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# IAPT: what does it mean for primary care?

The roll-out of the IAPT programme represents nothing less than a revolution in primary care, writes **John Hague**



The Department of Health Improving Access to Psychological Therapies (IAPT) programme began with the publication of a report

by Lord Richard Layard<sup>1</sup>, Professor of Economics at the London School of Economics, before the 2005 general election. The Layard Report, produced initially for the Prime Minister's Strategy Unit to be used at a seminar hosted by the unit, led to the following entry in the Labour Party Manifesto<sup>2</sup>:

*'Almost a third of people attending GP surgeries have mental health problems and mental health occupies approximately one third of a GP's time. So we will continue to invest in and improve our services for people with mental health problems at primary and secondary levels, including behavioural as well as drug therapies.'*

It was a vital moment for both mental health and primary care services, in that it provided official confirmation of the central role that primary care plays in everyday mental health, as well as an acknowledgement that services could be improved beyond the provision of medication by GPs, along with patchy implementation of counselling in primary care.

Those who read the Layard Report could see invisible links to earlier paragraphs in the manifesto<sup>2</sup>:

*'We will help people who can work into rehabilitation and eventually into employment, recognising the*

*practical assistance to disabled people of the Access to Work scheme. We will build on the successful Pathways to Work programme and reform Incapacity Benefit, with the main elements of the new benefit regime in place from 2008. The majority of claimants with more manageable conditions will be required to engage in both work-focused interviews and in activity to help them prepare for a return to work. Those with the most severe conditions will also be encouraged to engage in activity and should receive more money than now.'*

These links are important since the report, and the project, are built on a clear economic argument that runs as follows:

- Depression and other mental health conditions are common.
- About one million people nationally draw incapacity benefit due to a mental health problem.
- The total annual cost of depression to the economy is four per cent of the gross domestic product (GDP).
- 900,000 of people who draw incapacity benefit because of a mental health problem do not receive specialist mental health care, but instead receive whatever care their primary care team is able to provide (which may include some limited NHS-provided counselling); sometimes with the help of private counselling, etc, that people are willing to pay for or able to obtain from voluntary agencies.
- There are known effective treatments, recommended by the National Institute for Health and Clinical Excellence

(NICE)<sup>3</sup>, which include medication and various talking therapies.

- Medication is available from GPs, but talking therapies have not been delivered by the NHS as a realistic, timely choice, despite NICE guidance.

- There is evidence that the effects of talking treatments, such as cognitive behaviour therapy (CBT), are more enduring than those of medication, and that relapse from depression is less likely<sup>4</sup>.

- Effective treatment of depression and anxiety will lead to those affected being able to rejoin the workforce, stop claiming benefits, start paying taxes, and thus benefit the country economically.

- The economic benefits are calculated to be large enough to pay for a programme to introduce evidence-based talking therapies including, but not exclusively, CBT.

The economic argument won the day, and forms an important point for (practice-based) commissioners to remember – that IAPT is about treating anxiety and depression, but it is also about realising the cost-offsets that are available from treating them. Initially this was considered the cost-offset that would be made available nationally by reducing the incapacity

benefit bill. However, significant cost-offsets are also available in terms of reductions in the health (and social) costs associated with long-term conditions and medically unexplained symptoms.

### IAPT roll-out

In 2005, the two IAPT demonstration sites at Newham and Doncaster began to test two very different models. Newham was established initially to deliver mainly face-to-face talking therapy, whereas Doncaster was set up from the beginning to deal with high volumes of patients. To these two pilot sites have since been added 11 IAPT 'Pathfinder' sites, and more recently the Secretary of State for Health has announced further funding from April 2008, starting modestly, but rising to £173 million by 2010/11, with the intention that IAPT will cover half of England by this time.

Interestingly, last year, Newham added a 'low-intensity' step to help their face-to-face service manage the volume of patients referred in a timely fashion. This is in no way a criticism of GPs for over-referring – common mental health problems are by definition high-prevalence disorders, and services must be set up to cope with the

expected volumes. The higher-than-expected prevalence comes as no surprise to those of us in primary care or the counselling professions, although those working in mental health with a secondary care mindset may find it initially hard to comprehend. In a PCT covering about 600,000 people, there will be about 67,000 people over the age of 16 who suffer from high prevalence mental health disorders<sup>5</sup>, yet secondary mental health services will expect to treat only 5,000 patients annually. It is no wonder that patients and GPs have been complaining for years that there was 'nowhere to refer patients'. Our counsellors have often been so busy that it has been hard for new patients to access care within a reasonable time. Similarly secondary services have complained of 'inappropriate referrals', and used 'triage teams', and other ways of trying to hold back the tide. Unfortunately, as King Canute found, trying to hold back the tide is a losing battle. Fortunately, Lord Layard has allowed us to say out loud what many have felt for many years. With his economic argument driving the change, primary care should at last have access to talking therapies and collaborative care in sufficient volumes to meet the needs of those

## IAPT in practice: primary care case vignettes

The best way to illustrate the potential impact of IAPT in practice is with a series of typical primary care case vignettes:

### Case vignette 1: Accessing help with finding employment

Robin was a 48-year-old man who became unemployed. He developed depression, responding well at first to treatment from his GP's practice counsellor, with whom he had the maximum number of sessions allowed. Unfortunately, when he was well enough to look for work he relapsed. He then disclosed that he had a specific learning difficulty and found the usual help available at the local Job Centre very hard to access. He finally went onto Incapacity Benefit, and then had it withdrawn. Via IAPT, Robin had several sessions of CBT, and was helped back into the workplace by being introduced to the local volunteer centre. Some weeks later he was helped to revisit Job Centre Plus, who helped him to find suitable employment; he was able to complete his therapy during the lunch breaks at work, on his mobile phone.

### Case vignette 2: Screening diabetic patients for depression

Dr Rob Smith's practice was always proud of the care they

gave their patients with diabetes, though they found it very hard to achieve the results they felt they should be achieving with regard to control of the condition. The arrival of the IAPT service in the area at last gave them an option beyond medication, and they began to assertively screen every patient for depression. Rob and his practice nurse colleague developed a good working relationship with the service – and to their delight they found that 18 months after the service had started, the proportion of the patients in the practice with 'good control' had significantly increased.

### Case vignette 3: Stepping-up therapy for complex mental health issues

Verity had depression and generalised anxiety disorder, which failed to respond to two courses of selective serotonin reuptake inhibitors (SSRIs) from her GP. The GP subsequently referred her to IAPT. Verity met a therapist once, and then took part in six further sessions of therapy on the telephone, working through a CBT-based homework book in between sessions. However, halfway through the sessions her scores failed to show an improvement and, following discussion

with high-prevalence (common) mental health problems.

### Impact of IAPT in primary care

IAPT should ensure that stepped care for mental health conditions, as recommended in various NICE guidelines, is implemented in due course in every PCT in England.

With a stepped-care system the clinical pathway is always clear, and the steps intuitively logical. Patients with mild depression may be initially offered watchful waiting, as is usual in primary care, but once active treatment has become necessary they will have the choice of psychological therapy in addition to 'care as usual'. If all a patient wishes is pills from their GP, then of course this option is still available; indeed some services may request that patients have had one or two courses of medication in primary care before referral. Patients with panic disorder, generalised anxiety disorder, obsessive compulsive disorder, post-traumatic stress disorder and phobias have also been shown to benefit from psychological therapies, and thus these patients can also be referred<sup>4</sup>.

The clinical records of IAPT sites are run on a web-based software system

that prompts the therapist routinely to objectively rate the severity of a patient's illness, thus integrating a normal full clinical record with structured evaluation and delivery of care for every patient in the system. Integral to the system is clinical supervision. Every therapist has to have supervision in the case of every person they look after, thus ensuring that patients receive the highest quality care. The web-based record system allows notes to be made anywhere that there is an NHS net connection, and provides clinical audit as a matter of course.

Therapy will be provided using the stepped-care principle of initially offering the least burdensome treatment, for example low-intensity CBT-style interventions, supervised by an appropriate worker. These may take place face-to-face or over the telephone (working over the phone is an established, safe, method<sup>6,7</sup>), but it is likely that services will see patients face-to-face at least once – an initial meeting establishes a relationship and helps to make telephone working effective. Counter-intuitively, the experience in Doncaster has been that low-intensity therapists do not have

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to be graduates or professionally qualified. The low-intensity workers at the Doncaster IAPT demonstration site were recruited from the local community, underwent a specific, high quality,

with his supervisor, her therapist discussed Verity's case with the team's GPSI, who spoke with her GP, and together they changed her medication. By the end of the six sessions she had still failed to improve, and it became clear that post-traumatic stress disorder was contributing to her lack of progress, so she was 'stepped-up' to high-intensity therapy. She had 16 face-to-face sessions with a therapist, by the end of which she had recovered sufficiently to have started both a new relationship and a part-time job.

#### Case vignette 4: Psychological support for patients with heart problems

Dr Jones' practice-based commissioning group were keen to look at broadening the benefits of IAPT beyond the routine treatment of patients with depression and anxiety. They worked in concert with the PCT's long-term conditions team to change the pathway for patients referred to cardiology with chest pain, and found out that 20 per cent of those referred actually had panic disorder that had not been diagnosed. The patients were referred to the IAPT team, and the majority improved with the treatment. This

led to the group offering CBT-based education to all patients newly diagnosed with angina, beginning with the first consultation in the clinic. After one year, the number of patients being admitted with angina had dropped noticeably, and the number referred for revascularisation had also decreased.

#### Case vignette 5: Appropriate care for 'frequent attenders'

Dr Saxena's practice was heavily burdened with patients with 'unexplained symptoms', with one partner spending about 10 per cent of her time consulting with a relatively small number of so-called frequent attenders. The frequently consulting patients were invited to a long consultation by post, at which they were re-assessed, and then offered referral to the local IAPT service once the GP was happy that no new physical illness had been missed. The majority of patients who attended were offered a combination of counselling and CBT, which most accepted. Some months later the practice was able to report a continued reduction in this cohort's attendance, and the IAPT team showed progress with these patients as well.

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training course, and have been very successful. They can manage up to 16 patient therapy calls a day, and expect to treat about 250 patients each a year.

Low-intensity therapy, incorporating guided self-help using structured workbooks, computerised CBT, and elements of collaborative care, will last for up to about six sessions wherever appropriate. This will help to ensure that patients comply with self-help interventions and medication, and are not lost to follow-up. Although it is tempting to view this step as a poor relation to 'real' therapy, and some people may label it 'care on the cheap', in reality nothing could be further from the truth. I am in no doubt that a fully resourced low-intensity therapy team will be the keystone of a successful IAPT service – and that without it a service will rapidly become overloaded.

Routine assessment, using tools such as PHQ-9 and GAD-7 (for anxiety disorders)<sup>8</sup> forms an integral part of the programme; patients who fail to improve will be 'stepped up' to more intensive treatment. High-intensity treatment may last for up to 20 sessions, and will usually consist of conventional face-to-face therapy, which may be either CBT or other types of therapy

as appropriate. The therapists at this stage are likely to be counsellors, clinical psychologists, nurses or occupational therapists. The professional's background is much less important than possession of the appropriate qualification and competency to deliver the necessary psychological therapy. Many counsellors with appropriate competencies will be able to find a happy home in a high-intensity service. As before, regular review and supervision will ensure that each person's progress is monitored closely, with patients being stepped up to conventional secondary care if appropriate.

A stepped-care system such as the one being delivered by the IAPT programme in Doncaster, which covers a total population of approximately 300,000 (accepting referrals for adults) would be expected to manage 300 referrals a month. Of these, between 750 and 850 people at any one time will receive low-intensity treatment, and 45 to 65 people will be stepped up to high-intensity treatment, principally formal CBT. This level of activity will be achieved within six months of a stepped-care operating start date for low-intensity treatments, and within a year for high-intensity interventions.

A vital part of any IAPT service will be the development of networks to ensure that the service is able to deal with most of the practical life problems with which patients present. The team will require access to a GP with a special interest (GPSI) in mental health to provide advice on medication, as some patients will wish to continue taking medication. The most common issues to be encountered are likely to be debt, employment, and housing – so the team will also need in-house workers to help with these or, alternatively, will need close relationships with debt counsellors, employment coaches, and housing workers so that people can be directly helped. For GPs, the days of 'signpost and forget' should be over; instead they can have every confidence that their patients' practical problems will be addressed by their local IAPT team.

Those working in primary care have every reason to welcome IAPT with open arms. At last they and their patients will have an adequate volume of talking therapy to help them manage common

mental health problems and the psychological aspects of long-term conditions. Furthermore, this will be set within a logical framework of care. Indeed, I am sure that those involved in practice-based commissioning will be clamouring for their area to apply to be considered for the next wave of IAPT. ■

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