

IAPT and counselling: are they compatible?

Will the IAPT programme be a false economy? And is it compatible with a future for counselling in the NHS? **Francesca Haydon** reflects



For the past decade, the NHS multidisciplinary team in which I work has provided a counselling service in general practice in the west of Cornwall.

The team has faced a great many obstacles and challenges, emerging as a group of confident individuals with a powerful team ethic and high standards for service delivery and client care. Many of the team are highly trained in various modalities that include cognitive behaviour therapy (CBT), systemic, psychodynamic, solution-focused and Gestalt therapies and transactional analysis. The surgeries we work in have been happy with our service, which boasts short waiting times and is noted by GPs to benefit their patients and reduce the need for prescription medication. Our Clinical Outcomes in Routine Evaluation (CORE) data have shown gratifying results.

The Department of Health recently announced that Cornwall and the Isles of Scilly would become one of the new sites leading the roll-out of the Improving Access to Psychological Therapies (IAPT) programme^{1,2}. My team was confident, despite some reservations, that we would adapt with our usual creativity to this development. We particularly welcomed the promise of low-intensity interventions being added to our existing service. Our experience, however, is that our service is being replaced as a result of concurrent recommissioning and privatisation in advance of the programme roll-out. Low-intensity provision has been added, but at the expense of some of the counselling previously offered. High-intensity work will now routinely comprise 30-minute and 45-minute

sessions in equal measure. Our anxieties and demoralisation in these troubled times are defended against with indignation at the need for such a drastic redevelopment. We are accustomed to swaying in the breeze of change but we are saddened by the changes to our service, which threaten to disregard some of our skills and experience, and we remain unsure which changes are a result of the IAPT programme and which are a matter of its application. Some will argue that evidence-based practice is more appropriate than autonomy in a healthcare setting, but perhaps there is space for both in the ever-developing arena of psychological therapies.

I asked the members of my team what they would like to see covered in this article. Some mentioned their displeasure at a forthcoming reduction in the number of traditional 50-minute sessions of counselling that would be on offer. Many put forward the pressures of increased caseloads and shorter session times on the quality of their work and their ability to perform accurate assessments. Many were concerned that being expected to work harder was demoralising and potentially damaging to their wellbeing. Most mentioned the fact that IAPT seemed to be disregarding interventions other than CBT despite a strong evidence base for alternative therapies, with the result that highly trained and experienced clinicians were feeling deskilled and devalued. I will expand on some of these concerns.

The predominance of CBT

The practicalities of the IAPT roll-out are only just becoming apparent. For example, while it brings the promise of funding for training in CBT for therapists delivering high-intensity interventions, these fantastic training

opportunities are to be available only to full-time staff, and places are to be allocated only to those who can demonstrate a substantial prior commitment to this modality. My hope is that those who are not able to complete this training will continue to feel competent at delivering high-intensity therapy, that IAPT will in due course fund training in a range of modalities, and that BACP will campaign for this change.

In writing about the Doncaster IAPT pilot, operations manager, Dawn White, concluded that: '...a more integrative approach is required that incorporates different ways of working including psychodynamic approaches³. If it remains overly focused on CBT, I fear that IAPT will be experienced by many counsellors as a retrograde development. A big fear for many is that if CBT dominates psychological approaches in the NHS, other therapies will continue to be inadequately researched, leading to stagnation in the National Institute for Health and Clinical Excellence (NICE) guidelines. I hope that we can continue to keep afloat therapies such as counselling that feature in the NICE guidance in the face of the CBT tidal wave – if only to ensure that options remain for those clients who do not respond to CBT.

The IAPT programme is committed to offering choice⁴. As the programme continues to evolve, I hope that the misreading of NICE guidance as recommending only CBT (which is panicking some therapists) will be redressed, as is beginning to happen in the national press⁵. CBT is not a panacea – and this is not the message of IAPT. In this context I am pleased to note that competencies for psychodynamic, systemic and integrative/humanistic approaches are near

completion⁶. Moreover, in an IAPT climate, clinicians are likely to be completing outcome measures much more frequently. While many counsellors find this irksome, it should continue to provide the evidence of effectiveness on which our profession depends. One cannot overlook concerns about how heavily loaded such measures are, transferentially speaking, but no audit or research process is perfect and this is a price worth paying for further investment in psychological therapies.

Impact on counselling

Counselling in general practice already has a distinct agenda. Clients often expect diagnosis, advice and even cure in the context of a medical setting. As a result of these unique demands, primary care counselling has become increasingly directive, and CBT has rightfully been embraced. Many primary care counsellors work eclectically, using CBT ideas and techniques in their work, sometimes without formal training. Formal training would be a great enhancement to the counsellor's toolkit, and I hope that IAPT funding will in due course enable this training for all practitioners and not just those who qualify for university places.

IAPT is partially driven by the need to help more unemployed and incapacitated people back to work⁷. Might this cause a further change in the agenda of our work in future, for example through an increase in individual workloads? BACP information sheet G4, *Counselling and psychotherapy workloads*⁸, offers guidance on the number of client contacts for counsellors per week. Our service previously agreed a limit of around 20 client contacts per week to ensure safe practice. Under our new service provisions this number of client contacts will be exceeded, while therapy sessions will be shortened. If high-intensity work occurs in shorter than 50-minute sessions this will be no simple undertaking for therapists, and a potentially demanding pressure. BACP's guidance on workloads may need to be reviewed to account for this style of working, perhaps with new guidance specifically for brief therapy interventions in specific settings. I hope that BACP will seek to establish the impact on counsellors/ psychotherapists and their work of

delivering psychological therapies at speed and to larger caseloads in the NHS.

One might argue that if therapy as we know it (lasting 50 minutes and occurring face-to-face) is replaced by shorter and/or less intense interventions, then although access to psychological therapies may increase, it may not improve. One can appreciate the sense in offering minimally invasive treatments such as supported self-help where appropriate. I wonder whether the impact of these changes will be more strongly felt by therapists, having to change the way they work, or by clients. Will IAPT be a false economy? Time will tell.

This leads me to a more fundamental question. Should counselling adapt and alter from our traditional understanding of the process in order to be economically viable, or will it be forced partially to give way to other approaches? Counselling can be delivered in a variety of ways. It can be informative and reflective, and it may even be directive at times. The current definitions of counselling, psychotherapy and psychological therapies in the NHS are vague. Like many counsellors working in the health service, I undertake some work that would not usually be defined as counselling, though my qualifications provide me with the skills required for the work. Does the length and depth of a counselling session define it as such? Can counselling be delivered in shorter sessions? Can a 30-minute, integrative, high-intensity session delivered by a trained counsellor be considered a counselling session, or is it something else?

Counsellors all over the country are considering these issues. The roll-out of IAPT is at various stages nationally, and what is agreed in the early roll-out sites may set a precedent. The learning process cries out for debate and support among counsellors, through journals such as *HCPJ* and through conferences. I would like to see the introduction of a members' forum on the BACP website to enable this debate.

Few primary care counsellors work in a purist way, and if this were expected in the IAPT programme it would certainly be non-progressive. Counselling may adapt in the NHS, but I hope it will not lose its distinctive facets. Being

a counsellor or psychotherapist is not just about *what* you do, it is about *who* you are because the client-therapist relationship is paramount. We will find our individual ways through the myriad therapies endorsed by IAPT. We should be adaptable and allow it to shape our work, but ultimately we should also be ourselves and retain our identities as professionals as well as the essence of the valuable work we do. ■

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References

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