontiers in psychiatry, 11, 625380.

[154] Cook, S. C., Schwartz, A. C., & Kaslow, N. J. (2017). Evidence-Based Psychotherapy: Advantages and Challenges. Neurotherapeutics: the journal of the American Society for Experimental Neurotherapeutics, 14(3), 537–545.

[155] National Institute for Health and Care Excellence. (2022). NICE real-world evidence framework (ECD9). https://www.nice.org.uk/corporate/ecd9/resources/nice-realworld-evidence-framework-pdf-1124020816837

[156] National Institute for Health and Care Excellence. (2022). *Depression in adults: Treatment and management (NICE Guideline NG222).* https://www.nice.org.uk/guidance/ng222/chapter/Recommendations

[157] NHS England. (2024). *Planning and implementing real-world artificial intelligence (AI) evaluations: Lessons from the AI in Health and Care Award.* https://www.england.nhs.uk/long-read/planning-and-implementing-real-world-ai-evaluations-lessons-from-the-ai-in-health-and-care-award/

[158] NHS England. (2026). *NHS accelerates artificial intelligence rollout to cut waiting times and improve care for millions.* https://www.england.nhs.uk/2026/07/nhs-accelerates-artificial-intelligence-rollout-to-cut-waiting-times-and-improve-care-for-millions/

[159] Enock, F., & Margetts, H. (2026). Large language models in the UK: *Public trust and attitudes. Oxford Internet Institute.* https://www.oii.ox.ac.uk/news-events/reports/large-language-models-in-the-uk-public-trust-and-attitudes/

[160] *Self-Administered Interventions Based on Natural Language Processing Models for Reducing Depressive and Anxiety Symptoms: Systematic Review and Meta-Analysis.* (2024). JMIR Mental Health, 11, e59560. https://doi.org/10.2196/59560

[161] National Institute for Health and Care Excellence. (2022). *Evidence standards framework for digital health technologies.* https://www.nice.org.uk/corporate/ecd7

[162] Guo, Z., Lai, A., Thygesen, J. H., Farrington, J., Keen, T., & Li, K. (2024). *Large language models for mental health applications: Systematic review. JMIR Mental Health, 11,* e57400. https://doi.org/10.2196/57400

[163] World Health Organization. (2021). *Ethics and governance of artificial intelligence for health.* https://www.who.int/publications/i/item/9789240029200

[164] Medicines and Healthcare products Regulatory Agency. (2025). *Software and artificial intelligence (AI) as a Medical Device: Regulatory guidance.*

[165] Golden, A., & Aboujaoude, E. (2026). A transdiagnostic model for how general purpose AI chatbots can perpetuate OCD and anxiety disorders. npj Digital Medicine, 9, Article 137. https://doi.org/10.1038/s41746-026-02531-7

[166] Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work (2nd ed.). Routledge.*

[167] Rogers, C. R. (1957). *The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 21*(2), 95–103. https://doi.org/10.1037/h0045357

[168] NHS England. (2025). *Guidance on the use of AI-enabled ambient scribing products in health and care settings* (Version 2). https://www.england.nhs.uk/long-read/guidance-on-the-use-of-ai-enabled-ambient-scribing-products-in-health-and-care-settings/

[169] Tavory, T. (2024). Regulating AI in mental health: Ethics of care perspective. JMIR Mental Health, 11, e58493. https://doi.org/10.2196/58493

[170] World Health Organization. (2026). Towards responsible AI for mental health and well-being: Experts chart a way forward.

[171] NCPS' "Principles for relational safeguards in AI mental health tools" provides a framework for assessing the ethical implications of the use of artificial intelligence in mental health settings.

[172] National Institute for Health and Care Excellence. (2019). Service user experience in adult mental health services: Quality statement 3—Involvement to improve services (QS14). https://www.nice.org.uk/guidance/qs14/chapter/quality-statement-3-involvement-to-improve-services

[173] Social Care Institute for Excellence. (2026). *Co-production*.

[174] NHS England. (2023). Co-production: An introduction. https://www.england.nhs.uk/long-read/co-production-an-introduction/

[175] Health Research Authority. (2025). Best practice principles of public involvement. https://www.hra.nhs.uk/planning-and-improving-research/best-practice/public-involvement/principles-public-involvement

[176] McCall, A., Temple, P., Rose, R., Keohane, P., & Hewitt-Johns, L. (2026). Exploring the experience of co-designing mental health services in the National Health Service as an Expert by Experience. Mental Health Review Journal, 31(1), 63–74. https://doi.org/10.1108/MHRJ-08-2025-0062

[177] Mayer, C., & McKenzie, K. (2017). '… it shows that there's no limits': The psychological impact of co-production for experts by experience working in youth mental health. Health & Social Care in the Community, 25(3), 1181–1189. https://doi.org/10.1111/hsc.12418

[178] https://www.pcpb.org.uk/wp-content/uploads/2025/08/SCoPEd-Framework-January-2022-amended-2025.pdf

[179] SELCS - University of Warwick (School of Education, Learning and Communication Sciences). (2026). We were delighted to celebrate this year's Counselling and Psychotherapy Student Research Conference [LinkedIn post]. LinkedIn. https://www.linkedin.com/posts/university-of-warwick-school-of-education-learning-and-communication-sciences_warwick-selcs-counselling-activity-7469744373547737090-8YUf/

[180] Medical Research Foundation. (2026). SMaRteN Conference 2026: Shining a spotlight on eating disorders. https://www.medicalresearchfoundation.org.uk/projects/smarten-conference-2026-a-spotlight-on-eating-disorder

[181] Disability Rights UK. (2026). *Adjustments for disabled students and apprentices.* https://www.disabilityrightsuk.org/resources/adjustments-disabled-students-and-apprentices

[182] Donahue, K., Rooney, K., & Jochum, V. (2020). *Time Well Spent: Diversity and volunteering.* National Council for Voluntary Organisations. https://www.ncvo.org.uk/news-and-insights/news-index/time-well-spent-diversity-and-volunteering/

[183] Department of Health and Social Care. (2026). *Community mental health services: Government's response to the Health and Social Care Committee's report.* Department of Health and Social Care. https://www.gov.uk/government/publications/community-mental-health-services-governments-response-to-the-health-and-social-care-committees-report

[184] Department of Health, Public Health England, & NHS England. (2016). *Joint review of partnerships and investment in voluntary, community and social enterprise organisations in the health and care sector: Final report.* Department of Health. https://www.gov.uk/government/publications/review-of-partnerships-and-investment-in-the-voluntary-sector

[185] Centre for Women's Justice. (2024). *CWJ applauds courage of Ella Janneh and welcomes the judgment in her civil claim against sex therapist Mike Lousada.* https://www.centreforwomensjustice.org.uk/news/2024/6/19/cwj-applauds-courage-of-ella-janneh-and-welcomes-the-judgment-in-her-civil-claim-against-sex-therapist-mike-lousada

[186] Leigh Day. (2024). *Ella Janneh wins her civil claim for sexual assault against sex therapist* Mike Lousada.

[187] BBC News. (2024, December 6). *Ella Janneh: Victim urges tougher regulation for therapists.* https://www.bbc.co.uk/news/articles/clykr7zex68o

[188] Thomas, R. (2024). *Celebrity TV sex therapist who regressed patient into childlike state loses civil rape case.* The Independent. https://www.independent.co.uk/news/health/tv-sex-therapist-mike-lousada-rape-b2564781.html

[189] Johnson, M., & Reid, R. (2025). *Clamping down on quack counsellors*. Law Gazette. https://www.lawgazette.co.uk/features/clamping-down-on-quack-counsellors/5122105.article

[190] Nursing and Midwifery Council. (2026). *Insight into fitness to practise* (January 2026).

[191] Naulls, S., & Lally, C. (2025). *Regulation of psychological professionals in mental health care* (POST Rapid Response No. 85). Parliamentary Office of Science and Technology. https://doi.org/10.58248/RR85

[192] Newlands, G., & Lutz, C. (2024). Occupational prestige and occupational social value in the United Kingdom: New indices for the modern British economy. Research in Social Stratification and Mobility, 91, 100935. https://doi.org/10.1016/j.rssm.2024.100935

[193] Larson, M. S. (2022). The rise of professionalism: A sociological analysis. University of California Press. (Original work published 1977)

[194] Koumenta, M., Humphris, A., Kleiner, M. M., & Pagliero, M. (2014). Occupational regulation in the EU and UK: Prevalence and labour market impacts. Department for Business,

[195] Nursing and Midwifery Council. (2020). *Ambitious for change: Research into NMC processes and people's protected characteristics.*

[196] General Medical Council. (2026). Fitness to practise of doctors explained.

[197] Department of Health and Social Care. (2025). *Fit for the future: 10 Year Health Plan for England.* GOV.UK. https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future

[198] Skivington, K., Matthews, L., Simpson, S. A., Craig, P., Baird, J., Blazeby, J. M., ... & Moore, L. (2021). *A new framework for developing and evaluating complex interventions: Update of Medical Research Council guidance.* BMJ, 374, n2061. https://doi.org/10.1136/bmj.n2061

[199] The King's Fund. (2024). *Mental health 360: Workforce.* https://www.kingsfund.org.uk/insight-and-analysis/long-reads/mental-health-360-workforce

[200] The King's Fund. (2025). *NHS workforce in a nutshell.* https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/nhs-workforce-nutshell

[201] NHS England / NHS Digital. Adult Psychiatric Morbidity Survey (APMS).

[202] DHSC (2026) Independent review into mental health conditions, ADHD and autism: interim report. https://www.gov.uk/government/publications/independent-review-into-mental-health-conditions-adhd-and-autism-interim-report

[203] NHS England. Mental Health of Children and Young People in England Survey.

[204] Office for National Statistics. Economic inactivity because of long-term sickness.

[205] Health and Safety Executive. (2025). Work-related stress, depression or anxiety statistics in Great Britain, 2025. https://www.hse.gov.uk/statistics/assets/docs/stress.pdf

[206] NHS England (2025) *NHS Talking Therapies for Anxiety and Depression: Annual Report 2024/25.* London: NHS England.

[207] Department for Health and Social Care (2025) *10 Year Health Plan for England.* London: DHSC

[208] NHS England (2025) Neighbourhood Health Services: *Implementation Guidance.* London: NHS England.

[209] NHS England (2025) *24/7 Neighbourhood Mental Health Centres: Learning from the National Pilot Sites.* London: NHS England.

[210] NHS England (2025) *24/7 Neighbourhood Mental Health Centres.* London: NHS England.

[211] NHS England and Department of Health and Social Care (2025) *Neighbourhood Health Guidelines.* London: NHS England.

[212] Department of Health and Social Care (2026). *Major expansion of community mental health support across England* Available at https://www.gov.uk/government/news/major-expansion-of-community-mental-health-support-across-england

[213] Department of Work and Pensions (2024) *Get Britain Working White Paper.* London: DWP.

[214] Mayfield, C. (2025) *Keep Britain Working Review.* London: Department of Work and Pensions.

[215] Milburn, A. (2025) *Youth Employment and Mental Health Review.* London: Department of Work and Pensions.

[216] Noret, N., & Hillyard, S. (2026). *The impact of Survive - Support for Survivors of Rape and Sexual Abuse: An Independent Evaluation.* Zenodo. https://doi.org/10.5281/zenodo.20126357

[217] National Collaborating Centre for Mental Health (2024) *Psychological Therapies Evidence Review.* London: NCCMH

[218] Bagri, S. (2024). *Does the NHS Talking Therapies service have an attrition problem?* Nuffield Trust. https://www.nuffieldtrust.org.uk/news-item/does-the-nhs-talking-therapies-service-have-an-attrition-problem

[219] University College London. (2025). *NHS talking therapy is less effective for younger adults.* UCL News. https://www.ucl.ac.uk/news/2025/aug/nhs-talking-therapy-less-effective-younger-adults

[220] Mizen, S., Rost, F., & Cardoso, F. (2025). *Improving support for people with complex mental health difficulties.* Centre for Mental Health

[221] British Association for Counselling and Psychotherapy (BACP) (2024) *Bridging the gaps: the positive impact of third sector counselling services and the challenges they face.* Available at: https://www.bacp.co.uk/media/21907/bridging-the-gaps-report.pdf

[222] Mental Health Foundation and London School of Economics and Political Science (2022), The economic case for investing in the prevention of mental health conditions in the UK, February 2022.

[223] Audit Scotland (2023) Adult Mental Health, September 2023

[224] Scottish Government (2026) Programme for Government 2026 to 2031 https://www.gov.scot/publications/programme-government-2026-2031/pages/5/

[225] Scottish Government and COSLA. (2026). *Mental health and Wellbeing Delivery Plan*. https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2026/09/mental-health-wellbeing-delivery-plan/documents/mental-health-wellbeing-delivery-plan/mental-health-wellbeing-delivery-plan/govscot%3Adocument/mental-health-wellbeing-delivery-plan.pdf

[226] Public Health Scotland. (2026). Psychological therapies waiting times - Quarter ending March 2026- available at https://publichealthscotland.scot/publications/psychological-therapies-waiting-times/psychological-therapies-waiting-times-quarter-ending-march-2026/

[227] Public Health Scotland. (2026) Child and Adolescent Mental Health Services (CAMHS) waiting times. Available at https://publichealthscotland.scot/publications/child-and-adolescent-mental-health-services-camhs-waiting-times/child-and-adolescent-mental-health-services-camhs-waiting-times-quarter-ending-march-2026/

[228] Scottish Government & COSLA (2023), Mental Health and Wellbeing Workforce Action Plan 2023-2025, Nov 2023 – available at https://www.gov.scot/publications/mental-health-wellbeing-workforce-action-plan-2023-2025/

[229] PCPB estimation drawn from membership numbers of BACP (4100), COSCA (787) and an estimation of the other professional bodies operating in Scotland

[230] NHS Education for Scotland (2026), The Matrix - A guide to delivering evidence-based psychological therapies in Scotland, May 2026 https://www.nes.scot.nhs.uk/our-work/matrix-a-guide-to-delivering-evidence-based-psychological-therapies-in-scotland/

[231] Scottish Government (2018), Programme for Government (2018-19) available at https://www.gov.scot/publications/delivering-today-investing-tomorrow-governments-programme-scotland-2018-19/

[232] Scottish Government (2026), "Children and young people mental health services: school counselling and community support, January 2026 – available at https://www.gov.scot/publications/children-and-young-people-mental-health-services-school-counselling-and-community-support/pages/school-counselling-services/

[233] Scottish Government (2018), Programme for Government (2018-19)

[234] Scottish Funding Council (2025), Additional Counsellor Funding: Outcomes and Impact 2022-23, January 2025 https://www.sfc.ac.uk/wp-content/uploads/2025/01/Additional-Counsellor-Funding-Outcomes-and-Impact-2022-23-FINAL-VERSION.pdf

[235] Welsh Government. (2025). *NHS expenditure programme budgets: April 2023 to March 2024.* https://www.gov.wales/nhs-expenditure-programme-budgets-april-2023-march-2024-html

[236] Welsh Government (2026). National Survey for Wales (Mental Wellbeing dataset).

[237] Public Health Wales (2026) *Mental Wellbeing in Wales*

[238] Welsh Government (2025). *Chief Medical Officer for Wales Annual Report*

[239] NHS Wales. (2023). *Local services.* https://www.nhs.wales/hpb/local-services/

[240] NHS Wales Performance and Improvement. (2023). *Strategic Programme for Mental Health.* https://performanceandimprovement.nhs.wales/functions/strategic-programme-for-mental-health/

[241] Welsh Government (2025). Mental Health and Wellbeing Strategy 2025–2035.

[242] Welsh Government (2024). NEST Framework: Helping Children, Young People and their Families.

[243] Welsh Government (2014), Social Services and Well-being (Wales) Act 2014.

[244] Department of Health (2021) Mental Health Strategy https://www.health-ni.gov.uk/publications/mental-health-strategy-2021-2031

[245] Independent Reporting Commission. (2025). Seventh report (HC 704). https://www.ircommission.org/files/ircommission/2025-02/IRC%20Seventh%20Report.pdf

[246] Northern Ireland Audit Office (2023). Mental Health Services in Northern Ireland. Available at https://www.niauditoffice.gov.uk/publications/html-document/mental-health-services-northern-ireland

[247] Tomlinson, M. (2012). War, peace and suicide: The case of Northern Ireland. International Sociology, 27(4), 464-482. https://doi.org/10.1177/0268580912443579

[248] Mental Health Foundation (2022) 'The economic case for investing in the prevention of mental health conditions in the UK', available at https://www.mentalhealth.org.uk/about-us/news/mental-health-problems-cost-northern-ireland-least-gbp-34-billion-year

[249] Northern Ireland Audit Office. (2023). *Mental health services in Northern Ireland.* https://www.niauditoffice.gov.uk/publications/html-document/mental-health-services-northern-ireland

[250] Mental Health Champion Northern Ireland. (2023). *Professor Siobhan O'Neill speaks: Mental health services "struggling" as waiting lists grow.* https://www.mentalhealthchampion-ni.org.uk/news/professor-siobhan-oneill-speaks-mental-health-services-struggling-waiting-lists-grow

[251] Sheils, C. (2025). *Northern Ireland ranks bottom in UK mental health spending.* The Irish News. https://www.irishnews.com/news/northern-ireland/northern-ireland-ranks-bottom-in-uk-mental-health-spending-AM352JT7TZFUDLRASSJOSYZPQI/

[252] Royal College of Psychiatrists in Northern Ireland. (2025). *Response to Department of Finance consultation on draft budget 2025–2026.* Royal College of Psychiatrists. https://www.rcpsych.ac.uk/docs/default-source/members/devolved-nations/rcpsych-in-northern-ireland/consultations-2025/rcpsych-ni-march-25-response-to-dof-consultation-on-draft-budget-2025-2026-(002).pdf

[253] Department of Health, Northern Ireland. (2025). *Health and Social Care Reset Plan.* https://www.health-ni.gov.uk/publications/health-and-social-care-reset-plan

[254] Department of Health Northern Ireland (2026) *Mental Health Strategy Delivery Plan for 2026/27* https://www.health-ni.gov.uk/news/mental-health-strategy-delivery-plan-202627-published

[255] Evaluation undertaken by ICSS Service Provider

[256] https://www.health-ni.gov.uk/publications/northern-ireland-mental-health-services-workforce-review-2022-2032

[257] https://www.health-ni.gov.uk/publications/northern-ireland-mental-health-services-workforce-review-2022-2032

[258] Northern Ireland Audit Committee (2023) - Mental Health Services in Northern Ireland, May 2023

[259] Department of Health (2025), "NI Mental Health Strategy: A Review of the Deliverability of the Strategy's Actions 2026-2029"

[260] Department of Health (2025), Health and Social Care NI Reset Plan. Available at: https://www.health-ni.gov.uk/sites/default/files/2025-07/HSC%20RESET%20final_0.pdf

[261] PCPB Shared Membership Data, January 2026

[262] PCPB Commission Survey, January-March 2026

[263] Rethink (2025) Right Treatment, Right Time. https://www.rethink.org/media/hpapzday/right-treatment-right-time-2025-report.pdf [accessed 8th September 2026]

[264] Mental Health Foundation (2026) The Foundation Reports: The State of Mental Health Inequality in the UK https://reports.mentalhealth.org.uk/foundation-reports/june-2026/report/ [accessed 8 September 2026]

[265] PCPB Commission Survey, January to March 2026 [2,588 respondents to this question who also indicated they're qualified to practise at time of answering]

[266] Mental Health Foundation (2026) The Foundation Reports: The State of Mental Health Inequality in the UK https://reports.mentalhealth.org.uk/foundation-reports/june-2026/report/ [accessed 8th September 2026]

[267] Health Careers. Agenda for Change – Pay Rates. https://www.healthcareers.nhs.uk/working-health/working-nhs/nhs-pay-and-benefits/agenda-change-pay-rates [accessed 14th September 2026]

[268] Office for National Statistics (2025) Population Estimates. https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates [Accessed: 17th September 2026]

[269] NHS Employers (2026) NHS Terms and Conditions of Service Handbook: Amendment number 62 – TCS Advisory Notice (03/2026). https://www.nhsemployers.org/publications/tchandbook [Accessed: 14 September 2026]

[270] NHS Employers (2026) NHS Terms and Conditions of Service Handbook: Amendment number 62 – TCS Advisory Notice (03/2026). https://www.nhsemployers.org/publications/tchandbook [Accessed: 14 September 2026]

[271] Scottish Terms and Conditions Committee. Annual Leave and Public Holidays. https://www.stac.scot.nhs.uk/annual-leave-and-public-holidays [Accessed: 14 September 2026]

[272] NHS Employers (2026) NHS Terms and Conditions of Service Handbook: Amendment number 62 – TCS Advisory Notice (03/2026). https://www.nhsemployers.org/publications/tchandbook [Accessed: 14 September 2026]

[273] NHS Employers (2025) Public Holidays and Time Off in Lieu Guidance. https://www.nhsemployers.org/publications/public-holidays-and-time-lieu-guidance [Accessed: 15th September 2026]

[274] HSCNI. Public Holidays and Leave. https://jobs.hscni.net/Information/7/public-holidays-and-leave [Accessed: 15th September 2026]

[275] Scottish Government. NHS Scotland Annual Leave Policy for Agenda for Change Staff. https://www.publications.scot.nhs.uk/files/dl-2024-07.pdf [Accessed: 15th September 2016]

[276] Welsh Government (2021) Written Statement: Pay Enhancements for NHS Staff for 2021-22. https://www.gov.wales/written-statement-pay-enhancements-nhs-staff-2021-22 {Accessed: 15th September 2026]

[277] (May 2025-May 2026) https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

[278] (1 Apr 2024-31 Mar 2025) https://belfasttrust.hscni.net/wp-content/uploads/wpfd/preview_files/Belfast-Trust-Annual-Report-24-25%2844ae4524880502f96721515663652d04%29.pdf

[279] (1 Apr 2024-31 Mar 2025) https://www.northerntrust.hscni.net/wp-content/uploads/2025/07/Annual-Accounts-2024-2025.pdf

[280] (1 Apr 2024-31 Mar 2025) https://setrust.hscni.net/about-the-trust/publications/#234-235-annual-report

[281] (1 Apr 2024-31 Mar 2025) https://southerntrust.hscni.net/download/26/annual-reports/22916/aqr-2024-25.pdf

[282] (1 Apr 2024-31 Mar 2025) https://westerntrust.hscni.net/wp-content/uploads/wpfd/preview_files/WHSCT-Annual-Report-and-Accounts-24_2025-070725%2896c17354424631e0b919564012db2624%29.pdf

[283] (1 Apr 2024-31 Mar 2025) https://nias.hscni.net/download/21/annual-reports/9875/nias-annual-report-and-accounts-2024-25.pdf

[284] (1 Apr 2024-31 Mar 2025) https://turasdata.nes.nhs.scot/media/4gufho45/workforcereport_june2025-no-medical-agency.pdf

[285] (1 Apr 2024-31 Mar 2025) https://www.llyw.cymru/absenoldeb-oherwydd-salwch-y-gig-ionawr-i-fawrth-2025-html

[286] https://www.healthcareers.nhs.uk/working-health/working-nhs/nhs-pay-and-benefits/agenda-change-pay-rates

[287] https://questions-statements.parliament.uk/written-questions/detail/2019-09-02/284394

[288] Calculated as Total Employment Cost/ Annual FTE Sessions Deliverable

[289] https://jobs.hscni.net/information/8/pay-bands-in-health-social-care

[290] https://hscpensions.hscni.net/hsc-pension-scheme/hsc-pension-members-section/membership-contributions-pay

[291] https://questions-statements.parliament.uk/written-questions/detail/2019-09-02/284394

[292] Calculated as Total Employment Cost/ Annual FTE Sessions Deliverable

[293] https://www.gov.scot/publications/nhs-staff-pay/

[294] https://pensions.gov.scot/nhs/employers/employer-contributions

[295] https://questions-statements.parliament.uk/written-questions/detail/2019-09-02/284394

[296] Calculated as Total Employment Cost/ Annual FTE Sessions Deliverable

[297] https://www.nhs.wales/files/pc-resources/afc-w-02-2026-pdf-pdf/

[298] https://www.legislation.gov.uk/uksi/2015/94/note/

[299] https://questions-statements.parliament.uk/written-questions/detail/2019-09-02/284394

[300] Calculated as Total Employment Cost/ Annual FTE Sessions Deliverable

[301] https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dash

[302] https://www.niassembly.gov.uk/globalassets/documents/committees/2022-2027/pac/reports/2023-2024/mental-health-services/pac-report-on-mental-health-services-in-northern-ireland.pdf

[303] https://www.parliament.scot/about/news/news-listing/health-committee-launches-call-for-views-on-mental-health-budget

[304] https://www.gov.wales/nhs-expenditure-programme-budgets-april-2023-march-2024-html

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