

## IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES IN: A NATIONAL INITIATIVE TO ENSURE THE DELIVERY OF HIGH QUALITY EVIDENCE-BASED THERAPIES

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IAPT Programme

*Access to psychological therapies for people presenting with common mental health problems within the United Kingdom has tended to be poor and limited by the quality of local services. This is especially the case for people presenting to their general practitioner within primary care who historically have been faced with the unacceptable choice of either only medication or referral to psychological interventions but with the proviso of long waiting times, frequently in excess of 12 months.*

*Recent progress around the development of evidence based clinical guidelines within the UK, has meant that psychological therapies have been recommended as both highly effective, relatively safe and economically viable for a wide range of common mental health problems, particularly anxiety and depression. At the same time the significant costs to individuals and Society in terms of the adverse consequences of poor mental health on well-being, capacity to work and the economic impacts on both the health system generally and more specifically the exchequer, in the form of incapacity benefits and payments, has become more widely appreciated.*

*This paper describes the rationale behind and the implementation of a national programme of government investment, Improving Access to Psychological Therapies, within England, to provide a choice of well-resourced, evidence based psychological therapies to those individuals in primary care who experience common mental health problems, and to support generally their recovery and functioning within employment and Society.*

**Keywords:** Psychological therapy, anxiety, depression, primary care, access

*El acceso a las terapias psicológicas para las personas que presentan los problemas de salud mental comunes en el Reino Unido ha tendido a ser pobre y limitado por la calidad de los servicios locales. En especial, este es el caso de las personas que acuden al médico de familia en Atención Primaria, el cual históricamente ha tenido que hacer la inaceptable elección de hacer uso sólo de la medicación o bien de derivar el caso para una intervención psicológica; pero con la condición de largos plazos de espera que, con frecuencia, exceden a los 12 meses.*

*Los recientes progresos en el desarrollo de directrices clínicas basadas en datos, en el Reino Unido, ha significado que las terapias psicológicas han sido recomendadas por ser a la vez altamente efectivas, relativamente seguras y económicamente viables, para un amplio rango de problemas comunes de salud mental; especialmente ansiedad y depresión. Al mismo tiempo, ha sido ampliamente apreciado por los significativos costes para las personas y para la sociedad, en cuanto a las adversas circunstancias que tiene una pobre salud mental sobre el bienestar, la capacidad de trabajo y el impacto económico, tanto para el sistema de salud en general como especialmente para el erario público, en forma de prestaciones y pagos por incapacidad.*

*Este artículo describe el fundamento teórico subyacente y la puesta en práctica del programa nacional de inversión gubernamental, Mejorando el Acceso a Terapias Psicológicas (Improving Access to Psychological Therapies) en Inglaterra, para ofrecer la elección de terapias psicológicas basadas en datos, con buenos recursos, a aquellas personas que experimentan problemas de salud mental comunes en atención primaria, y generalmente para apoyar su recuperación y funcionamiento en el trabajo y en la sociedad.*

**Palabras clave:** Terapia psicológica, ansiedad, depresión, atención primaria, acceso.

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**T**he purpose of this paper is describe the rationale, design and implementation of a national programme, Improving Access to Psychological Therapies, co-ordinated by the Department of Health in England<sup>1</sup> and initiated in October 2007 to invest over 200m euros over the next three years in widening access to psychological therapies within primary care (<http://www.iapt.nhs.uk>). The investment in mental health services globally has failed to match the demand for service to adequately provide effective treatments (Andrews & Tolkein II Team, 2006). This has been particularly the case for psychological treatments for common mental health problems such as anxiety and depression. Despite the production of clinical guidelines by National Institute of Clinical Excellence (NICE) within England, (<http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7281>), recommending these treatments as generally safe and effective, many people seen by their general practitioner within primary care have either been offered the choice of *only* medication or having to endure long waiting times for psychological treatments due to the scarcity of trained psychological therapists. The Improving Access to Psychological Therapies (IAPT) programme seeks to redress these inequalities and offer access to all those patients experiencing common mental health problems.

## BACKGROUND

Equitable and timely access to evidence-based psychological therapies has the potential to improve radically the lives of many UK citizens; alleviating distress in individuals and families, promoting well-being and understanding of mental illness, reducing stigma, and supporting people in the workplace and to return to work. Although counselling, psychotherapy and psychology services have been available through the National Health Service (NHS) within the UK for at least the last three decades, it has been only recently that these services have started to attract the degree of attention from service users and commissioners that they deserve. There are many reasons why access to psychological therapies is now regarded as a priority area. These include its effectiveness, demonstrated through the publication of

National Institute for Health and Clinical Excellence (NICE) guidelines, patient choice in wanting greater access to talking therapies (Department of Health, 2006; Department of Health, 2004; Rankin, 2005; SCMH, 2006), and the socio-economic benefits on individuals' wellbeing and the nation's wealth in the form of its impacts on disability and welfare benefits, as recently argued by Lord Richard Layard (Layard et al, 2006; Layard, 2006). The cost of mental ill-health on productivity in work and 'presenteeism' has been emphasised recently by the Sainsbury Centre for Mental Health (2007) as exceeding the overall costs of disability and benefits.

It is perhaps worth questioning why psychological therapy services have failed to thrive in the past. Possible reasons include a lack of recognition of the efficacy of psychological treatments; inter-professional rivalries and a lack of clear leadership; few distinct models of service organisation and delivery; a myriad of qualifications and professional accreditation bodies, a lack of statutory regulation within the UK; poor access to education and training in psychological therapies for NHS staff, and poor workforce information on psychotherapy delivery. Many of these issues are still relevant today, though an emphasis on ensuring equitable access to therapies is proving an effective force in removing these obstacles through the IAPT programme.

The new IAPT services will be provided by a range of professionals including psychologists, together with professionally non-aligned staff, particularly within the third sector (i.e. voluntary and charitable organisations). They will be located across a range of primary and secondary care services; they will involve NHS and third sector providers, and it is likely that no single model of service delivery will satisfy either the individual requirements of local health communities or those responsible for commissioning (i.e. planning and purchasing) such services. Although local commissioners will ultimately determine how these services are delivered on the ground, the IAPT Programme has established a clear service specification articulated through the National Implementation Plan and the

<sup>1</sup> The IAPT programme is essentially an England only programme since the responsibility for health care lies with the individual legislatures of each of the devolved nations within the UK. For one perspective of developments in Scotland, readers might wish to refer to the innovative STEPS programme (White, 2008)



Commissioning Toolkit (<http://www.iapt.nhs.uk/publications/>); nationally available documentation provided to guide the design and delivery of these new services. A major distinguishing feature of these services will be their commitment to collect session-by-session standardised outcome data from all patients seen within the service. The implementation of these new services are overseen clinically by the National Clinical Adviser: Professor David Clark from the Institute of Psychiatry, Kings College, London.

Over the next three years the IAPT programme seeks to train an additional 3,600 therapists competent in both high and low intensity interventions (see next section), treat an additional 900,000 patients and establish over 100 new IAPT services within primary care. To date, in the first year of the programme, around 24 new training providers have been commissioned to train the first wave of over 700 therapists, and 34 primary care trusts have been selected to be the first IAPT implementer services delivering enhanced psychological therapies throughout the 10 strategic health authority regions of England.

Having provided the background and overview to the implementation of the IAPT programme, we offer a brief review of stepped and collaborative care services, which we believe will be a major organising principle around the development of IAPT services. We will review the evidence collated to date and also set out to examine the implications of the IAPT programme on the existing workforce within both primary care and more traditional psychotherapy services.

### MODELS OF SERVICE DELIVERY

One of the most important determinants of access to psychological therapies, in addition to the resources that are invested, is how these resources are organised within models of service delivery. A major feature of IAPT services is the 'stepped-care model', which is represented in various different guises within recent NICE guidelines, and also forms the basis of the service specification (<http://www.iapt.nhs.uk>). The implementation of the model with respect to current service delivery is illustrated at two demonstration sites located at Newham and Doncaster, and established in the last three years by the IAPT programme. We will briefly review the development of the Doncaster model, which was designed following reviews of three principle sources of evidence - the clinical

effectiveness of low- and high-intensity variants of cognitive behaviour therapy (CBT), the organisational effectiveness of collaborative care, and the evidence for stepped care. These evidence bases were used to design a model of care that would explicitly reflect the philosophy of primary care and public health. Treatment had to be delivered according to these principles, and was explicitly focused on delivering care to high volumes of people. The Doncaster model had to be able to accommodate an expected referral volume of greater than 5000 clients per annum.

*The clinical effectiveness of low and high-intensity variants of CBT.* The most recent reviews of psychological therapies conducted by NICE (National Institute for Clinical Excellence 2004a; 2004b) recommend CBT for both depression and anxiety. Although CBT is not the only recommended psychological treatment, the skill set and clinical materials necessary for its delivery are much more readily available among clinical and educational providers than those for other alternatives (such as interpersonal therapy for depression). One advantage in choosing CBT at Doncaster is that variants have been developed that can be characterised as both low-intensity and high-intensity. This allows the same theoretically consistent and empirically valid treatment to be delivered in different formats and settings according to patient need and response. Although it should be stressed that Low-intensity treatments are not "watered down" CBT, and involve aspects of work (employment support, signposting to other services, social inclusive practices) which are not traditionally associated with CBT. High-intensity treatments usually involve considerable therapist input, akin to traditional therapy models. In contrast, low-intensity treatments emphasise patient self-management, with much less contact between mental health workers and patients, for example by the use of guided self-help or telephone case management(?). Within the IAPT programme, a competency framework has been identified for the CBT components of both high and low intensity interventions, and national curricula published in order to influence the delivery of training by education providers (<http://www.iapt.nhs.uk/publications/>).

In randomised controlled trials, the controlled clinical effect size - i.e. the therapeutic 'power' of the treatment - for high-intensity CBT is large, ranging between 0.89 for depression (Pilling and Burbeck, 2006) and 1.6-2.9 for



anxiety disorders (Clark, 2006). High-intensity CBT is therefore less effective in depression than anxiety disorders, with an effect size for depression (0.89) just over half that for generalised anxiety disorder (1.7). The effect size for low-intensity CBT for depression (0.8) is very similar to that for high-intensity CBT (Gellatly et al, 2007), though low-intensity CBT is generally less effective and more variably effective for anxiety disorders (range 0.18-1.02) (Hrai and Clum, 2006), excepting generalised anxiety (0.92).

*The evidence for stepped care.* Although evidence for the efficacy of some psychological therapies is strong, the evidence for organisational systems by which they are delivered is less so. NICE guidelines for depression and anxiety recommend that treatments should be organised along a 'stepped-care' model. Stepped care has two fundamental principles. First, treatments should always be the 'least restrictive', in that the burden on patients should be as low as possible while achieving a positive clinical outcome (Sobell and Sobell, 2000). This principle is usually interpreted as the delivery of a low-intensity treatment, such as guided self-help, unless high-intensity treatments are indicated. Second, stepped care should be self-correcting (Newman, 2000). This refers to the systematic scheduled review of patient outcomes to assist in clinical decision-making using validated outcome tools such as symptom schedules. Although based on the common sense proposition that it is as harmful to over-treat as to under-treat common mental health disorders, NICE guidelines provide little evidence to support the implementation of stepped care.

A narrative review of stepped care (Bower and Gilbody, 2005a) concluded that it has the potential to improve the efficiency of delivery of psychological therapy, but that the exact form of stepped care needed to maximise patient benefit was unclear. There are two possible ways that stepped care might be implemented. One, the pure 'stepped' approach, allocates a low-intensity treatment for all patients, and uses the scheduled review principle to 'step-up' patients who do not benefit from the initial intervention. In contrast, a 'stratified' approach initially allocates patients to interventions at different steps according to objective measures of their symptoms and/or risk. Both approaches have benefits and disadvantages, and NICE hedges its bets by recommending both systems simultaneously (NICE,

2004a). Using the stepped approach, the danger is that some patients will be inappropriately allocated to a weaker 'dose' of treatment than required, and the duration of their contact with services will thereby be unnecessarily extended. Using the stratified approach, the danger is that services may take a very risk-averse approach and opt to over-treat many people, thus compromising the efficiency of the system as a whole. Bower and Gilbody (2005b) have noted that the benefits of stepped care may be compromised if complex assessment and treatment allocations require significant resources. Indeed, a stratified approach relies on the ability to accurately predict who would not benefit from low-intensity treatments – so called 'aptitude treatment interaction' (Sobell & Sobell, 2000), the evidence for which is questionable at the very least. In practice, it might be that versions of stepped care attempt to achieve a balance between the two approaches, though the degree of emphasis on stepping or stratifying could alter system performance dramatically.

*The evidence for collaborative care.* The evidence for organisational models is much stronger in respect of collaborative care (Von Korff & Goldberg, 2001; Simon, 2006). Collaborative care is a 'systems level' quality improvement approach, consisting of a multi-professional approach to patient care, a structured patient management plan, scheduled patient follow-ups, and enhanced inter-professional communication (Wagner et al, 1996; Gunn et al, 2006). It has been comprehensively tested in depression management. A recent systematic review (Bower et al, 2006) found that the combined effect size for collaborative care in 36 studies was relatively modest, although the actual models implemented on the ground in these trials were extremely heterogeneous. Using meta-regression techniques to identify the critical components of this complex systems-level intervention, the review found that the effectiveness of collaborative care could be optimised by including within it the employment of case managers with a specific mental health training who also received regular expert supervision. Recent UK trials incorporating these effective ingredients, which included case managers who conducted most contacts on the telephone and who delivered a blend of medication management and low-intensity CBT achieved effect sizes of between 0.42 and 0.63 (Pilling et al, 2006; Richards et al, 2008). These findings have led to a Europe-wide

research effort to test variants of collaborative care in Spain, Germany, the Netherlands and the UK (Aragonès et al, 2007; Gensichen et al, 2005; IJff et al, 2007; Richards et al, 2008).

*The evidence for the IAPT programme to date.* The rationale of the IAPT programme is based on the systematic review of the psychological therapies evidence-base through the process of clinical guideline development co-ordinated by NICE. In order, to demonstrate the effectiveness of IAPT services, two national demonstration centres were established, together with a number of smaller Pathfinder sites throughout England. The demonstration centres have run for around 24 months and will be subject to a rigorous and independent three year evaluation due to be published in 2010. In the meantime, a short-term internal evaluation of the clinical outcomes collected by the two demonstration sites has recently been published by Clark, Layard and Smithies as a LSE Working paper (<http://www.iapt.nhs.uk/publications/>). We should, however, be cautious since judgements on the effectiveness of treatments for depression, in particular, require longer term follow ups in order to establish the stability of recovery rates (Andrews, 2001). Nevertheless, the preliminary data from the two demonstration sites suggest that these IAPT services have been successful in reliably capturing clinical outcomes (i.e. between 88 and 99% of outcome data returned). That the initial recovery rates are of the same order of magnitude as many of the published RCTs upon which the interventions have been selected (i.e. around 52%) and that the throughputs through the service and the numbers of patients seen (i.e. 5,500 patients referred and 3,500 concluded their involvement with services across the two sites and within 13 months) demonstrate the potential for enhanced access.

### IMPLICATIONS FOR THE PSYCHOLOGICAL THERAPIES WORKFORCE

Finally, we want to examine some specific implications of the IAPT programme upon existing psychologists and psychotherapists. Many of the workforce challenges facing professionals involved with the delivery of psychological therapies are being addressed through the 'New ways of working' projects for mental health (DH 2005; DH 2007a Lavender and Hope, 2007;

[www.newwaysofworking.org.uk/](http://www.newwaysofworking.org.uk/)). Generally, these reports describe how new roles and responsibilities, more flexible working, new opportunities for training in order to broaden competencies in psychological therapies, and an overarching career framework for all staff who contribute to the delivery of psychological therapy services, might collectively contribute to enhancing the capacity and capability of the workforce. We have recently written elsewhere an overview of the issues involved (Turpin et al., 2006), including an estimation of workforce demand in relation to existing staff, skills mix and service redesign; career frameworks and new roles; and education and training capacity. More recently, the IAPT Workforce Team has published a practical IAPT guide to workforce development as part of its guidance for the new IAPT services (<http://www.iapt.nhs.uk/2007/01/practical-approach-to-work-force-development/>). Rather than revisiting these issues here, we will focus instead on the specific challenges for the psychological therapies workforce.

*Building capacity.* Various independent estimates of the workforce to deliver the IAPT programme, based on Lord Layard's hypothesis, highlight the shortfall in existing numbers of psychological therapists and the need for future investment to increase the numbers of therapists (Glover et al., 2007; Boardman & Parsonage, 2007). Leaving aside the numbers of therapists required, the critical questions are: what types of therapists and what competencies are needed? Further, although new investment is necessary, if the demand for IAPT is to be effectively met, there is still the question as to how the existing workforce might be utilised in redesigning services.

IAPT services will require competent and qualified psychological therapists who are able to deliver evidence-based therapies, particularly CBT, at levels three to five within the stepped-care model as described within NICE Guidance and the National Implementation Plan for IAPT. We envisage that many qualified primary care counsellors and psychotherapists will deliver these therapies, along with clinical and counselling psychologists. It will be necessary for some therapists to undertake further training in specialist psychological therapies in order to provide the range and depth of therapeutic skills needed. In order to ground the development of IAPT services around relevant competences underpinning evidence-based therapies, the



IAPT workforce team, in conjunction with Skills for Health, initially commissioned the development of a set of CBT competences derived from the trials underpinning the NICE guidelines' development. Conducted by Tony Roth and Steve Pilling, this has recently published by the DH (Roth and Pilling, 2007). Current work has extended these competency frameworks to supervision within IAPT services, and also on psychodynamic, systemic/family therapy, and humanistic/counselling ([http://www.ucl.ac.uk/clinical-psychology/CORE/competence\\_frameworks.htm](http://www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm)).

*Career frameworks.* A key issue in recruiting competent psychological therapists is that there is currently no unified career framework for psychological therapy. Despite recent attempts within the NHS to construct a common salary structure (i.e. Agenda for Change) for all NHS staff, different psychological therapy practitioners are represented by different job profiles that tend to reflect their professional roles and specific jobs within the workplace (e.g. counsellor, psychologist or nurse). This results in many psychological therapists being accorded different status and receiving different salaries. Many of the inconsistencies reflect the different attainments and qualifications associated with professional pre-registration training (i.e. for nurses, psychologists, medical practitioners) and levels of responsibility inherent in a practitioner's core profession. In addition, there are several new groups of workers who now contribute to the delivery of psychological therapy services, including primary care graduate mental health workers (GMHWs) and self-help support workers. These new groups of workers tend to be, in the main, new graduates from three year academic undergraduate psychology programmes who have yet to receive a professional or postgraduate training either as nurses or as clinical psychologists. Instead, they have received a years training in how to assist in the delivery mental health care within primary care (cf. Bower, Jerrim & Gask, 2004). Should these new workers be considered psychological therapists? What are their career pathways within the NHS? We know that the success of the GMHWs has been limited by a lack of clear career progression other than their applying for clinical psychology training (Harkness et al, 2005). Given the range of competencies and roles within the psychological therapies' workforce (from graduate worker to expert therapist and supervisor), we believe it would be appropriate for a career framework to be

developed around the delivery of psychological therapy.

A further reason for developing such a career framework is the poor relationship between job titles and training in psychological therapy. The IAPT national workforce group (<http://www.mhchoice.csip.org.uk/>) has identified many local audits of the training and qualifications of practitioners, which demonstrate a worryingly wide range of training experience and qualifications among people who consider that they are providing psychological therapy within the NHS, together with varying levels of access to expert supervision. Such training can range from one-day in-house workshops through to five-year part-time doctoral training. The situation is further aggravated by the current lack of statutory regulation of the counselling and psychotherapy professions within the UK. Although it is hoped that the government will soon introduce legislation to regulate psychological therapists (Department of Health, 2007). The IAPT programme has recently commissioned national curricula and training in both high and low intensity psychological therapies (re: the two curricula), with supporting documentation available throughout the UK to support the low-intensity training in particular (Richards y Whyte, 2008).

In addition to scoping the competencies for psychological therapists and related healthcare workers in the course of developing a career framework, it will be necessary to identify other skills and competencies required to deliver a comprehensive and integrated psychological therapy service. These will include management and clinical governance, supervision, training, audit, research and development skills and expertise. Other workers, such as GPs and other primary care staff, employment and accommodation support workers, and administrative support workers, including receptionists, IT and clerical support staff, would also contribute. People with experience of mental ill-health likewise have a role to play in supporting the process as staff members, trainers and auditors. It will be important that all workers are psychologically aware and understand the therapeutic ethos of such services. Currently, Skills for Health is taking forward work around developing sets of National Occupational Standards (NOS) and career frameworks for both generic mental health workers and psychological therapists.

*The critical role of supervision.* If IAPT services are to be



delivered safely and effectively, and to retain fidelity with the efficacy research that underpins the NICE guidelines, it is important that outcomes are regularly obtained, that IT systems are employed to enable clinical supervisors and therapists to effectively track and manage cases, and that effective systems of supervision and support are in place for therapists whether they are working with a high or low volume of clients. Regular supervision, for example predicts better patient outcomes in collaborative care systems (Bower et al, 2006). Services should also be routinely audited and evaluated, with strong clinical governance processes and frameworks in place. The IAPT workforce team has just completed some preliminary guidance on the importance of clinical supervision within services ([www.iapt.nhs.uk/2008/02/supervision-comptences-framework/](http://www.iapt.nhs.uk/2008/02/supervision-comptences-framework/)), and will be commissioning training courses to support the development of supervisors within IAPT services. Many of these issues have also been addressed in a recently British Psychological Society published Good Practice Guide for IAPT, which is aimed at psychologists, and forms part of the New Ways of Working project for applied psychologists (BPS/CSIP, 2007).

*Choice and equality.* At a superficial level at least, there is an inherent tension reflected in the IAPT and choice agendas between traditional mental health services, characterised by diagnostic systems and drug treatments, and a broader psychosocial perspective. Psychologists, counsellors and psychotherapists, through the adoption of a wide range of psychological models and approaches, can provide mental health staff with a rich variety of explanations with which to understand psychological distress and disability and how they impact generally on communities, services, and service users and carers beyond the expression of individual symptoms and their amelioration. Such an approach underpins more socially inclusive services that attempt to address a range of social and psychological needs (such as employment, meaningful and valued work or volunteer activities, housing, and family and parenting issues), and may hopefully help to mend the broken communities within which many clients and service users currently live.

Equality of access, especially for black and ethnic minority (BME) communities, is also an area in which psychological therapists can contribute. People from BME communities experience particular difficulties accessing

psychological therapy services. The barriers range from practicalities, such as the range of languages used for health information, through to attitudinal challenges faced by mainly eurocentric-focused health professionals in understanding the cultural diversity of both the expression and treatment of mental health problems (Nadirshaw, 1999; Patel et al., 2000; Williams, Turpin & Hardy, 2006). Much has been published recently around race equality and discrimination within health services (DH, 2007b), which needs to inform the IAPT programme. With respect to the psychological therapies, there is an extensive literature around providing culturally sensitive counselling and therapy, much of it having been written in the USA, which ought to inform the practice of psychological therapists within the IAPT programme (Maxie et al., 2006; Hays & Iwamasa, 2006; Hays, 2001).

#### SUMMARY

If fully and properly implemented, the IAPT programme should have a significant and considerable positive impact on the wellbeing of the population, and bring about improvements to the mental health services offered to the public of the same scale of magnitude as the closure of the old mental asylums and the move to community care. Appropriately training and supporting the workforce is one of the key challenges in successfully achieving this aim. It is inevitable, however, that these fundamental developments in service provision will challenge traditional ways of working held by many professions, not least psychology. Other perspectives around the IAPT Programme have been recently published in a special issue of *Clinical Psychology Forum* (2008); the practitioner journal of the British Psychological Society's Division of Clinical Psychology. Clark and Turpin (2008) have also argued that the IAPT programme holds many opportunities for both clinical and counselling psychologists within the UK. We now await the clinical outcomes that will be routinely collected from these new services to finally evaluate the success or otherwise of this programme.

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