

IAPT: a brief history

The IAPT programme is committed to offering choice and providing data on outcomes. This has to be a good thing, writes **Alan Cohen**



On 10 October 2007, World Mental Health Day, the Secretary of State for Health announced new funding to improve access to psychological therapies¹. The announcement represented the realisation of a Government manifesto commitment and, more importantly, an acknowledgement that psychological therapies are an integral part of the NHS that have benefits beyond 'just' the mental health needs of individuals.

This paper will review the early stages of the Improving Access to Psychological Therapies (IAPT) programme and where the programme is likely to go next. Inevitably it can be only a brief review, identifying some of the major headlines. I will also discuss some of the current debates that exist around psychological therapies, including evaluation and the effectiveness of different interventions.

The history: 2005 to spring 2007

The 2005 Labour Party Manifesto² committed the party, if elected, to '...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'.

The Department of Health identified two sites, in Newham and Doncaster, to demonstrate the effectiveness of psychological therapies in practice. Each site was supported by considerable new money, and the requirement was that they were not only to implement best practice derived from research evidence, but also to pilot new ways of working and evaluation of the services that they developed.

The two demonstration sites took different approaches to the challenge, but shared some important principles regarding implementation. Two of

these were:

- Implementation of National Institute for Health and Clinical Excellence (NICE) guidelines for the management of mental health disorders. In 2004 NICE published guidelines for the management of anxiety³ and depression⁴, and in the latter there was a proposal for a stepped-care approach to management of the condition.
- Evaluation of the care that individuals received. The two demonstration sites were required to demonstrate that, across a number of domains, the care that individuals received was high quality, and that improvements in outcomes could be evaluated.

Both of these principles, entirely laudable, proved harder to implement in practice than anticipated. For example, the interpretation and implementation of stepped care (illustrated in figure 1) differed between the two sites. Both sites agreed that Steps 4 and 5 were the remit of the specialist mental health services.

Beyond this, however, the Doncaster approach was to deliver the majority of services at Steps 1 and 2, with the anticipation that patients/clients, if treated early and appropriately with simple interventions and followed up effectively and efficiently, would not deteriorate further to need an intervention at Step 3. The Doncaster services thus invested in a relatively large number of new therapists who could deliver low-intensity interventions, such as counselling, bibliotherapy, exercise support, and computerised cognitive behaviour therapy (CCBT). These workers, called case managers, were trained at a new educational course developed at the University of York. They were drawn from the local community, and were not required to have any postgraduate mental health qualification.

The Newham site, by contrast, took

the view that they needed to provide more treatment at Step 3, and that primary care services that were already available in the community could manage those patients/clients who would respond to interventions at Steps 1 and 2. The Newham service thus concentrated on employing experienced therapists who could deliver high-intensity face-to-face interventions.

Evaluation

While a useful debate could be had on which approach (Doncaster – emphasising low-intensity work, or Newham – emphasising high-intensity interventions) was 'correct', the most important thing was to demonstrate that patients/clients were improving as a result of the interventions offered.

To do this, the IAPT Expert Reference Group (which was set up early in the project to provide the expert advice it would need to succeed) developed a minimum data set for psychological therapies that would evaluate client/patient improvement across four domains. Complete and up-to-date details of the minimum data set are available via the DH guidance, *Specification for commissioner-led Pathfinder sites*^{5,6}. The four domains are:

- wellbeing – ie mental and physical health
- social inclusion – including employment status
- choice – of interventions and services
- access – improvements in access and waiting times.

The minimum data set, besides describing the questionnaires that could be used to assess patients/clients, also specified how frequently the different questionnaires and measures should be used in their care. For example, people treated for depressive disorder would be required to complete a PHQ-9 and/or GAD 7 measure at each contact with a therapist.

Products

As the two demonstration sites started developing and comparing the service models, it became clear that there needed to be a shared description of the various professionals involved and the types of interventions offered.

A dedicated workforce team was therefore set up to develop a very detailed shared description of interventions employed, competencies required, etc., full details of which can be found via the IAPT website⁷.

Two broad types of intervention were described: low-intensity interventions, requiring typically five or less patient contacts, and high-intensity interventions, requiring usually 12 or more patient contacts. Competencies and training needs required for delivering both are described by the workforce group. One of the very strong messages is that low-intensity interventions include many therapeutic options other than cognitive behaviour therapy (CBT).

It is interesting to find that as the programme has progressed, the Doncaster and Newham models have moved closer to each other, with Doncaster investing in more therapists qualified to deliver high-intensity interventions, and Newham investing in more therapists for low-intensity work.

As a spin-off from this workforce planning, a tool was developed to help

commissioners estimate the numbers of new workers who would be needed to deliver both low-intensity and high-intensity interventions to meet the health needs of their populations. This tool can also be found via the IAPT website⁷.

The design of the minimum data set to assess outcomes across four domains was important because it allowed commissioners of services to commission for outcomes, rather than contracting for a process of care – in line with the current policy direction of the NHS. Nevertheless, there was considerable initial disquiet that therapeutic relationships would in some way be undermined by the completion of questionnaires. Happily, therapists' experience of collecting data as part of the clinical process has proved that it does not interfere with the therapeutic relationship, and, indeed, in some cases allows greater insight for patients/clients⁸. The cultural shift for this in terms of accepting outcome measures has been a significant success of this programme of work.

Recent history: spring 2007

In the spring of 2007, plans were developed to expand the IAPT programme to PCTs around the country. The intention was to further explore how psychological therapy services

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could be applied to several groups that were hard to reach; specifically:

- black and minority ethnic peoples
- the prison population
- older people
- children and adolescents
- people with long-term physical conditions and medically unexplained symptoms
- mothers and mothers-to-be.

In the event, 70 per cent of all PCTs in England submitted expressions of interest in trialling the IAPT programme, and 50 per cent of all PCTs submitted final bids – a testament to the level of commitment to this area of care. Eleven sites were eventually accepted

Who is responsible for care?	What is the focus?	What do they do?
Step 5: Inpatient care, crisis teams	Risk to life, severe self-neglect	Medication, combined treatments, ECT
Step 4: Mental health specialists, including crisis teams	Treatment-resistant, recurrent, atypical and psychotic depression, and those at significant risk	Medication, complex psychological interventions, combined treatments
Step 3: Primary care team, primary care mental health worker	Moderate or severe depression	Medication, psychological interventions, social support
Step 2: Primary care team, primary care mental health worker	Mild depression	Watchful waiting, guided self-help, computerised CBT, exercise, brief psychological interventions
Step 1: GP, practice nurse	Recognition	Assessment

Figure 1: Stepped-care approach to the management of depression, as described in the NICE guideline⁴

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as IAPT Pathfinders, and went live in the autumn of 2007.

As part of the support being offered to the IAPT Pathfinder sites by the Department of Health, a bespoke software programme was commissioned to allow each of the 11 new sites as well as the two demonstration sites to record and manage high volumes of patients efficiently⁹. The benefits that this delivers are great, since it also allows PCTs to compare outcomes across populations, as well as allowing for services to be evaluated and commissioned based on these.

Various networks have in addition been developed to support different aspects of care, including the workforce development group to look at issues around training and recruitment for the new services, and an informatics group – looking at how and which data is recorded and how it is analysed. There is also a network for primary care leads, which provides for local GP and primary care leads, and a development course that gives participants the skills needed to engage their local colleagues effectively. The intention is that these local champions will then spread the benefits of the improved access more widely in their areas to ensure that all patients benefit from the new service.

The present and beyond...

A landmark announcement from the Secretary of State for Health on 10 October 2007 pledged more than £30 million, more than £100 million and

more than £170 million over three years, starting in April 2008, to develop psychological therapy services¹.

The new resource would treat up to 900,000 people (of whom 450,000 would be likely to improve significantly), would allow the recruitment and training of 3,600 new therapists to deliver that care, and enable patient access to the new service within 10 working days from GP referral to treatment.

The process by which these ambitious targets will be implemented was being negotiated at the time of writing, and is now published¹⁰.

Some areas for debate

One of the criticisms levelled at the IAPT programme is that it is dependent on NICE guidelines for describing evidence-based practice. One argument is that the process for developing guidelines is rigid in its interpretation of what constitutes 'evidence', and that this prejudices some interventions for which there is little or no published evidence. Another is that this model of explaining therapeutic interventions is not appropriate for people with mental health problems. This view seems to be linked with another criticism of the IAPT programme: that it is designed to deliver only CBT and not other interventions. The link is that CBT has a strong evidence base of published research, including randomised controlled trials, that has been included in NICE guidelines.

The debate is further complicated by differing perspectives as to what type of intervention is more effective, and for what sort of mental health problem. Is psychotherapy better or worse for depression or anxiety than CBT and, if so, what sort of psychotherapy is effective? How is that 'better' outcome measured – and is it also cost-effective?

These are difficult and complex questions, and attempting to address them here would be inappropriate. However, from a very personal perspective, as a practising GP who wishes to be able to offer his patients some form of psychological intervention now, rather than after a six to 18-month wait, the debate could be much better formulated in terms of how access should be improved. My experience, and the evidence, suggests that the choice of intervention is important to

a successful outcome, ie that allowing patients to choose what sort of intervention they want will improve the effectiveness of that intervention. New services should have a range of psychological treatments to offer, including CBT and different varieties of counselling and psychotherapy. The IAPT programme is committed to offering that choice; it is not just about delivering CBT. The current situation for the vast majority of patients is that they can 'choose' between medication now or an 18-month wait for talking therapy – it really is no choice.

A second broad criticism of the IAPT programme has been of the requirement to collect data – as has been discussed briefly above. A further comment is worth making in considering the value of collecting data: there is an absolute need to demonstrate that outcomes for patients/clients are improved. Without this information there is no way that commissioners can invest in a service. Further, such outcomes data will provide commissioners with the information that health and wellbeing are being improved, and make the case for continued funding. Every other part of the NHS is expected to demonstrate cost-effectiveness. In a cost-limited healthcare system, this is inevitable. The collection of data described in the minimum data set provides not only valuable information on clinical outcomes, but also information to prove to commissioners that the service is worth their continuing investment. To put the debate about effectiveness and resources into perspective, the BBC reported in November 2007 that the NHS spent £100m on treating 500 patients with herceptin¹¹. The debate concerned whether or not the £100m would have been better spent on machines that deliver radiotherapy and could have treated 30,000 people for the same money. The argument over cost-effectiveness is not going to go away, and we need to be sophisticated as to how we participate in that debate. Strengthening the discussion with hard data on outcomes for health and wellbeing is a necessary contribution. ■

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References

- 1 Department of Health (10/10/07). Johnson announces £170 million boost to mental health therapies. Press release. Accessed: 20/2/08. Available via: <http://www.gnn.gov.uk/environment/fullDetail.asp?ReleaseID=321341&NewsAreaID=2&NavigatedFromDepartment=False>
- 2 The Labour Party Manifesto. London: The Labour Party; 2005.
- 3 National Institute for Health and Clinical Excellence. Clinical guideline 22: Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. London: NICE; 2004.
- 4 National Institute for Health and Clinical Excellence. Clinical guideline 23: Depression: management of depression in primary and secondary care. London: NICE; 2004.
- 5 Department of Health. Improving access to psychological therapies: specification for the commissioner-led pathfinder programme. London: Department of Health; May 2007. Available via: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074555 Accessed: 8/2/08.
- 6 CSIP/NIMHE. IAPT commissioner-led pathfinder sites: resources. Available via: <http://www.mhchoice.csip.org.uk/psychological-therapies/-iapt-commissionerled-pathfinder-sites/resources.html> Accessed: 8/2/08.
- 7 www.mhchoice.csip.org.uk
- 8 Thompson L. Client-centred primary care. *Healthcare Counselling and Psychotherapy Journal*. 2008;8(1):18-21.
- 9 University of York Department of Health Sciences. Patient case management information system. Available via: <http://www.pc-mis.co.uk/> Accessed: 8/2/08.
- 10 Department of Health. Improving access to psychological therapies implementation plan: national guidelines for regional delivery. London: Department of Health; 2008. Available via: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/dh_083150
- 11 Cox S. Call to redirect cancer drug cash. BBC Radio 4, The Investigation. 29/11/07. Available via: <http://news.bbc.co.uk/1/hi/health/7115540.stm> Accessed 6/02/08.

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 Layard¹, 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 Manifesto²:

'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 manifesto²:

'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