

# Bringing up IAPT

*therapy today* asks Lord Layard about the genesis of the Improving Access to Psychological Therapies project, how it is expected to develop and what part BACP members might play in its future

by Phillip Hodson  
and Sarah Browne

**What sparked your personal decision to do something about people who are anxious or depressed?**

I've always been interested in these problems, but I wrote a book on happiness, which led me to the question 'Who are the least happy people in our society?' I knew what the answer would be but I looked at the adult sample from the National Child Development Study and the factors influencing who were the most miserable people, and, not surprisingly, found that the most powerful factor was a record of mental illness. If you are talking about people suffering from anxiety and depression, rather than psychotic conditions, and if you look at how many of them are being treated, it's only a quarter, which is a scandalous area of neglect.

**You say you were always interested in this...**

Yes, I did think of becoming an analyst or a psychiatrist when I was in my 20s. In fact I started doing a year of Pre-Med after my history degree, but I was slightly put off by various aspects of that.

**But was it something to do with your family tradition that you were interested in this?**

My father was a Jungian analyst so I obviously knew something about it. I was also very influenced by the fact that the Dean of King's College, Cambridge threw himself off the top of the chapel, rather dramatically, while I was there, which made me reflect on what were the main problems in human life.

**What was the key argument, do you think, in persuading the Government to put money into psychological therapy provision?**

The most persuasive thing for many people was the extent of human suffering. There are people who are not receiving care according to the NICE Guidelines, which would never be tolerated for any physical condition. But, of course, another argument was that since people suffering from depression and anxiety are already costing the Government quite a lot of money, there could be significant savings if they got better.

**So, how did you go about getting the programme funded?**

As a result of the 2005 manifesto commitment, the Department of Health set up a process that led to the involvement of at least 70 professionals and a very

good so-called business case was developed for the comprehensive spending review, which was taking place in 2007. Then there was the process of discussion with the Treasury, and also an internal discussion within the Department of Health about what priority they were willing to give it in the things for which they were making a pitch to the Treasury. Bit by bit it crept up their priorities, mainly because of the force of the argument and also because more people were talking about it and more cabinet ministers becoming interested. Of course, there was interest in the Department of Health – which became particularly strong when Alan Johnson took over. If any one person should claim credit for this it's Alan Johnson. He immediately saw the importance of it. But there was also support from Gordon Brown when he was Chancellor and then Prime Minister, and support from the Department of Work and Pensions, because of the problem of people on incapacity benefit.

**So, Gordon Brown is behind it?**

Yes, I had a talk with him and he is definitely in support of it. From his point of view, this is closely linked



to social exclusion and that whole agenda, as it is in the case of Work and Pensions, and Health. To give more support, I tried to widen the concept of deprivation to include something beyond material deprivation, ie psychic deprivation. This was an important change of mindset that was necessary to get this thing through

**So, you didn't get everything you originally wanted? You talked about 10,000 therapists...**

We always argued that this problem was too big to be solved in just three years. You had to think of it in a six-year period, getting halfway there in the first three years. And basically what the Government has said is: 'Yes, we are in principal committed to solving this problem and getting to where we can implement the NICE Guidelines. We are now providing the money which you requested, for the first three years because we don't provide money further than that in any detailed form.' The idea is that the typical PCT area serving a quarter of a million people should have a team of 40 fully qualified therapists. That's if it's in average need. It's a long way from where anybody is at the moment.

But there is no question of the money being reduced in the future after the first three years. The only issue is whether it should be further increased.

**We have concerns obviously for our members. Is there anything members of BACP could think about doing in order to help the IAPT initiative?**

Perhaps I should briefly describe the initiative. First we need a big training programme, especially in CBT, because this is where there is the greatest shortage. Not that the services to be developed will only provide CBT but the training programme will initially be CBT only.

In parallel with the training programme (where we are talking about approximately 500 trainees next year, then 1,400 in the following years), there has to be development of services which are implementing the NICE Guidelines. That's what the Government's commitment is, and we have to have good services in which people can be trained and properly supervised. But you can't do that across the board on day one. So, the so-called IAPT money will be used to promote a process of staggered growth where some PCT areas get there before others, but all of them are subject to big pressure to come up with plans over a six-year period to implement the NICE Guidelines. So, that's the general framework.

Obviously, how your members can help is in all the things that have to be done, and it's crucial that they do.

Any members who are involved in CBT therapies should come forward and offer to provide training programmes and to help

develop state-of-the-art services, together with non-CBT colleagues, where the population can be adequately served and the trainees trained. But it's not only the CBT trained therapists who should come forward. Your members should be trying to push forward wherever they are, but also trying to play a particular role in developing the early-stage services.

**To help train and also to be trained?**

Well, if they are not trained to develop NICE-recommended services, why not think of being trained in those therapies as well? It's really important that these trainees are outstanding people. The trainee positions, which are on full salary, should be widely advertised and people selected entirely on merit.

**So it's an opportunity?**

Yes. And while we are on the subject of NICE, let me point out that NICE is reviewing its guidelines at the moment, so NICE-recommended treatments may include a wider range in future than they do now.

**So the initial phase of advertising trainee positions etc is already happening?**

The National Operating Plan published on 26 February\* makes everything clear. Associated with it are the criteria for being selected as a training centre; there will be one or two in each Strategic Health Authority (SHA) area. And there will be two to four state-of-the-art services started next year. By 2010 we shall have 70 or 75, covering half the country. Your members should be looking into participating in training and supervising, and, if they need to, adding a string to their bow.

**Is this going to have an impact on existing services? I mean will jobs disappear from GP surgeries that are presently occupied by ordinary counsellors?**

The first point to make is that nobody will get any IAPT monies towards running a service that is not additional to what they are already financing. So if they start cutting their existing expenditure, they won't get any support for providing services. But that's not the same as saying that the exact existing arrangements will remain and this will grow up alongside them; there will obviously have to be some process of integration, which should proceed sensitively on the basis of local need and local circumstance.

**So, any cuts happening now are nothing to do with this?**

Not at all, no. There's no question of that.

**How would a fully trained counsellor with BACP accreditation – which can take up to five years to get – be treated in the new system compared to somebody who has perhaps done a short training course?**

I'm not sure that I know the detail of that. There are obviously two issues to do with grading – one in the year-long training period and one in the years after that. Obviously people who have a lot of experience and are more mature should be able to move into leadership positions quite quickly.

**But are you going to get into a position where people with relatively short trainings are going to be doing relatively senior work?**

I would be surprised if that were so because we

know there are a lot of talented people already around in this area and we also know that formal training is not enough to be a good therapist. I would be astonished if you saw anomalies of that kind emerging.

**You mentioned that NICE is reviewing the guidelines and you sort of teased a little that they may look at other forms of research...**

I don't know. This is not my field of expertise and I really have no knowledge of what they are thinking.

**Do you have a whisper that the Government is interested in anything other than CBT research?**

Oh yes, very much so, and I think there is quite a lot of pressure to get adequate funding for sound research into other therapies.

**Because it's in the patients' best interests that the best methods are applied and it's a question of whether NICE – and you can't speak for NICE – but whether NICE is perhaps going to have a bit more pressure put on it to look at the non-CBT stuff?**

Well, you probably know more than I do about what pressure is being put on whom.

**Well do you think it's a good idea?**

Yes, they should look at all the evidence. But all I can say is, we are very lucky to have this process because without it, we wouldn't have got a penny. When my seminar was put on at the Cabinet Office before the 2005 election, I, as an economist, was asked to suggest two people who could prove to these advisors that there was anything

that worked, because I think that most of them were completely unaware that there was anything with any outcome evidence. David Clark flew back from Stanford to give a five-minute talk. The notion that you can measure outcomes is very important – that things can be measured just as you can measure the state of a person's angina – and that we have strong scientific ways of testing whether the outcomes are being affected by the treatment offered. I know some of your members don't like RCTs but I can tell you that if there hadn't been RCTs done within this field, we wouldn't have had this money.

**I guess some of our members have questions about only looking at RCTs, but we are very fond of the RCTs that are in our favour, particularly Professor King's study of depression... So will there be a different approach with the four countries, with the IAPT process?**

Oh, I know nothing about that. This is England basically.

**So there is nothing really developed on what Scotland might be doing?**

No.

**What sort of new benefits will patients be offered under the IAPT?**

In terms of treatment? Well, they should be able to access what's in the NICE Guidelines, which means in cases where there is a stepped care system proposed, they would normally be offered step 2 first unless they are very sick. But for some of the anxiety disorders we go straight to step 3 and of course, anybody who is not

responding to step 2 should go rapidly to step 3. I think that some people have been worried that it's going to be too much step 2 relative to step 3; step 2 being what you might call low intensity and step 3 high intensity. In fact, there will be 60 per cent high intensity staff to 40 per cent low intensity staff.

What is important about this initiative is that we are going to get a real profession of high quality therapists available within the NHS, providing decent numbers of sessions and a means to transform lives. That is the most important thing about this and if we hadn't got that, quite frankly it wouldn't have been worth doing.

**So do you think we are going to have a change of culture?**

Yes. The patient, instead of getting a GP for ten minutes and maybe a pill, is now going to have some talking treatment. Some patients will be very glad, some may be more hesitant, so it's a change of culture both for doctors and patients.

**If Gordon is replaced by David Cameron, do you know anything about the safety and continuity of the programme?**

The Conservative mental health spokesman, Tim Loughton, has been understanding and supportive of the importance of this. So I am hopeful that this is a bipartisan policy.

**Moving on, on 19 January *The Times* criticised positive psychology and you by saying that human beings can learn a lot from depression. What's your response to that?**

Well, I've never thought there was a value in

suffering. Of course, if you experience suffering you will learn something from it and maybe learn about how to rise above it, but I think it's a terrible view to think that there is some virtue in suffering itself.

**Whilst we are on the subject of criticisms, Darian Leader, a psychoanalyst who writes in *The Guardian*, says that CBT has grave limitations because it treats symptoms rather than causes and ignores the whole question, coming back to your dad, of the unconscious mind. Are you concerned that CBT is simplistic in some ways?**

I am simply concerned with long-term outcomes for people, and if understanding how your mind works helps you to deal with negative thinking and to exploit the positive aspects of your personality and situation effectively and if it can be shown to do so, that's just about good enough for me. I don't think that one would say there is something shallow about somebody who is really flourishing and enjoying their lives but doesn't completely know why they once had some problem. Just as with a physical condition, if it can be cured – even if nobody knows why you had it – this is a very good thing. So I wouldn't consider that a legitimate criticism. But I do think there are a lot of other issues that arise in people's lives that do not fall into the mainstream of CBT.

**I think maybe his point is that you may find over the short term that CBT is effective and helpful but that because the underlying issues aren't tackled, after about 18 months or two years there will be a new**

**problem because you haven't addressed the causes.**

There is obviously a difference between anxiety disorders and depression because, as I understand it, many anxiety disorders disappear for good if treated and the cognitive tools are there to hand whenever the situation recurs if it does. Depression is more cyclical and I have been impressed by some of the long-term follow-ups which show that therapy does an awful lot

relevant to Leader's comment, how it had. He said he is a fully fledged bipolar case but he has not had a day off work for the last 15 years. He has a little book which he carries around and whenever he has funny thoughts coming into his mind, he turns to the relevant page, according to what kind of thought it is or if he has a mood attack, and he does exactly what it says on the page. Now, you could say that's mechanical. I say that

**you would see that occasionally looking at the past may be a source of illumination?**

Of course, and I do think that for people who have been severely abused and so on, there is really nothing else.

**Oliver James wrote recently that mental illness owes its increase to selfish capitalism, ie placing too high a value on money, appearances and fame, and it would**

**massive taxation and redistribution to solve these mental health issues?**

I strongly support that agenda, but somewhat separately from the agenda of helping people who get into serious depression and anxiety conditions. I think one can try and tackle both problems without saying they are the same problem. I have spent much more time in my life trying to deal with inequality than with mental

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better than medication in preventing relapse. I have read some criticisms of CBT which either assert that it doesn't work in the long term, which certainly can't be asserted, but more reasonably they may assert that there have not been many long-term follow-ups, which is true. But that's true of any therapy so it's not a very fair criticism of one therapy on behalf of another.

### **Got your point.**

The most striking experience I've had in the last few years was when the Chief Executive of a Mental Health Trust came up to me after a committee meeting and thanked me for what I was doing to raise this issue and said his life had been saved by CBT (and incidentally, I must have had 1,000 emails from people who said their lives had been saved by CBT). But this chap showed me in a very interesting way,

it's brilliant and not so different, you know, from what Jesus or any other great healer did for people.

**I noticed in your book, *Happiness*, that you refer to cognitive therapy as a forward looking substitute for backward looking psychoanalysis and it sounded as if you were quite anti anything that explores the past. Is this so?**

No. In fact CBT does focus on the past when it's appropriate, especially in treating PTSD and Personality Disorder. But I know many people who have spent years going over the past and in many cases getting more and more angry with their parents, which doesn't really help. And I know quite a few of them who, once they got onto CBT, really started moving forward.

**But in the right hands,**

**be halved in a generation if we took up the unselfish capitalism of our neighbours in Western Europe. As an economist, do you agree with him?**

I don't think it's the most important issue, but I think that there is an important issue of values and I do think that the sort of competitive habit of comparing yourself with other people all the time is not good for people's mental health. It is promoted in the very sort of individualistic society that we have become and America has become, and Europe not so much yet. But I think it's pretty superficial to suppose there aren't some major psychological casualties on the continent and they may not even be getting as much help as we hope to be providing for people here.

**And may not be able to afford it. So, the answer in your view is not**

illness. I think it is a really serious problem but I do think also that if you look at the Psychiatric Morbidity Survey, you can see – and this is partly why we have managed to get this money – you can see that this is a problem that is affecting all social classes. The idea that it's confined to people who are socially excluded on other grounds is completely wrong.

**Thank you.**

Please send all correspondence relating to this interview to *therapy today*, BACP House, 15 St. John's Business Park, Lutterworth, Leicestershire, LE17 4HB or email [therapytoday@bacp.co.uk](mailto:therapytoday@bacp.co.uk)

*\*Implementation Plan:* National guidelines for local delivery was launched on Tuesday 26 February 2008 and is available for download from <http://www.networks.nhs.uk/news.php?nid=2102>.