

We need to talk

Getting the
right therapy
at the right time



About the We need to talk coalition

The We need to talk coalition is a group of mental health charities, professional organisations, Royal Colleges and service providers that believe in the effectiveness of psychological therapy. Together, we are calling for the maintenance and development of these treatments on the NHS.

We want the NHS in England to offer a full range of evidence-based psychological therapies to all who need them within 28 days of requesting a referral.



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mental health

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rethink

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British
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Society



The New Savoy Partnership



The We need to talk coalition is calling for the NHS in England to offer a full range of evidence-based psychological therapies to all who need them within 28 days of requesting a referral.

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Executive summary

The We need to talk coalition is calling for the NHS in England to offer a full range of evidence-based psychological therapies to all who need them within 28 days of requesting a referral.

Giving people access to the right therapy at the right time will deliver cost savings in the treatment of both mental and physical health problems and a reduction in wider societal costs such as unemployment. For example, extending NICE-recommended treatment to those with depression would result in £1 billion of economic benefits each year.

The introduction of the Department of Health's Improving Access to Psychological Therapy (IAPT) programme in 2007 was an important step forward for the provision of psychological therapies. In many places, this programme provides an invaluable service to those with mild to moderate depression and has led to heavily reduced waiting times, achieved high recovery rates and helped people get back to work.

However, the overall picture is patchy. Our research found that the way in which some local areas have interpreted and implemented IAPT has actually led to a reduction in both choice and access to psychological therapies, particularly for those unsuitable for the programme but still requiring psychological therapies.

There is still a long way to go in the improvement of psychological therapy provision if evidence-based interventions are to be available to all who need them.

Choice

- Only eight per cent of those surveyed had a full choice in the therapy they received.
- Just 13 per cent of those surveyed had a choice in where they received therapy.
- Half of those surveyed had a choice in the time of their appointments.

Choice is a fundamental part of the newly proposed NHS reforms. However, it is clear that the majority of people accessing psychological therapies have minimal choice in what treatment they have and when and where they receive it.

Waiting times

- One in five of those surveyed has been waiting over a year to receive treatment.
- One in 10 of those surveyed has been waiting over two years to receive treatment.

Waiting times can have a devastating impact on a person's life. They can exacerbate mental distress and cause relationships to break down, jobs to be lost, people to be isolated and, in extreme cases, lead to suicide attempts. But far too many people are still waiting far too long to receive treatment.

Universal access

- Less than two-thirds of people with severe mental health problems are offered evidence-based psychological therapies.
- Children, older people, men and those from black and minority ethnic groups remain underserved by psychological therapies.

The coalition government has given a strong emphasis to fairness in its policy-making. Yet, current access to psychological therapies is inherently unfair for particular groups of people trying to access psychological therapies.



“You have to fight and fight to get access and those who are well enough to shout the loudest get access. The people who are too sick to confidently represent themselves are the victims of the current set up.”*

1 in 5

people have been waiting over a year to receive treatment.

only 8%

had a full choice about which therapy they received.

People who had a choice of therapies were

3 times

more likely to be happy with their treatment than those who wanted a choice but did not get it.

People offered a full choice of therapy were

5 times

more likely to report that therapy helped them back to work than those who weren't.

Those waiting less than three months from assessment to treatment were almost

5 times

more likely to report that therapy definitely helped them get back to work than those waiting one to two years.

*Unless otherwise specified all quotations are taken from anonymous respondents to Mind's survey of 527 mental health service users in April 2010.

Recommendations

For the coalition government

- The Government should use the upcoming comprehensive spending review to commit funding for the maintenance and development of the IAPT programme.

For local commissioners of psychological services

- People should be given a full and informed choice when accessing psychological therapies. This should include choice around therapist, therapy type, appointment times and location of treatment.
- Commissioners must not use IAPT funds as an excuse to cut resource to other psychological therapy services.
- Commissioners should aim to integrate all psychological therapy provision at local level.
- Commissioners should commission IAPT services that have the capacity to provide people with an appropriate number of therapy sessions to achieve the best outcome for people using the service.
- Commissioners should ensure that those with complex and severe mental health needs have access to suitable and specialist psychological therapies.
- Commissioners should build upon the existing workforce, as well as supporting training for future practitioners, to ensure that psychological therapy services are led by senior clinicians and that different therapies are delivered by professionals of corresponding levels of competency.
- Commissioners should support third sector organisations to continue their current provision of psychological therapies and better enable them to bid for IAPT contracts on a level playing field with other potential providers.
- Commissioners should commission more support for early intervention and specialist non-IAPT services, particularly those for children and adolescents, to ensure that capacity meets local need and demand.

For the Improving Access to Psychological Therapy (IAPT) programme

- IAPT should adapt its services in order to reach marginalised groups. This could include raising awareness of IAPT among schools, better publicising self-referral routes and making GPs aware of the benefits IAPT can bring to older people and men.

For primary care practitioners

- Primary care practitioners should be better trained to ensure that they are able to provide accurate information to those wishing to access psychological therapies.
- Assessments for all psychological therapy services should be completed by experienced and highly qualified practitioners to ensure appropriate referrals.

For the Care Quality Commission (CQC)

- The CQC should undertake a special review of adherence to NICE guidance on psychological therapies within both primary and secondary care.

For the National Institute of Health and Clinical Excellence (NICE)

- NICE should take into account the needs of psychological therapy groups that seek to gain an evidence base when making recommendations on where new research is targeted. Funding bodies should consider NICE recommendations when making new grants available.

Methodology

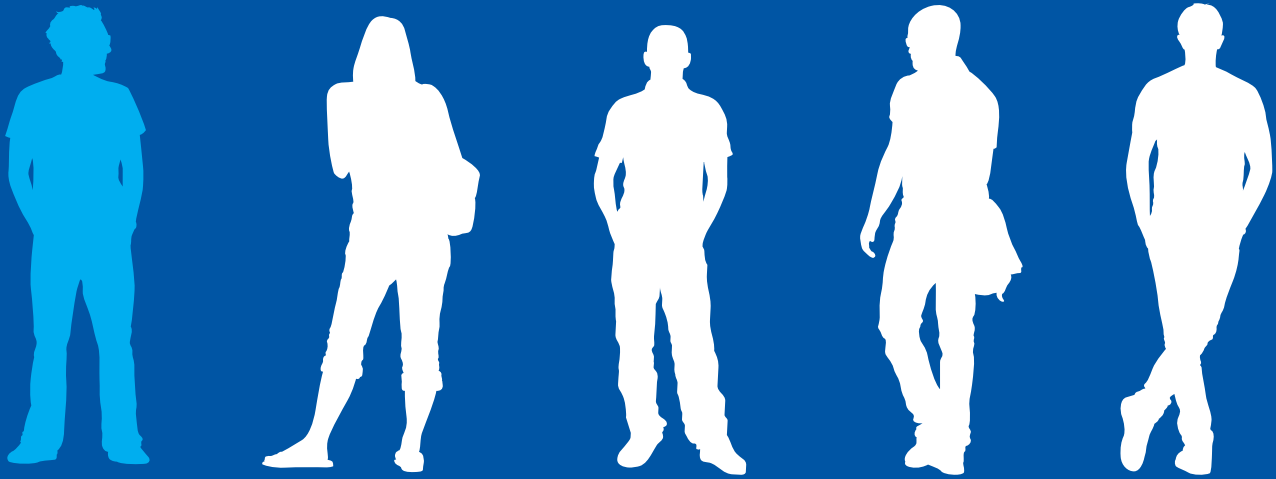
The following report is based upon research undertaken by Mind between March and August 2010. The research involved:

- surveys of people attempting to access psychological therapies
- local Mind associations and primary care trusts
- a call for evidence to the We need to talk coalition members
- a consultative event with local Mind associations
- discussions with service planners and providers across the country.

The survey of people attempting to access psychological therapies was carried out in April 2010. It was open to those who had attempted to access therapies on the NHS in England within the last two years. The survey was distributed to service user networks and also hosted on the websites of some coalition members. We received 527 responses.



“Receiving psychological therapy turned out to be the best thing that could possibly happen for me, it was exactly what I needed... a place for me to finally look at my past and put the pieces together and come to understand why I felt the way I did.”



One in five people have
been waiting over a year
to receive treatment.

Introduction

One in four people experiences mental distress in any one year (Goldberg and Huxley, 1992) and this number is set to increase – the World Health Organization predicts that within 20 years depression will be the second most common cause of ill health.

We already know that the recession has led to more people experiencing mental distress and the impact of the tightening of the public purse is likely to make things even worse.

Psychological therapies can provide a lifeline to those with mental health problems but many people across the country are still waiting months and sometimes years to get the treatment they desperately need. In some cases, people are simply never offered therapy in the first place. Even when therapy is available, the vast majority of people are not able to choose the treatment they want at a time and place suitable to them.

The proposed NHS reforms provide opportunities to change this. However, the focus on choice and fairness must be translated into the provision of psychological therapies. Ensuring access to a wide range of psychological therapies will be a litmus test of the Government's commitment to choice in mental health.

"In the end I fell apart and had to go down the massively expensive private route (a big struggle for us). Why could the NHS not have helped me when I was seriously unwell? I realise how very fortunate I have been to have had some access to private healthcare. I can't bear to think where I'd be if I'd been completely dependent on the NHS. It really shouldn't be this way in a country where healthcare is meant to be available to everyone based on clinical need and not ability to pay."

Why is psychological therapy important?

Psychological therapies are widely recognised as effective treatments for a wide range of mental health problems, with the National Institute for Health and Clinical Excellence (NICE) recommending many forms of therapy as first-line interventions.

Access to the right therapy at the right time can have an enormously positive impact on a person's life. It can help people to better manage their condition and, in many cases, enable a full recovery.

"Therapy has turned my life around – sorted out my behaviours, helped me manage my emotions, has made me live again."

The economic benefits of psychological therapy

The economic cost of mental distress is very high.

- Mental distress costs the economy in England £105 billion each year (Centre for Mental Health, 2010).
- Depression alone costs £7.5 billion, of which only £1.7 billion is to NHS services with the rest going on the cost of lost employment (McCrone et al., 2005).
- Although the prevalence of psychosis is relatively low (0.45 per cent), the societal cost of schizophrenia is £6.7 billion (Mangalore and Knapp, 2007).

Providing the right therapy at the right time to those in need has the potential to deliver substantial savings to both the NHS and the wider economy. For example:

- Extending NICE-recommended treatments to all those with depression could deliver £1 billion in economic benefits each year, with treatment costs vastly outweighed by higher government revenues and reduced welfare payments as well as wider social benefits (Foresight, 2008).
- Delivering cognitive behavioural therapy (CBT)* to those with a diagnosis of schizophrenia can lead to savings of £1,000 per person (Rethink, 2010).

*CBT therapies work by changing people's attitudes and behaviour. They focus on the thoughts, images, beliefs and attitudes that we hold (our cognitive processes) and how this relates to the way we behave, as a way of dealing with emotional problems.

Cost savings in the treatment of physical health conditions

The effective provision of psychological therapies also has the potential to provide savings in the treatment of physical health problems. Many people with these problems experience mental distress.

- 20 to 30 per cent of consultations in primary care are for people with medically unexplained symptoms (MUS). It is thought that 70 per cent of those with MUS also have depression or anxiety and that mental distress may be the underlying cause in a significant number of MUS cases (IAPT, 2008).
- Depression is two to three times more common in people with a chronic physical health problem than those in good physical health (NICE, 2009).
- Depression rates double for those with diabetes, hypertension, coronary artery disease and heart failure and triple for those with end-stage renal failure, chronic obstructive pulmonary disease and cerebrovascular disease (Egede, 2007).
- 23 per cent of those with two or more chronic physical conditions have depression compared with 3.2 per cent of those without physical problems (Moussavi et al., 2007).

Including psychological therapies in the care pathway of those with MUS or long-term health conditions will lead to people being in a better position to look after themselves. It can also have a direct impact on the physical problem itself. For example, CBT has been found to reduce symptoms in those with chronic pain conditions (Eccleston et al., 2009).

Better self-management and a reduction in physical symptoms will result in cost savings through a reduction in primary care consultations, acute care appointments and the duration of hospital stays.

The human cost

Beyond the economics, the human cost of failing to deliver effective psychological therapies to those that need them is the critical issue. Lack of access to psychological therapy can shatter lives, affecting people's livelihoods, relationships and general wellbeing. There is a strong moral and social imperative to relieve mental distress and the burden of physical illness and disability across the whole population.

"I was not considered in enough need – it's a very sad state of affairs when you have to be much, much worse or suicidal before you will be taken as someone 'in need'... well, I'm on my way there..."

Paul's story



“The speed at which I was seen was incredibly helpful.”

“I've suffered from mental illness for almost half my life; for most of that I resisted being diagnosed with anything more than 'anxiety' and 'stress' out of fear of the stigma that being 'mentally ill' still carries. I managed to keep my depression under control, or so I thought.

“Last summer I was involved in a car crash which shook me up. The injuries I sustained stopped me running, and running was one of the few things that kept me calm. I returned to work a few weeks after the crash, and tried to settle back into a routine. The Monday after I returned to work, I was sitting at my desk when I noticed that the heel on my right shoe was hanging off. Just after I noticed this, my iPod battery ran out. Suddenly I broke down in tears. I realised this wasn't right and that I needed to get help.

“My GP signed me off work and I was put on a mild dose of antidepressants, though this was doubled within a month as I started to get worse. My doctor also referred me for counselling. I had to wait a little while for my referral to come through, but once that happened I very quickly started therapy. I had my six sessions and then it was decided that it would be good if I had some psychotherapy so I was referred for this too.

“I continued to see my counsellor for some extra sessions whilst I started a number of assessments to find out if I was suitable for psychotherapy. It was decided that I would respond well to psychodynamic therapy, so after another fairly short wait I started that earlier this year and it's still ongoing. I am now completely off antidepressants.

“To be honest, if I hadn't been able to have the counselling followed by the psychotherapy then it's debatable whether I'd still be here now; at my worst I became suicidal, and was almost sectioned for my own good. It's only been very recently that my wife has stopped hiding all the knives and razor blades in our house. Certainly, if I wasn't dead then I would not be in any fit state to talk to anyone, or lead my life as I do.

“The speed at which I was seen was incredibly helpful. If I'd been told I could have therapy but that I'd have to wait six months, a year, or more, the impact that would have had on me would have been unimaginable. The progress I've made through counselling and psychotherapy has been phenomenal. At various points over the last twelve months I've looked in the mirror and not recognised the person staring back at me, seeing instead someone who scared me. I felt that I've been this confused mess of different people.

“Now I know who I am again.”



Only eight per cent
had a full choice about which
therapy they received.

The policy context

Over the last few years, the major development in psychological therapy provision has been the introduction of IAPT (see right). The We need to talk coalition is supportive of IAPT and believe it represents a great step forward for psychological therapy provision on the NHS in England.

However, there is still much to do in order to improve access to psychological therapy. IAPT is only designed to address access to psychological therapies for a limited number of people – those with mild to moderate depression and anxiety. Regrettably, the way in which some local areas have interpreted and implemented the programme has actually led to a reduction in both choice of and access to psychological therapies.

We welcome the coalition government's recent commitment to ensure greater access to talking therapies and subsequent statements confirming this pledge. We also believe the proposals within the recent health White Paper, *Equity and Excellence: Liberating the NHS*, could lead to many opportunities for improving the delivery of psychological therapies.

"In future, patients and carers will have far more clout and choice in the system; and as a result, the NHS will become more responsive to their needs and wishes. People want choice, and evidence at home and abroad shows that it improves quality."
(Department of Health, 2010)

The White Paper goes on to state that there will be "choice of treatment and provider in some mental health services" from April 2011. This vision should provide the impetus to ensure that a full range of psychological therapy is offered wherever appropriate, regardless of postcode.

In order to achieve such positive change, a national focus remains vital to ensure that the key principles for effective psychological therapy provision are put in place across the country.

Improving Access to Psychological Therapies (IAPT)

In 2007, the then Government pledged £173 million over three years to the development of the IAPT programme. IAPT's remit is to deliver NICE-compliant psychological therapies to those experiencing mild to moderate depression and anxiety.

By 2010/11, the IAPT programme aims to: train 3,600 new therapists; extend access to psychological therapies to 900,000 more people; and get 25,000 people off sick pay and benefits.

IAPT sites are being set up across most of England over a three-year period. Some sites have been chosen to focus on particular groups or activities, such as black and minority ethnic (BME) populations or employment support.

In July 2010, the coalition government took the welcome decision to ensure that the programme received the full £173 million originally intended.

The current situation: what's working?

There are many examples from around the country of good practice in providing psychological therapy. Areas where an IAPT service has been well integrated with other broader psychological therapy provision show particular success.

In these places, waiting times have been cut drastically, recovery rates are good, people are returning to work and satisfaction is high among people using the services.

“I have found the whole process to be excellent. After seeing my GP, I was referred through Choose and Book... and had an appointment within two weeks. During this time I have had counselling and CBT... It's a real lifeline.”

TalkingSpace

Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust and Oxfordshire Mind submitted a successful joint bid to deliver the IAPT service in their local area.

TalkingSpace (the Oxfordshire IAPT service) opened in the summer of 2009 and received 8,000 referrals in its first year. The service is locally based with 24 delivery points across Oxfordshire both in primary care and community settings. Service users have access to a wide range of NICE-approved psychological therapies, such as computerised CBT (delivered via an interactive computer programme), individual counselling and behavioural activation. Employment support is also delivered as part of the programme and additional funding has enabled a pilot scheme to be developed that provides CBT to those with long-term conditions.

The results are impressive. Target recovery rates have been exceeded, with up to 53 per cent achieving recovery compared to the goal of 50 per cent. The number of service users moving off benefits has also exceeded expectation with 96 achieving this in the first year – the target was just 26. Importantly, service user approval is very high with 92 per cent satisfied or very satisfied with the service.

“It's been the best thing that I could have done. These sessions have done more than any medications I had previously.”

“When I started I felt worthless and now I feel in control of my life again.”

Pre-existing counselling services have also been sustained and now work alongside TalkingSpace. This was something local GPs argued for strongly and their pressure has had a significant influence on the PCT's commissioning plans.

The service still faces challenges, such as increasing access through self-referral and ensuring it has capacity to meet very high demand. Nevertheless it is clear that TalkingSpace has truly improved access to psychological therapies within Oxfordshire and benefited the lives of many.

Innovation in the voluntary sector

Many voluntary sector providers of IAPT have built local partnerships in order to increase access from otherwise hard-to-reach groups.

Stoke

In Stoke, the very first externally commissioned IAPT site, staff from national mental health charity Rethink have run sessions at the local football club, Port Vale. The service uses a range of interventions, from CBT to group therapy, and increases the intensity according to people's needs. The programme has proved very popular with young men who have often found it difficult to speak about mental health needs. A partnership has also been developed with the local cardiovascular service to ensure that people experiencing physical health problems get essential psychological treatment. At the same time, the service has ensured all patients are now contacted on the same day as referral and has received patient satisfaction ratings of over 95 per cent.

North East Essex

At the North East Essex site, run in partnership by Rethink, Colchester Mind and North Essex Partnership NHS Foundation Trust STaR (Support Time and Recovery) workers have promoted the service to groups such as older people, carers and 16- to 19-year-olds. A new relationship has developed with the local college to help young people recognise their underlying mental health problems. STaRs have also worked with users on employment issues, resulting in 53 people returning to work in the service's first year. Over 80 per cent of users are satisfied or very satisfied with the type of treatment and overall experience, and the rest neutral.

"It was a good service and I can't fault it. I was seen a couple of times and came off antidepressants soon after."

"I found the way I was listened to in the service absolutely fantastic. My therapist was great and really listened to me and offered lots of options of things to do to help."

Clinicians and managers have also reported that the service has transformed local healthcare.

"If I am proud of anything in my time as a manager with the PCT, it has to be my involvement with establishing such an excellent service."



People who had a choice of therapies were **three times more likely** to be happy with their treatment than those who wanted a choice but did not get it.

The current situation: what's the problem?

In April 2010, the We need to talk coalition carried out a survey of people who have tried to access psychological therapies on the NHS in England within the last two years. We received 527 responses. Respondents may or may not be from IAPT sites.

The survey results showed wide variation across the country. Many people are now getting access to their choice of psychological therapy within weeks, while others are still waiting years for a service that is not right for them in the first place.

Choice

- Only eight per cent had a full choice about which therapy they received.
- 40 per cent had the different psychological therapies explained to them.
- Just 13 per cent had a choice of where they received therapy.
- Half had a choice about the time of their appointments.
- 28 per cent had to pay privately because the therapy they wanted was not available.

Waiting times

- One in five people have been waiting over a year to receive treatment.
- One in 10 people have been waiting over two years to receive treatment.
- Around a third of people are waiting under six months to receive treatment.

Treatment

- Half got the treatment they felt they needed.
- 40 per cent felt that therapy did or might have helped them get back to work quicker.
- Of those for whom treatment was not successful, 43 per cent were not offered any other treatment.
- Only 40 per cent felt they had enough therapy sessions.

Satisfaction with therapy

- Those waiting three months or less from assessment to therapy were over twice as likely to be happy with their treatment as those waiting 10 to 11 months.
- People who had had their choices explained to them were twice as likely to be happy with their treatment than those who hadn't (67 per cent compared to 34 per cent).
- Having a full choice of therapy was associated with people being three times more likely to be happy with their treatment than those who wanted a choice but did not get it (91 per cent compared to 28 per cent).
- Being able to choose a location of treatment that was right for them was associated with people being much more likely to be happy with their treatment than those who could not (73 per cent compared to 41 per cent).
- Being able to choose a time of appointment that was right for them was associated with people being almost twice as likely to be happy with their treatment as those who could not (64 per cent compared to 36 per cent).

Getting back to work

- Those waiting less than three months from assessment to treatment were almost five times more likely to report that therapy definitely helped them get back to work than those waiting one to two years (19 per cent compared to four per cent).
- Having a full choice of therapy was associated with people being five times as likely to report that therapy definitely helped them back to work than those who did not (38 per cent compared to eight per cent).
- Being able to choose a location of treatment that was right for them was associated with people being almost twice as likely to report that therapy definitely helped them back to work as those who could not (24 per cent compared to 14 per cent).
- Being able to choose a time of appointment that was right for them was associated with people being over twice as likely to report that therapy definitely helped them back to work as those who could not (20 per cent compared to eight per cent).
- Having enough therapy sessions was associated with people being over three times as likely to report that therapy definitely helped them back to work as those who did not (26 per cent compared to eight per cent).

Choice

The coalition government has made choice a key part of its NHS reforms. However, our survey shows that there is a long way to go if choice is to become a real part of psychological therapy provision. Across the country, people consistently lack choice in the therapy they receive.

Only a small number (eight per cent) of those surveyed reported having a full choice. Even if people were given a choice, only 40 per cent had the different options explained to them. This is significant because our survey also found that those who were given a full and informed choice were considerably more likely to feel that therapy was effective and that it helped them back to work.

“No choice has ever been offered and no explanations.”

Our survey also showed that many people are reporting very limited treatment options from their IAPT service, with programmes often having a disproportionate focus on cognitive behavioural therapy (CBT). While CBT is known to be a very effective treatment, it simply will not work for everyone. Although guidance has been issued to encourage IAPT programmes to widen the types of therapy they offer, it seems that many areas have not taken this on board and the reality is that often there is little, if any, choice available.

People accessing psychological therapy services were also very unlikely to be given a choice in the time of their appointments or where they received therapy. Only half had a choice in appointment times and just a tiny minority (13 per cent) had a choice in location. However, as with choice in therapy type, those able to choose an appropriate time and location for them were much more likely to find that therapy was effective and that it helped them back to work.

Many survey respondents also reported that they wanted a choice in the gender of their therapist but that this was often not available.

Jenny's story



“...not getting the help I needed nearly caused me to lose my life.”

Jenny was diagnosed with bipolar disorder the same week that she found out that she was pregnant.

“Two weeks before the birth of my baby, things started to get really bad for me but they kept saying ‘Wait till you have the baby, wait till you have the baby.’ Then my son was born, but it was a very traumatic birth. I was really struggling after that but I couldn’t get any help, the psychiatrist just didn’t address my needs. I developed post-traumatic stress disorder (PTSD) as a result of the traumatic birth and all my community psychiatric nurse said was ‘Talk to your friends.’

“Things got worse and worse for me but there’s no perinatal mental healthcare available where I am. In March 2009, I was put on the waiting list for CBT, even though the NICE guidelines say you shouldn’t have to wait for perinatal mental health problems as the baby ends up suffering.

“In the time that I was waiting for CBT I had a major crisis and made a suicide attempt. I ended up spending three months on a mother and baby unit, which was not in my area. Whilst I was in there, they addressed the problems with my meds and I started doing art therapy, which was very effective at dealing with trauma and the feelings of being trapped in depression.

“I was discharged back to my own area but there was no art therapy available through the NHS. I eventually started CBT in October 2009, but my therapist was a man and I didn’t really feel comfortable with him as I couldn’t talk to him about childbirth or body image issues which were major things for me at the time. To be honest, the CBT wasn’t very effective but I kept being told I wasn’t stable enough for psychotherapy to address the PTSD.

“Having to wait for therapy and not getting the help I needed nearly caused me to lose my life. It exacerbated the despair and it exacerbated the hopelessness I was feeling. I didn’t bond with my son for 10 months and I feel so sad that I’ve lost that early part of his life. I’ve lost a year and a half of my own life, I’ve had to give up a job and a career that I loved and I’ve had to give up my financial stability now that I’m on benefits.

“I just don’t feel like myself anymore – to be honest I wouldn’t know how to introduce myself to new people. If I lived just one county next door I’d have all the support I need. It’s just not on offer where I live.”

Waiting times

Waiting times for psychological therapies still vary dramatically across the country. Although a high number of people are waiting less than six months from referral to treatment, one in five are having to wait over a year.

Our survey found that long waiting times not only reduce the effectiveness of therapy, but also cut the likelihood of therapy helping people to get back to work.

The wider human cost of long waiting times is devastating, exacerbating mental distress and having a negative impact on all aspects of a person's life. Survey respondents explained that long waiting times put pressure on their relationships and led to family breakdown, social isolation, homelessness, financial problems, damaging coping strategies, job losses and, in extreme cases, suicide attempts.

"I had a complete breakdown, was unable to work and was hospitalised. If therapy had been available when I needed it, I believe I could have been helped to manage the illness and not reach the stage where everything fell apart."

Number of sessions

Evidence shows the number of sessions offered by IAPT programmes is often falling below NICE guidelines. A review of the first year of IAPT roll-out found that the median number of sessions for low-intensity interventions was just two and for high intensity interventions it was only three (Glover et al., 2010). This compares poorly with NICE guidance that recommends at least six sessions for most low intensity interventions and up to 20 sessions for some high-intensity interventions. These findings were supported by our survey with just 40 per cent of people feeling that they received enough sessions.

"I felt that I was taken to the bottom of a truly dreadful situation. The budget ran out before I was properly 'put back together'. My counsellor suggested in a very positive way that I would benefit from more help, but I can't face the prospect of going through referral and assessment again."

Reduction in non-IAPT therapies

The IAPT programme was introduced in order to provide a model for delivering NICE-approved psychological therapies to those with a diagnosis of mild to moderate depression and anxiety. This would therefore free up waiting lists for other forms of therapy for those with more complex needs, such as people with substance misuse problems, and those with more severe mental health problems. IAPT was never intended to act as a comprehensive service delivering all psychological therapies.

Although Department of Health guidance has made it very clear that IAPT money should not be used to replace funding for other psychological therapy services, our research has shown that this is happening in a number of areas. In these situations, non-IAPT services are either having their funding cut or being decommissioned entirely – this simply replaces, not improves, the provision of psychological therapies.

As a result, those ineligible or unsuitable for IAPT are either being left without any support or pushed into an IAPT service that doesn't meet their needs. Where inappropriate referrals to IAPT are happening, some people may be put through a therapy that is actually damaging to their mental health. Consequently, IAPT outcomes are unfairly skewed and undue pressure is placed on IAPT workers due to having deal with complex conditions that they are not trained to work with.

"I was just simply told 'not eligible'... I was devastated, I needed the help."



"I'm waiting at the moment and the last parts of my life are falling apart in front of me and I can't do anything about it. I honestly don't feel like I will be alive by the time the therapy is meant to start."

The impact of decommissioning non-IAPT services

The following account describes the experience of one local Mind association. This is not an isolated case – we have heard many similar stories over the last few months from around the country. We have chosen to keep the local Mind association anonymous as the aim of this report is to look ahead to how provision can be improved, not to name and shame local areas.

For many years, a local Mind association in northern England has been delivering psychological therapies to all those that may benefit. It is the only service in its area to implement such an open-door policy. However, the introduction of IAPT led local commissioners to cut funds to existing psychological therapy services. Subsequently, £50,000 of the local Mind association's funds were cut.

The effect on local service users has been catastrophic. The IAPT service only offers CBT or self-help as the PCT does not believe other therapies are 'strategically relevant'. Although the PCT does provide some limited psychotherapy, waiting lists are very long and the service often turns people away for having too complex needs. As a result, there is minimal long-term counselling available on the NHS in this area. Those ineligible or unsuitable for IAPT services are falling through the gap.

Although GPs have been told to advise people wanting long-term therapy to approach private practices, many GPs are still referring people to the local Mind association. The local Mind association is therefore experiencing a high level of demand even though the service is no longer funded by the PCT to provide therapy. If the rest of their funding is cut, people needing therapies other than CBT or self-help will lose one of their last options and many will be left with nowhere to go.

Provision for those with severe mental health problems

People with severe mental health problems are among the most vulnerable members of our society. However, there is a worrying lack of psychological therapy provision for those in this group, particularly on inpatient wards. A recent Rethink report highlighted that fewer than two-thirds (61 per cent) of service users with severe mental health problems are offered psychological therapy as recommended by NICE (Rethink, 2010). The Royal College of Psychiatrists (2010) also notes that those who self-harm have limited access to psychological therapy and another report from the British Psychological Society (2010) states that only a minority of those with a diagnosis of bipolar disorder access psychological therapy, and that those who do are very unlikely to have a choice in the type they receive.

This research was confirmed anecdotally by our discussions with service providers across the country. One clinical psychologist explained that there had been no real increase in funding for psychological therapies for inpatients in the local area for decades and that, as a result, "if you're an inpatient, there is no help." Unlike all other healthcare areas, psychological therapy provision is often being restricted to those with less severe conditions. This is simply wrong and must change urgently.

"I was told that because I suffer from the condition of paranoid schizophrenia that I was not eligible for psychotherapy."

The impact on therapists

The recent developments in psychological therapy provision over the last few years have had a mixed impact on therapists. Psychological therapy training is now available on the NHS with IAPT funding 3,600 new therapists. This is a fantastic opportunity for the profession. However, research by the British Association of Counsellors and Psychotherapists has found that, where areas implement IAPT in a way that reduces funding for other services, therapists not trained in IAPT modalities, particularly CBT, are losing their jobs. For example, many in-house GP surgery counsellors are being let go, depriving services of the local knowledge and valued relationships with service users that these counsellors have built up over the years. Underusing an existing trained workforce is simply not practical, particularly in the current financial climate.

In discussions with service providers we were also told that many IAPT therapists are experiencing stress as a result of having to work with complex problems they are not trained for, due to inappropriate referrals. This has led to some therapists leaving the IAPT programme.

The impact on the voluntary sector

Our research found variations in the experience of some voluntary sector service providers of psychological therapies. For example, some local Mind associations were successfully delivering IAPT-funded services through partnerships with local NHS providers and were able to roll out the programme without a reduction in the provision of pre-existing therapies.

However, other local Mind associations reported concerns with the implementation of their local IAPT programme. Many had been unable to tender for IAPT funds due to the way in which contracts were advertised. Contracts were either impossibly large, timescales were too tight for capacity-stretched voluntary services to work with or, in some cases, contracts were not put out to tender at all. The third sector has much to bring in terms of expertise, with many charities already delivering effective psychological therapy services. However, the potential of this resource is often being wasted due to a tendering system that makes it hard for existing local services to become a part of IAPT programmes.

Even though numerous voluntary sector services are not receiving IAPT funds, many have seen their referrals rise sharply as a result of the programme. With non-IAPT services being reduced in some areas, both primary and secondary care practitioners are increasingly referring people with more complex problems to the charity sector. As a consequence, waiting times for charity delivered services are going up but there is often no new funding from PCTs to enable these providers to match capacity with demand. Worst still, funding is actually being cut in some cases. The inability of charities to perform effectively or even survive without access to statutory funds has implications for the 'big society' agenda. If the voluntary sector is to be successfully developed as a key provider of services, charities will require more support in order for their services to be sustainable.

“Our service is of a high standard but remains unfunded and there was no opportunity to tender for IAPT because of how it was advertised.”

“This has created huge extra demands on our counselling service because of referrals of 'unsuitable' clients from the primary care counselling service.”

Equity of access

Children and young people: Half of mental disorders start before the age of 16 and three-quarters before the age of 25. Ten per cent of 5 to 15 year olds have a mental health disorder and the lifetime cost of a single case of untreated childhood conduct disorder is approximately £150,000. Early intervention for young people with emotional, behavioural or social difficulties can help prevent mental health problems becoming more serious or developing in the first place. However, only a quarter of children with mental health problems have seen a mental health professional within the last year and average staffing levels for specialist Children and Adolescent Mental Health Services (CAMHS) are approximately 33 per cent below that recommended by the National Service Framework (Maughan and Kim-Cohen, 2005).

There has been little development in the provision of psychological therapies for children and young people over the last few years. IAPT exists only for those aged 16 or over and only one IAPT site to date has been aimed specifically at younger people. In fact, only one per cent of those accessing IAPT services are under 18 years old. Those aged under 16 need to rely on non-IAPT services yet, as previously discussed, many of these services are having their funding cut or being decommissioned.

Older people: A consistent concern among the people we spoke to throughout our research was the lack of psychological therapy provision for older people. It is estimated that a quarter of all people over 65 living in the community and at least 40 per cent of those in care homes have depression serious enough to warrant intervention. However, in both cases, only half of them are treated and, of those offered treatment, only a very small proportion receive psychological therapy (Age Concern, 2007). For example, only four per cent of those accessing IAPT are over 65 (NHS, 2008).

Black and minority ethnic groups: The old National Service Framework (1999) noted that people from black and minority ethnic (BME) groups are much less likely than other groups to be referred to psychological therapies (NHS, 1999). More recently, the equality impact assessment for IAPT acknowledged that BME groups experience particular barriers to accessing psychological therapies (NHS, 2008). These barriers are twofold. Firstly, BME groups are less likely than other groups to access statutory services in the first place. Secondly, many areas lack culturally sensitive services where tailored support, such as interpreters, is available.

It is commendable that certain IAPT sites have been developed to target BME communities specifically. However, overall, BME groups are not accessing IAPT services in line with expectation. Although self-referral is known to work more effectively with BME groups, it is not being used or publicised consistently across IAPT sites, even though this is recommended in the programme's guidance. Whilst some sites report a third or more of all people are accessing IAPT through self-referral, self-referral counts for just 2.1 per cent or fewer of referrals in half of the sites (Glover et al., 2010).

Men: IAPT is well placed to benefit men. Research suggests that men may be more receptive to treatments that emphasise outcomes, goals and productivity, such as CBT (Mind, 2009). However, men are only half as likely to access IAPT services as women (Glover et al., 2010).



People offered a full choice of therapy were **five times more likely** to report that therapy helped them back to work than those who weren't.

The way forward

It is clear that the provision of psychological therapies has greatly improved in many parts of the country over the last few years. However, much more needs to be done to ensure that everyone has access to the help they need, when they need it.

The key principles underlying a comprehensive and effective psychological therapy service are that:

- people needing access to psychological therapy services are given a real choice in the therapy they access
- waiting times for therapy should be no longer than 28 days from referral to treatment
- the therapies provided are available to all those who may benefit from them.

Choice

“Patients will have choice of any provider, choice of consultant-led team, choice of GP practice and choice of treatment.” (Department of Health, 2010). This vision to deliver choice on the NHS needs to include those accessing psychological therapies. People should be given an informed choice that includes not only a choice in the forms of therapy available to them but also choice in therapist, appointment times and location. People with dependents (such as parents and carers) should also be provided with care support to ensure that they are not unfairly prevented from accessing treatment.

Recommendation

- People should be given a full and informed choice when accessing psychological therapies. This should include choice around therapy type, therapist, appointment times and location of treatment.
- Primary care practitioners should be better trained to ensure that they are able to provide accurate information to those wishing to access psychological therapies.



“I had to travel 10 miles for the only counselling available on IAPT. This is really difficult as I struggle with travel as part of my problems, but there was no other help except paying a lot for it.”

Funding

Across England, IAPT programmes provide an invaluable service to those with mild to moderate depression and anxiety. These sites will need a continued resource to maintain and expand provision. The original, centrally provided funding for IAPT is due to end in 2011, but no commitment has been made of further resource to sustain the programme. Without this, there is a real chance that all progress made through IAPT will be lost.

Beyond IAPT, it is vital that non-IAPT services are retained and developed – in both primary and secondary care – to ensure that those who do not meet the criteria for IAPT are not discriminated against.

Commissioners are crucial to the support and development of psychological therapy services. With NHS reforms in mind, GP consortia should ensure that psychological therapies are on their agenda ahead of their future commissioning role.

Recommendations

- The coalition government should use the upcoming comprehensive spending review to commit funding for the maintenance and development of psychological therapy services.
- Commissioners must not use IAPT funds as an excuse to cut resource to other psychological therapy services.

An integrated service

Where possible, all local psychological therapy services should be fully integrated with multiple points of access, such as self-referral. Particular programmes, such as IAPT, would still work as separate provisions within this model but there would be more effective joined-up working. This should better enable the identification of gaps in provision, for example lack of psychological therapy services for those with personality disorder.

A fully integrated system would also allow for a smoother care pathway. In our survey, 14 per cent of people for whom treatment was not successful had to wait for a different therapy and 43 per cent were not offered further treatment of any kind. This would be unheard of in other healthcare areas, such as cancer treatment, where the failure of one intervention would never result in a service effectively giving up on the person in need. If psychological services were better integrated, service providers would be better able to refer those not yet achieving recovery on to other appropriate services.

“If I had cancer, surely they wouldn’t let the tumour take over my body and kill me, but mental health just doesn’t seem to matter.”

Recommendation

- Commissioners should aim to integrate all psychological therapy provision and provide multiple points of access at local level.

Assessment

At present, assessments for IAPT services are often done by low-intensity IAPT workers (sometimes trainees) who are not necessarily equipped to identify service users with more complex problems who should be referred to other non-IAPT services. In many cases, this has led to inappropriate referrals. Assessments for all psychological therapy services should therefore be carried out by a highly qualified and experienced psychological therapy practitioner. This would be relatively simple to achieve in areas where an integrated service with a single point of access is in place.

Recommendation

- Assessments for all psychological therapy services should be completed by experienced and highly qualified practitioners to ensure appropriate referrals.

Number of sessions

Many IAPT sites are not providing people with the number of sessions recommended by NICE. Local Mind associations explained that commissioners were unlikely to commission services with a high number of sessions due to cost. However, this is a false economy as people are more likely to relapse if they have not fully recovered.

Recommendation

- Commissioners should commission IAPT services that have the capacity to provide people with an appropriate number of therapy sessions to achieve the best outcome for people using the service.

Provision for those with severe mental health problems

The reduction of non-IAPT services has led to those with the most severe problems being denied access to psychological therapy. Commissioners need to ensure that psychological therapy services are available for those with severe mental ill health, including within inpatient settings.

Recommendation

- Commissioners should ensure that those with complex and severe mental health needs have access to suitable and specialist psychological therapies.

Workforce

Psychological therapy provision needs to be locally led by senior clinicians, ideally at consultant level, who have the skills and experience required to manage such a complicated service. They should be charged with overseeing assessment, supervising and training staff and taking on the most complex and risky work. Service providers also need to employ therapists of varying grades in order to ensure that the different forms of therapy are delivered by professionals at corresponding levels of competency. To support this, services should aim to build upon the trained workforce already in existence as well as supporting training for future practitioners.

Recommendation

- Commissioners should build upon the existing workforce, as well as supporting training for future practitioners, to ensure that psychological therapy services are led by senior clinicians and that different therapies are delivered by professionals of corresponding levels of competency.

Supporting the voluntary sector

Commissioners of psychological therapies need to acknowledge the value that voluntary sector services can bring to the provision of psychological therapy. The assumption should not be that IAPT services need to be developed from scratch. Instead, commissioners should build on existing expertise by giving charities an opportunity to bid for IAPT contracts on a level playing field with other potential providers. To support this, tendering processes should be simplified, timescales expanded where possible and split contracts (enabling bids to provide just part of a service) made available where this makes sense in a particular locality.

Recommendation

- Third sector organisations should be supported by local commissioners to continue their current provision of psychological therapies and better enable them to bid for IAPT contracts on a level playing field with other potential providers.

Equity of access

IAPT should continue its efforts to make the programme equitable to all groups. Project sites should learn from the specific programmes targeting black and minority ethnic (BME) groups and adapt their services in light of these findings. Sites should also be encouraged to better publicise self-referral routes and take efforts to create a diverse IAPT workforce.

In addition, IAPT should develop programmes that aim to target groups not currently accessing its services as hoped. As part of this, IAPT programmes could work with schools to publicise its service and raise awareness among primary care practitioners of the benefits that therapy can offer to older people and men to ensure that these groups are referred to IAPT where appropriate.

Beyond IAPT, more support should be made available to develop capacity for specialist services, particularly for those aged under 16.

Recommendations

- IAPT should adapt its services in order to reach marginalised groups. This could include raising awareness of IAPT among schools, better publicising self-referral routes and making GPs aware of the benefits IAPT can bring to older people and men.
- Local commissioners should be commissioning more early intervention and specialist non-IAPT services, particularly those for children and adolescents, to ensure that capacity meets local need and demand.

Monitoring NICE adherence

Better monitoring is required to ensure that primary and secondary care services provide access to psychological therapies as recommended by NICE, particularly to those ineligible for IAPT. The Care Quality Commission (CQC) should undertake a special review of access to evidence-based psychological therapies across all care pathways, as part of its regulator role in ensuring quality of care in our mental health services.

Recommendation

- The CQC should undertake a special review of adherence to NICE guidance on psychological therapies within both primary and secondary care.

Research base

Many psychological therapies have a strong evidence base and are NICE-approved first-line treatments. However, many forms of psychological therapy are able to achieve good outcomes but have not yet had the opportunity to go through the research procedures necessary to achieve NICE approval. As a result, people are potentially losing out on accessing a wider range of effective therapies through the NHS. We ask that NICE takes this into account when making recommendations on where new research should be targeted. These recommendations should be considered by research funders to ensure that support is given to psychological therapy groups wishing to achieve NICE approval.

Recommendation

- NICE should take into account the needs of psychological therapy groups that seek to gain an evidence base when making recommendations on where new research is targeted. Funding bodies should consider NICE recommendations when making new grants available.

Conclusion

The We need to talk coalition recognises the developments within psychological therapy provision over the last few years. In particular, we welcome the strides that the IAPT programme has made.

It is essential that this momentum is not lost. It is clear that there is still a long way to go in improving psychological therapy services. The majority of people trying to access these services lack choice in the therapy they receive and how they receive it, and far too many people are waiting months if not years to get the treatment they need.

With the numbers of people experiencing mental distress due to rise, it is imperative that this situation is improved so that those in need have access to the right therapy at the right time, now and in the years to come.



“I was placed on a waiting list. Six months later I decided to refer myself to a private therapist, which has worked out well. About a year later I received a letter from the unit apologising for the delay and asking if I still wanted to be considered for therapy. Thankfully, I’m doing so much better with my new therapist I’m glad to say I didn’t have to go back to the NHS provider. I’m so grateful that my parents are able to afford private therapy, otherwise I think I would probably be dead now.”



References

- Age Concern (2007), *Improving services and support for older people with mental health problems: The second report from the UK Inquiry into Mental Health and Well-Being in Later Life*
- British Psychological Society (2010), *Understanding Bipolar Disorder: Why some people experience extreme mood states and what can help*
- Centre for Mental Health (2010), *The economic and social costs of mental health problems in 2009/10*, CMH, London
- Department of Health (2010), *Equity and Excellence: Liberating the NHS*
- Eccleston C., Williams A., Morley S. (2009), 'Psychological therapies for the management of chronic pain (excluding headache) in adults', *Cochrane Database of Systematic Reviews* 2009, Issue 2
- Egede L. (2007), 'Major depression in individuals with chronic medical disorder: Prevalence and correlates and associates of health recourse utilisations, lost productivity and functional disability', *General Hospital Psychiatry*, pp.29, 409–16
- Foresight (2008), *Mental health: Future challenges*
- Glover G., Webb M., Evison F. (2010), *Improving Access to Psychological Therapies: A review of the progress made by sites in the first roll-out year*, North East Public Health Observatory
- Goldberg D. and Huxley P. (1992), *Common mental disorders – a bio-social model*, Routledge
- IAPT (2008), *Commissioning IAPT for the whole community*
- Mangalore R. and Knapp M. (2007), 'Cost of schizophrenia in England', *Journal of Mental Health Policy and Economics*, pp.10, 23-41
- Mughan B. and Kim-Cohen, J. (2005), 'Continuities between childhood and adult life', *Br J Psychiatry*, vol.187, pp.301-303
- McCrone P., Knapp M. and Fombonne E. (2005), 'The Maudsley long-term follow-up of childhood and adolescent depression: predicting costs in adulthood' *European Child and Adolescent Psychiatry*, pp.14, 407–13
- Mind (2009), *Men and Mental Health: Get it off your chest*
- Moussavi S., Chatterji S., Verdes E. et al. (2007), 'Depression, chronic disease and decrements in health. Results from the world health surveys', *Lancet*, pp.370, 851-8
- NHS (1999), *A National Service Framework for Mental Health*
- NHS (2008), *Improving Access to Psychological Therapies Equality Impact Assessment*
- NICE (2009), *Depression in adults with a chronic physical health problem: treatment and management*
- Rethink (2010), *Fair Treatment Now*
- Royal College of Psychiatrists (2010), *Self-harm, suicide and risk: helping people who self-harm*

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