



We still need to talk

A report on access to talking therapies

About the *We need to talk* coalition

The We need to talk coalition is a group of mental health charities, professional organisations, Royal College 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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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, and this wait should be even shorter when someone presents with a mental health emergency.

Accessing the right treatment at the right time can mean recovering well from a mental health problem. Timely access to good quality psychological therapy provision is essential and although the Government has made good progress with its Improving Access to Psychological Therapies (IAPT) programme, there is still much to do before people with mental health problems receive the crucial help and support they need.

The Health and Social Care Act 2012 put mental health on a par with physical health and the Government reiterated this commitment through its current mental health strategy *No health without mental health*. Furthermore, the current Mandate to NHS England clearly requires NHS England to achieve parity of esteem between mental and physical health. As a first step towards achieving this commitment, timely and appropriate access to psychological therapies must be available in the NHS to all who need them.

The Mandate sets specific objectives on establishing access standards for IAPT services, yet our research has shown that demand for crucial psychological therapies continues to increase while people are still waiting far too long to access a service. While the We need to talk coalition fully welcomes the pledge to establish access standards for IAPT services, we remain extremely concerned that the Government are at risk of failing to meet their duty to deliver parity of esteem between mental and physical health, if waiting times for psychological therapies continue to increase.

Waiting times

- One in 10 people have been waiting over a year to receive treatment.
- Over half have been waiting over three months to receive treatment.
- Around 13 per cent of people are still waiting for their first assessment for psychological therapy.

Timely access to mental health services is a critical issue. Considerable harm can be caused by long waits for psychological therapies, which can exacerbate mental health problems and lead to a person experiencing a mental health crisis. The wider human costs of long waiting times are devastating and can have detrimental effects on all aspects of a person's life. Yet far too many people are still waiting too long to receive treatment.

Choice

- 58 per cent of people weren't offered choice in the type of therapies they received.
- Three quarters of people were not given a choice in where they received their treatment.
- Half felt the number of sessions weren't enough.
- 11 per cent said they had to pay for treatment because the therapy they wanted was not available on the NHS.

Choice is a fundamental part of delivering good quality NHS healthcare and it also underpins the Government's recent NHS reforms. Choice is also associated with better response to treatment. In our survey, people were more likely to report therapy helped them recover if they were able to choose the type of treatment, where they access the appointment and when. However, from our research it is clear that many people are still not being offered a choice in the type of therapy they receive or when and where they receive this treatment.

Equity of access

- 40 per cent of people had to request psychological therapies rather than being offered them.
- One in ten people, after being assessed, were not offered psychological therapies.
- Only one in ten people felt their cultural needs were taken into account by the service they were offered, though most others said this didn't matter to them.

Universal and equal access to psychological therapies is crucial for many people in our society, who are still struggling to access therapies which can benefit them hugely. Despite Government commitments to address unequal access to psychological therapies, evidence shows that currently access rates and availability of psychological therapies among certain groups remain poor. Accessing psychological therapies is still not the reality for many, including people from black and minority ethnic (BME) communities, older people, children and young people, people with severe mental illness and homeless people.

Recommendations

For the Government and NHS England

- To urgently establish and deliver waiting time standards – as set out in the Mandate – for evidence-based psychological therapies available on the NHS.
- The maximum waiting time from referral to first treatment should be 28 days and when someone presents with a mental health emergency, the wait should be even shorter. These commitments should be enshrined as a right for patients in the NHS Constitution.
- To commit further investment to psychological therapies to ensure services everywhere in England can meet the rising demand for mental health support, within the 28 day target period and even sooner when someone is in a mental health crisis.
- To immediately begin recording and publishing the waiting times for people who are in-between the stepped care model and are waiting to access a higher intensity therapy.
- To commit further investment for the wider roll out and central data collection for IAPT for:
 - older people
 - children and young people
 - people with severe mental illness and long term conditions
 - people who are homeless and with co-occurring substance dependency.

NHS England must ensure sufficient access for all groups is incorporated into the CCG Outcomes Indicator Set and monitor access among these groups, including people from BME communities.

- To make sure counselling is available in all schools.
- To reverse the decline in overall funding for mental health services, to enable greater

access to other types of therapy as well as IAPT-funded psychological therapies.

- To ensure national frameworks, such as the NHS Mandate and CCG Outcomes Indicator Set, make explicit that psychological therapy outcome measures refer to non-IAPT and IAPT services, to incentivise availability of a wide range of psychological therapies.
- To reverse the decline in overall funding for mental health services and commit further investment to psychological therapies to ensure services everywhere in England can meet the rising demand for mental health support.
- To ensure the IAPT programme re-prioritises its training focus in order to deliver a more balanced workforce that can deliver universal access to the complete range of the National Institute for Health and Care Excellence (NICE) recommended psychological therapies. Existing counsellors and therapists in the NHS should be offered top-up training in the IAPT therapies. Primary care practitioners should be targeted for top-up training in order to improve the decision-making at each point in the treatment path.
- To support investment in high quality research into psychological therapies. This would include encouraging funding bodies to invest in future research to address gaps in the evidence base and identify innovative methods for analysing evidence from a range of research methods and studies.

For Clinical Commissioning Groups (CCGs)

- To prioritise and invest more resources in ensuring all psychological services which are commissioned in their local area meet the 28 day waiting time target from first referral to access. This should be shortened further when someone is in a mental health emergency, as it is the equivalent for physical health emergencies.

- To commission a wide range of psychological therapy types and also ensure people have a choice of therapists, appointment times and locations.
- To commission psychological therapy 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.
- To place a greater emphasis on informing the public about the range of evidence-based treatments that are relevant for their mental health problems.
- To commission more culturally appropriate services and engage with their local community to find out what the needs of their local BME communities are in relation to talking treatments. Services should be commissioned once providers have demonstrated there is sufficient diversity and cultural appropriateness within the service wishing to be commissioned.
- To commission more early intervention and specialist psychological therapies so children and young people, older people and people with severe mental illness are able to access services. This can be achieved by working closely with the Health and Wellbeing Board to actively encourage involvement from BME communities with the Joint Strategic Needs Assessment process to help inform the CCG's commissioning process.
- To raise awareness of psychological therapies via schools, faith groups and other community networks and better publicise self-referral routes. Make education staff and GPs aware of the benefits talking therapies can bring to children and young people, older people, people with severe mental illness and people from BME communities.
- To commission from a wide range of providers of psychological therapies, including those from the voluntary and community sector, and better enable them to compete for psychological therapy contracts on a level playing field with other providers.
- To take account of the structure and service models which already exist in the local community when working with voluntary sector providers of psychological therapies.
- To actively work with the voluntary sector to adopt best practice and allow for a commissioning model which encourages innovation and understands the needs of the local community.
- To sustain local provision of non-IAPT psychological therapies, which provide an important additional resource in supporting people with mental health problems.
- To encourage GP practices to invest in high quality psychologically trained practitioners to work alongside GPs in practice settings.
- To work with existing services to support providers in collating information on clinical outcomes and cost efficiencies to help commissioners better understand the impact and cost-benefit of therapy provision to inform long-term decisions about service development and ensure continuous improvement in commissioning.
- To address the funding imbalance between mental and physical health and to ensure adequate investment in commissioning psychological therapies.

For National Institute for Health and Care Excellence (NICE)

- To take forward the review of its approach to guideline development in mental health, which means considering a more flexible approach and valuing a wider range of evidence types alongside RCTs in developing future clinical guidelines. We would welcome further discussions with NICE about how the evidence base for psychological therapies can be broadened.
- To urgently establish a review group, which brings experts together from across the psychological therapy profession and is led by an independent chair.

For providers of services

- To ensure that people are offered an informed choice of the full range of NICE-recommended psychological therapies, as well as choice of therapist, appointment times and the location of treatment. Providers of psychological therapy must ensure their services offer a full choice to everyone who is referred to their service.
- To meaningfully engage with all diverse communities to learn and collate information about their individual needs and tailor services appropriately, including by varying methods of delivery to ensure they are accessible.
- For services to explicitly demonstrate how they meet the cultural diversity and needs of their local community and provide services which are tailored to these local needs.

For research funders

- To prioritise research funding that expands the evidence base for psychological therapies.

Introduction

Mental health problems can affect anyone. At any one time 17 per cent of adults and 10 per cent of children are affected by mental health problems. Depression alone accounts for seven per cent of the health responsibility within the NHS.

In any one week 104 people in the UK will take their own life, 250,000 people will visit their doctor about a mental health problem and 750,000 prescriptions for antidepressants will be issued.

Psychological therapies have been recognised for a long while as effective treatments for a wide range of mental health problems, with the previous Government introducing the Improving Access to Psychological Therapies (IAPT) programme in 2007. This signalled a welcome commitment to increasing access to psychological therapies.

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. But many children, young people and adults of all ages across the country are still waiting months and sometimes years to get the treatment they desperately need. In some cases, people are 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 Health and Social Care Act 2012 has changed the way the NHS provides care to people in local communities, and this has also affected the way in which psychological therapies are provided. The Act put mental health on a par with physical health. However, this parity of esteem cannot be realised if waiting times continue to increase for crucial psychological therapy services. Many people are still waiting much longer than 28 days to receive psychological therapy through the NHS.

The last time I was offered anything apart from medication was four years ago and that was CBT (Cognitive Behavioural Therapy). No one's mentioned it to me again since then.

Mind survey respondent

The new look NHS has the opportunity to improve the way psychological therapies are delivered. National and local commissioners must take urgent action to reduce long waiting times and improve access to important therapies. Without the necessary action, thousands of people will continue to wait for much-needed talking treatments while their conditions deteriorate, and in some cases spiral into a mental health crisis.

The commissioning of psychological therapies through the NHS can be complex and often poorly integrated. Local Clinical Commissioning Groups (CCGs) commission psychological therapy services through their contracts with mental health trusts and other providers, such as voluntary organisations. An important focus for NHS England, which now holds responsibility and resources for the overall delivery of IAPT, and for all local CCGs, must now be on waiting times, on equity of access and on improved choice in therapies available.

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. This should be even sooner when someone is in need of urgent access when they are in a mental health crisis. We want the Government and NHS England to commit to this and invest sufficient resource to begin to deliver parity of esteem for mental health alongside physical health.

I was very relieved to be offered a talking therapy and it really made a difference. It has given me tools to support myself if I become ill again and to catch myself before falling so far next time.

Mind survey respondent

Why are psychological therapies important?

Psychological therapies are widely recognised as effective treatments for a range of mental health problems. The National Institute for Health and Care Excellence (NICE) recommends several forms of therapy as first-line interventions.

Timely access to mental health services is a critical issue. The harm caused by long waits for psychological therapies is well documented – mental health problems can worsen, relationships can break down and some people are forced to take time off from work or give up a job completely¹. Untreated mental health problems cost the NHS even more as symptoms escalate and more costly treatments are required to address the consequences. The impact on schools, business and families is also very considerable and the damage from untreated mental health problems to a person's life chances can last for a lifetime.

Major public health issues, such as cardiovascular disease, cancer and obesity, have complex presentations, encompassing both mental and physical health. Health and social care interventions must be designed to respond to this complexity. People with long-term physical conditions have a several-fold increased incidence of depression², while a child who experiences a physical illness is two to five times more likely to develop an emotional disorder³.

A recent report by the London School of Economics found that the 'under treatment' of people with mental health problems is the largest cause of health inequality in the UK and highlighted the urgent need for mental health to be treated with as much respect and equality as physical health. The report recommended that this form of discrimination can be avoided through better access to psychological therapies⁴.

Cost effectiveness of psychological therapies

The economic cost of mental health problems remains very high and we know demand for mental health services is rising. The Mind Infoline received 50 per cent more calls during 2012–13 than the previous year.

- Mental health problems cost the economy in England £105 billion each year⁵.
- Mental ill health represents up to 23 per cent of all ill health in the UK – the largest single cause of disability⁶.
- Nearly half of all ill health among people under 65 is due to mental health problems, yet only a quarter of them get any treatment⁷.
- Estimates have suggested that the cost of treating mental health problems could double over the next 20 years⁸.
- But money can be spent more efficiently. In 2008, it was estimated that £1 billion in economic benefits could be achieved each year by extending NICE-recommended treatments to all those with depression, with treatment costs vastly outweighed by higher government revenues and reduced welfare payments, as well as wider social benefits⁹.

Provision of psychological therapies is a largely low cost activity in the NHS. Providing the right psychological therapy interventions has consistently been shown to improve recovery rates¹⁰. Investing more money in treating mental health problems earlier would mean fewer people are likely to require more costly crisis care services, ultimately saving money for the NHS and wider society.

The IAPT programme has already proved that cost effective psychological therapies can be delivered. The original proposal indicated that the services would more than pay for themselves with an estimated cost of £750 per course of treatment and 50 per cent of treated people recovering. The IAPT Three Year Report shows recovery is reaching the target and cost per treatment is in fact less than £750¹¹.

Policy context

The We need to talk coalition believes that IAPT represents a great step forward for psychological therapy provision in the NHS in England.

Since the introduction of the IAPT programme, access to psychological therapies has increased overall with the programme alone providing access to services to over a million people in England. The Government provided additional funding in 2010 to continue the roll out of the IAPT programme and also to extend access to children and young people, people with long-term conditions, with medically unexplained symptoms, to older people and to people with severe mental illness, such as psychosis, bipolar affective disorder and personality disorder.

The programme has helped provide effective treatment for many people who otherwise may have been left without support. Since April 2013 the responsibility for the national delivery of the IAPT programme has moved from the Department of Health to the newly established NHS England, a non-departmental public body responsible for

commissioning all primary care in England. The central IAPT team within NHS England has more limited responsibilities and resources compared to the previous team in the Department of Health. We therefore seek assurance that NHS England gives comparable priority and dedicated resources to the oversight of IAPT, in order to make parity a reality.

There is still much to do in order to improve access to psychological therapy for everyone who needs it. Our findings show that the way in which some local areas have interpreted and implemented the IAPT programme has led to a reduction in both choice of, and access to, psychological therapies. Many people are still waiting too long and are not offered a choice of therapy that is right for them – and some may not get access to psychological therapies at all.

Medication can be a lifeboat, but CBT teaches you to build your own lifeboats whenever you need them.

Mind survey respondent

IAPT and the commitment to parity of esteem

In 2007, the 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 people experiencing depression and/or anxiety, and to monitor outcomes in everyone who received treatment.

In February 2011, the Government highlighted its commitment to improving mental health in England through *No health without mental health* – a strategy for treating mental and physical health services equally in the NHS. At the same time the Government affirmed its

commitment to IAPT by publishing *Talking therapies: A four-year plan of action* which made clear commitments to improving access and continuing the roll out of IAPT up until 2015.

The 2010 comprehensive spending review committed a further £400 million for the IAPT programme over the course of the four year plan. The 2013 comprehensive spending review also committed further resource “so that more adults and young people have access to clinically proven psychological therapies”¹².

The NHS Mandate

The Mandate to NHS England – which sets out what the Government expects from the NHS – clearly requires NHS England to achieve parity between mental and physical health. Part of this is ensuring that everyone who needs it receives timely access to an IAPT service including children and young people, to those out of work, to people with severe mental illness, with medically unexplained symptoms and long-term conditions.

The Mandate sets specific objectives on establishing access standards for mental health services, including IAPT. This would be akin to the NHS Constitution's waiting times commitments for physical health, which the We need to talk coalition fully supports. Proposed access standards must extend to include everyone who is accessing talking therapies, including, but not limited to, children and young people, older people, people with long term conditions, people with severe mental illness, and people from black and minority ethnic (BME) communities.

We want to see NHS England prioritise waiting times as an essential requirement for service provision for all psychological therapies. The 28 day waiting time standard must be established for everyone. For people in a mental health crisis the waiting time should be even shorter with much faster access to psychological therapies.

In some cases, persistent inequalities in access to IAPT are still not recorded and monitored. For example, up to now IAPT key performance indicators have not monitored access among BME communities, even though the equality impact assessment for IAPT acknowledged they are disproportionately less likely to access psychological therapies and face particular barriers. The Mandate should include a commitment to identifying and addressing gaps in data in order to monitor such stark inequalities.

Our research

Between 2012 and 2013, the We need to talk coalition carried out research with people who have either used or tried to access psychological therapies on the NHS in England within the last two years. We wanted to explore whether the situation has improved since the last time we conducted research in 2010.

We conducted two focus groups with 10 participants and carried out a survey of more than 1500 people with mental health problems, who have used psychological therapies. The focus groups looked specifically at the needs of BME communities, given previous research has shown they often face particular barriers to accessing psychological therapies. We also surveyed local Minds, many of which provide psychological therapies, and received 30 responses.

Members of the We need to talk coalition also conducted two surveys where over 800 members of the British Psychoanalytic Council and the UK Council for Psychotherapy working in the NHS responded (November 2012), and another survey of NHS psychological therapists received over 1,000 respondents (October 2013).

Our findings

Our survey of people with mental health problems showed wide variation in people's experiences of psychological service provision, availability, access and quality. While many people are now getting access to their choice of psychological therapy within weeks, some still wait years for services that are not right for them in the first place.

All statistics refer to respondents in our survey of people with mental health problems, unless otherwise specified – full details of response rates for each question are in Appendix A.

All quotations are from people who responded to our survey and gave permission for their experiences to be cited anonymously.

Waiting times

- One in 10 people have been waiting over a year to receive treatment
- Over half have been waiting over three months to receive treatment
- Around 13 per cent of people are still waiting for their first assessment for psychological therapy

Our survey found that although 38 per cent of people who responded are receiving their first treatment within three months of being assessed, one in 10 people are still waiting over a year. While this is an improvement on our survey findings in 2010, (where one in five people were waiting over a year), it remains unacceptable that so many people wait for such a long period, with huge detriment to their health.

Although the NHS has made some progress in decreasing waiting times, the length of time someone has to wait for psychological therapies varies dramatically across England. Recent IAPT data showed that the fewest people waiting more than 28 days for talking treatments was in the East of England, and the most people waiting more than 28 days were in the North West. One area had more than 4,000 people waiting over 28 days for their first treatment session¹³.

The waiting list is detrimentally long, and my condition has got much worse in the time I have been waiting. Originally I was given a referral for CBT, without being given the choice of counselling, and my referral was lost which led to me waiting months longer than I should have. This has negatively impacted on my career as I have not been able to work for over a year.

Mind survey respondent

In October 2013, the British Psychological Society undertook a survey of over a thousand NHS psychological therapists working in a variety of settings across England. The respondents were providing NHS psychological therapies to over 21,000 service users at the time of the survey. In nearly two thirds of cases from the survey,

waiting times for initial assessment were reported to be less than four weeks although in 14 per cent of cases people were reported to typically wait more than 12 weeks to be seen. Furthermore, significant waiting times were reported between initial assessment and beginning therapy; 50 per cent of respondents reported that waits typically exceed four weeks in their service and one in six reported people normally waiting in excess of 18 weeks to start therapy.

Similarly, a survey conducted in November 2012 by the British Psychoanalytic Council and the UK Council for Psychotherapy of over 800 NHS psychotherapists suggested waiting times for patients were increasing. Compared to a year before, 45 per cent of therapists reported increased waiting times for services, with only 20 per cent reporting decreases.

Waiting for treatment exacerbated my anxiety. I found it harder and harder to leave the house and interact with people. This made me feel more depressed. My relationship with my parents and sister became strained because I saw little of them and they don't understand mental illness. My children, aged 16 and 19, had to do a lot for me because I was often unable to leave the house.

Mind survey respondent

Psychological therapies can provide a lifeline for many people with mental health problems. Access to treatments as soon as possible after referral and assessment can make the difference between recovering well and a mental health problem spiralling into a crisis. The wider human costs of long waiting times are devastating and

can have detrimental effects on all aspects of a person's life.

The 28 day maximum waiting standard for NHS psychological therapy services should be a right for everyone who needs them. This should be enshrined in the NHS Constitution, as this is the mental health equivalent to the waiting time for people with physical health problems in the NHS. However, when someone is in urgent need of help, they should be able to access psychological therapies even sooner. Urgent access can sometimes make a difference between whether someone manages their immediate crisis or takes their own life. This would be a right to urgent care which is already established in physical health care emergencies and must be equally available to people in mental health emergencies.

Particular attention should also be given to avoiding additional waiting times within stepped care therapy programmes. People who have not benefited sufficiently from a course of low intensity therapy should be promptly stepped up to high intensity therapy. However, some people join another waiting list for step-up treatment and begin waiting again. Worryingly these 'hidden' step-up waiting times are not recorded or published by the NHS which means that many people can potentially wait even longer before receiving the therapy they need.

Recommendations

For the Government and NHS England

- To urgently establish and deliver waiting time standards – as set out in the Mandate – for evidence-based psychological therapies available on the NHS.
- The maximum waiting time from referral to first treatment should be 28 days and when someone presents with a mental health emergency, the wait should be even shorter. These commitments should be enshrined as a right for patients in the NHS Constitution.
- To commit further investment to psychological therapies to ensure services everywhere in England can meet the rising demand for mental health support, within the 28 day target period and more quickly when someone is in a mental health crisis.
- To immediately begin recording and publishing the waiting times for people who are in-between the stepped care model and are waiting to access a higher intensity therapy.

For CCGs

- To prioritise and invest more resource in ensuring all psychological services which are commissioned in their local area meet the 28 day waiting time target from first referral to access. This should be shortened further when someone is in a mental health emergency, as it is for physical health emergencies.

Choice

- 58 per cent of people weren't offered choice in the type of therapies they received.
- Three quarters of people were not given a choice in where they received their treatment.
- Half felt the number of sessions weren't enough.
- 11 per cent said they had to pay for treatment because the therapy they wanted was not available on the NHS.

Over half of people in our survey were not offered a choice in the type of therapies available to them. 43 per cent of people did not have the different psychological therapies explained to them at the time of referral. Our survey showed that many people are reporting limited treatment options from their psychological therapy service. Cognitive Behavioural Therapy (CBT) was the most common psychological therapy offered to people, accounting for 43 per cent of all courses of therapy. Next most common was counselling (19 per cent), followed by psychoanalysis/ psychotherapy (13 per cent) and group therapy (7 per cent). Some people had more than one type of therapy recommended for them.

Almost half of local Minds taking part in the survey agree that IAPT has increased the choice of therapies in their area. Our survey suggests some improvement in choice of therapies since 2010, when only 8 per cent were offered a full choice compared to 13 per cent in 2013. However, this remains unacceptably low and 58 per cent of survey respondents still report receiving no choice of therapy. With only half of people being offered a choice of appointment time, and three quarters of people not offered a choice of treatment location, improvement in these other areas has been minimal.

In mental health the active involvement of the individual is crucial to their recovery. A key part of this is choice. We need to move beyond a one-size-fits-all approach to therapy. The right to choose the type of therapy, the therapist, the location and timing of their appointment, will help to improve engagement and recovery outcomes.

Lack of choices, as shown in our survey, is forcing some people to pay for private treatment. Eleven per cent of all respondents said they had to pay for private treatment because the therapy they wanted was not available. This leaves many people, who cannot afford or are unwilling to pay for private treatment, either going untreated, incompletely treated or ineffectively treated by a type of therapy which was not their preferred option.

I have had to go for private healthcare at a significant cost to my family due to lengthy waits and poor quality treatment. This is unlikely to be sustainable for much longer as I simply cannot continue this for much longer but I was at rock bottom at the time. I just became tired of nobody listening to my opinions regarding my care, assessment and treatment and having no say.

Mind survey respondent

Natalie's story

I spent from the age of 14 to 22 in local authority and psychiatric institutions.

My therapist and care coordinator at the Specialist Psychotherapeutic Hospital from where I was finally discharged from inpatient care strongly recommended that I continue with therapy. My social worker and psychiatrist in my local community mental health team did not support this. I found it difficult to adjust to living in the community again after 8 years of living in institutions. I had come off all medication during my last few months of inpatient psychotherapy, but I was not given any alternative way to manage my emotional and psychological states.

I started university and saw a counsellor there for three years until I graduated. Then my psychiatrist did not encourage me to pursue further therapy. I concluded that as I was not presenting now with risky behaviour and as my ability to function was better, that my emotional and psychological health was not

given very much consideration. I spent a long time alone looking for therapists online. It was extremely hard trying to work out what sort of therapist may be best for me and what sort of approach would be most appropriate for my needs. The research I did into this seemed only to make me more confused. I also had practicalities to think about relating to fees, location and transport. I felt in quite a vulnerable position trying to weigh these things up on my own without the help, support or guidance of any professionals.

In looking for another therapist to work with I decided to focus on seeing someone for therapy in a therapy centre thinking that would feel more safe than meeting with therapists in their own homes. I currently work with a therapist who is based in one of these practices.

It has been very hard not to have communication or agreement about choosing and working with a suitable therapist from my GP or community mental health team.

Choice among evidence-based treatments is critical because it is well-established that the extent to which a person believes in the approach affects the outcome of their treatment¹⁴. In our survey, people were more likely to report therapy helped them recover if they were able to choose the type of treatment, where they access the appointment and when. People who had a full choice of therapies were over four times more likely to report feeling well after treatment than those who weren't offered any choice. People who had a choice of where and when they received treatment were twice as likely to report feeling well afterwards than those who did not have those choices.

We were referred to a bi-weekly full day group therapy programme almost 50 miles away from home. This is not do-able. I don't know anybody who is in a situation where they could travel a 100 mile round trip twice a week to get therapy.

Mind survey respondent

The Government and NHS England have committed to expanding patient choice and this is crucial to fulfilling the commitment to parity for mental and physical health. Choice of treatment for many physical health conditions is now the rule rather than the exception. Choice is a key part of the Health and Social Care Act 2012 and the Government has promised to increase patient choice through information, shared decision-making and better treatment options. We know that providing choice can lead to better value for money. When people are actively involved and given options for the type of therapy they would prefer, treatment is more likely to be effective and lead to a speedier recovery. However, our survey shows that there is a long way to go if choice is to become a real part of psychological therapy provision.

I was offered other therapies but they were not explained in terms of how they would benefit me compared to the therapy that I was being offered. They didn't take into account because of my emotional state doing extra legwork is excruciatingly difficult.

Mind survey respondent

NICE recommends a range of different evidence-based treatments for conditions such as depression but only one or two for some other conditions (such as phobias, post-traumatic stress disorder and schizophrenia). When accessing psychological therapies through the IAPT programme, patients' choice is very often limited to one therapy type, CBT. CBT can be an effective treatment for many but does not always work for everyone.

I was only offered CBT... nothing else was even presented as an option.

Mind survey respondent

Recommendations

For NICE

- To take forward the review of its approach to guideline development in mental health which means considering a more flexible approach, valuing a wider range of evidence types alongside RCTs, in developing future clinical guidelines. We would welcome further discussions with NICE about how the evidence base for psychological therapies can be broadened.

For research funders

- To prioritise funding for further research on the effectiveness of psychological therapies.

For CCGs

- To commission a wide range of psychological therapy types and also ensure people have a choice of therapists, appointment times and locations.
- To commission psychological therapy 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.
- To place a greater emphasis on informing the public about the range of evidence-based treatments that are relevant for their mental health problems.

For providers and services

- To ensure that people are offered an informed choice of the full range of NICE-recommended psychological therapies, as well as choice of therapist, appointment times and the location of treatment. Providers of psychological therapy must ensure their services offer a full choice to everyone who is referred to their service.

Equity of access

- 40 per cent of people had to request psychological therapies rather than being offered them.
- One in ten people, after being assessed, were not offered psychological therapies.
- Only one in ten people felt their cultural needs were taken into account by the service they were offered, though most others said this didn't matter to them.

Our findings indicate problems with unequal access to psychological therapies. 40 per cent had to ask for psychological therapies rather than being proactively offered them by a health professional, while 10 per cent of people did not get access to treatment after assessment at all.

Black and minority ethnic (BME) groups

There are cultural barriers. You worry about how you are going to be perceived and whether you can trust the other person. What is their reaction to you going to be? In how much detail in English can you describe your feelings. There is a language barrier.

Mind survey respondent

94 per cent of respondents to our survey reported their ethnic origin as White British. However, we also conducted two focus groups with people from BME communities to explore the issues facing this group more fully.

Only one in ten people from our survey said the service met their cultural needs (though 68 per cent said this didn't matter to them) and a third of local Minds who responded disagreed with the statement that IAPT services meet the needs of BME people in the community. From the survey of therapists and professionals, the majority of respondents felt that their services provided appropriate access to psychological therapies for

people from ethnic minorities (75 per cent) and older people (60 per cent) and rates for IAPT services were consistently higher (87 per cent and 83 per cent respectively).

Professionals understanding culture shows that they've made an effort. It helps to establish a connection with the therapist. Knowledge of cultural references, experience and significance is important to understand the person.

Mind survey respondent

People from BME communities have long been underserved in primary mental health services and are much less likely than other groups to be referred to psychological therapies¹⁵. This group face significant barriers to accessing psychological therapies as often many local areas lack culturally sensitive and tailored services which meet the diverse needs of the local population. Secondly, people from BME communities often first come into contact with mental health services at the acute stage of their condition due to a range of issues, from stigma and discrimination in the NHS to cultural attitudes within communities which prevent people seeking help.

I referred a person who only spoke Portuguese to IAPT and they had a translator in the room who was from the same community. The person didn't trust the interpreter, he was afraid they would go back and talk about him. He wanted to have a bilingual therapist instead which would allow more flexibility.

Mind survey respondent

We spoke to people from BME communities through the two focus groups we held. People explained that accessing an IAPT service often depended on the type of service that was available locally and whether self-referral options were publicised. Self-referral is known to work more effectively with BME groups, and recommended in IAPT guidance, but it is not being used or publicised consistently across IAPT services. 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 sites¹⁶. In our focus groups, people talked about therapists not taking account of how therapy interacted with their religion and spirituality. They also raised issues with language barriers both due to lack of interpreters and differences in how people describe and talk about mental health in different cultures.

Between now and the completion of *Talking therapies: A four-year plan of action* in March 2015¹⁷, the current unequal access among BME groups must be adequately addressed.

Children and young people

Due to being 16 when I needed help the system struggled to deal with me, they put me with child therapy services rather than adult therapy services. I don't think this was the best for me as a 16 year old.

Mind survey respondent

One in ten children and young people – around three in every classroom – live with a diagnosable mental health condition¹⁸. Therefore there is a clear need to provide effective evidence-based therapies for children and young people. We also know that it is vital that we start early in supporting the mental health of children and young people, so that the problems they may experience – such as anger, bullying, relationship problems and bereavement – do not escalate into long-term diagnosable conditions. More than half of all adults with mental health problems were diagnosed in childhood, however less than half were treated appropriately at the time¹⁹. Giving children and young people early access to psychological therapies is vital to reduce the number of adults suffering from entrenched mental ill health in future generations.

Despite the progress of the children and young people's IAPT project, many children and young people are waiting for long periods to receive access to psychological therapy. YoungMinds Parents' Helpline took a record number of calls – three times as many as in 2008 – from parents desperate to be able to get help for their child. The Government's mental health strategy *No health without mental health* rightly calls for early intervention and stresses the importance of children and young people's mental health, yet the reality on the ground is of services struggling to deliver in the face of financial cutbacks.

Children and young people, parents and clinicians continue to feel the impact of financial cuts on Children and Adolescent Mental Health Services (CAMHS). Since 2010 two-thirds of local authorities have reduced their budgets for CAMHS²⁰ and this has often meant CAMHS are unable to meet demand and as a consequence are having to raise the thresholds for when they will see a child or young person. In addition, a survey conducted by YoungMinds Magazine of over 300 CAMHS staff revealed that 68 per cent said that their local service had raised thresholds in response to budget cuts²¹. This means that a child or young person is only seen if the mental health problem is at a raised level of severity.

I was ridiculed by my GP when first taken for treatment because I was 'too young to be depressed'. I was passed on from person to person from the age of 17 until I was 21 when I went into primary care. My therapist was amazing and I have nothing but praise for her, I just think it's a terrible shame people can't get the help they need quicker or aren't taken seriously.

Mind survey respondent

At the end of its current Government funding, children and young people's IAPT services will be available in an area covering 65 per cent of the children's population in England – therefore a third of children will still not be able to access children and young people IAPT in their local area. It is crucial that children and young people IAPT is expanded to the rest of the country so that all children can benefit from the progress children and young people's IAPT has made in expanding the ability of Children and Adolescents Mental Health Services to deliver evidenced

based psychological therapies that meet nationally agreed quality standards.

Providing counselling in schools is a form of psychological therapy which can be an effective treatment for young people who have a range of mental health problems. Early and easy access to counselling in schools can prevent mental health problems developing or becoming more serious, and can help to build up trust and confidence to enable young people to access more specialist services if required. However, provision in England is patchy and many children do not have access to a counsellor in their school.

Older people

I am 69 years old, I live on my own. I was diagnosed as suffering from Bipolar. When I moved to Somerset I came off my meds and became unstable, [my previous psychiatrist] wrote to my GP with details of my medication needs and a request that I be referred to a psychiatrist here, as I was in need of monitoring and psychosocial support, but I was referred to the 'Older People's Service' as I am 69, despite my diagnosis. [...] For more than six weeks I suffered a mostly avoidable crisis, in which I lost the excellent support I had had for 13 years and floated in a limbo of miscommunication.

Participant, Mind's call for evidence 2012:
Experience of mental health services

In 2010, the Government first announced that the IAPT programme was being extended to address the needs of people over 65 with anxiety or depression. NICE guidance on the treatment of anxiety and depression makes no variation in its recommendations relating to age, yet older people experience more barriers to accessing psychological therapies. A possible barrier is that older people are less likely to be diagnosed with depression in the first place by their GP as depressive symptoms can present differently in older people²². However, older people respond to counselling just as well as younger people do²³.

Estimated prevalence of common mental health problems for adults over the age of 64 in England is 18 per cent²⁴, however access rates to IAPT is an average of 5.2 per cent for this group compared with a rate of at least 12 per cent for

all adults set out in the *Talking Therapies: four year plan of action*²⁵.

Psychological therapy services themselves will also need to re-configure their services to meet the needs of older people – for example by offering home visits (relatively rare in IAPT but common in older people's services) and develop and adjust the therapy itself (the pace, length and frequency of sessions) to fit with the older person's capacity to engage and respond to treatment²⁶. The diversity among older people, such as ethnicity, religion and physicality must also be considered, as well as recognition that there will be a range of needs within older people – someone in their 60s may have very different needs to someone in their 80s or 90s.

IAPT started out as a service predominantly focussed on working age adults and despite recent attempts to ensure that older people can access talking treatments through IAPT, policy and practice will need to go the 'extra mile' to ensure services are truly accessible and responsive to older people's needs. The targets set by IAPT may well need to be reviewed to better account for older people, BME communities and others.

Severe mental illness

As a voice hearer and someone who experiences paranoia and 'psychotic' experiences I have been able to access psycho-social intervention talking therapy this summer after being in the mental health system for 20 years. I have found it very, very useful in terms of understanding how so much of what I experience comes from extreme social anxiety and low self esteem.

Mind survey respondent

Psychological therapies of different types are recommended for a range of mental health problems, including those referred to as severe mental illness (SMI). These include psychosis and schizophrenia, bipolar disorder and for these purposes, personality disorder. Access to talking therapies for these conditions is notoriously poor. The original IAPT programme was intended to 'free up' resources for specialist psychological therapies in secondary care. However, these services have been vulnerable to cuts and we

have seen very little provision for these groups. The 2012 National Audit of Schizophrenia found that 34 per cent of people currently being treated had not been offered any form of psychological therapy²⁷.

Our survey of respondents with a diagnosis of schizophrenia, bipolar disorder or personality disorder found that:

- less than 30 per cent of people referred to psychological therapies accessed these within three months
- one in five people waited for more than a year to access psychological therapies
- over half had no choice of therapy service
- only around a third of people who had accessed therapy felt they'd had as many sessions as they needed

From the survey of therapists, 65 per cent of therapists felt that their service did not provide appropriate access to psychological therapies for people with severe mental health problems.

These poor figures are not likely to change without significant intervention from NHS England, to ensure local commissioners are supported with roll out, and to collate data centrally. The importance of doing this has been underlined recently through findings that talking therapy can play a preventative role in the development of psychosis, rather than only the management of anxiety and depression associated with this diagnosis²⁸.

We have so far seen a relatively small amount of the overall central IAPT funding dedicated to an IAPT programme for psychosis and personality disorder. Although IAPT for anxiety and depression has made significant progress, mainly due to Government investment for a national roll out, it is not enough to now leave it to local commissioners to choose whether to prioritise talking therapies for severe mental illness. Further central investment will be necessary to ensure wider roll out and the collation of a national data set.

I was referred to a service for people with severe psychological needs. I was turned down as they did not deem me to be receptive enough to their type of psychodynamic therapies. I was told it was not worth having

IAPT because it wouldn't cover more than 6 sessions and would be pointless. Therefore there was no other therapy despite me wanting to commit suicide and having been receptive to psychotherapy in the past. I was told psychotherapy is not available on the NHS. So I now go to a charity and feel extremely guilty for using their psychotherapy. I am disgusted that the NHS doesn't cater for long term psychological therapies because there simply not funded.

Mind survey respondent

The delivery of psychological therapies for those with severe mental illness needs to be closely integrated with the delivery of other interventions such as effective multidisciplinary team working, cross agency working, and medical treatments so that the full programme of care is cohesive and understandable for the person and staff. It is essential that models of talking therapy provided are properly aligned with NICE guidelines, as providers are not always clear on this. An important outcome for people of better psychological therapy delivery will occur through transforming the current NHS workforce working with people with severe mental illness. Such a transformation will only be achieved through commitments from NHS England, CCGs, providers of services and clinical staff.

Homelessness and co-occurring substance dependencies

Mental health problems are far more common amongst homeless people than amongst the general population, in particular personality disorders (60 per cent compared to 5 to 15 per cent), depression and schizophrenia (30 per cent compared to 1 to 4 per cent)²⁹. A number of forms of psychological interventions have been found to be useful in treating homeless people, including family therapy, therapeutic communities, behavioural contingency programmes, CBT, psychodynamic psychotherapy, 12-step programmes, and generic counselling in the context of supported housing³⁰.

However, although many homeless people seek help for their mental health problems at some stage (70 per cent of the 103 people interviewed for St Mungo's Happiness Matters report)³¹, the

The Devon Specialist Personality Disorder Service

The Devon Specialist Personality Disorder Service addresses the therapeutic needs of people with severe and complex personality disorder who would otherwise be placed in secure units out of the county due to their high risk of suicide.

To address the complex needs of these people the service has adapted the best of evidence based practice from personality disorder national treatment centres. These innovative adaptations include working therapeutically with:

- people who are detained under the Mental Health Act
- people with personality disorder and eating disorder
- people with personality disorder and medically unexplained symptoms
- people with personality disorder and substance misuse.

People attending the service may be offered:

- seven months of intensive day treatment with twice weekly individual psychodynamic

therapy, group analysis, family therapy and psychosocial practice, followed by two and a half years of an outpatient psychodynamic therapy programme

- Mentalisation Based Therapy (MBT)
- Cognitive Analytic Therapy for personality disorder (CAT)
- Family therapy
- Psycho-education groups.

The service has been open for two years and is measuring outcomes as well as developing a research collaboration with Exeter University to develop and test the model. Early results show 80 per cent of patients have been successfully returned from placements out-of-county or have been diverted from being sent on placements. For fewer financial resources, people can receive more effective treatment closer to home, and the service provides training, supervision and support for work with personality disorder for professionals across the mental health trust and other agencies.

common occurrence of substance dependency alongside mental health issues means that many homeless people are denied mental health treatment. St Mungo's 2009 Call for Evidence on mental health and homelessness found remarkably consistent evidence from over 90 statutory and voluntary agencies across Britain that people were not being offered mental health treatment if they had substance dependencies³². Homeless people may also be denied access to mental health treatment due to no previous contact with the mental health system or non-attendance due to chaotic lifestyles.

There is a need for greater provision of psychological therapies which are appropriate and accessible for both people who are homeless and those with co-occurring substance dependencies. Psychological therapies should not exclude those who experience drug and alcohol problems.

Recommendations

For Government and NHS England

- To commit further investment for the wider roll out and central data collection for:
 - IAPT for older people
 - children and young people
 - people with severe mental illness and long term conditions
 - people who are homeless and with co-occurring substance dependency.

NHS England must ensure sufficient access for all groups is incorporated into the CCG Outcomes Indicator Set and monitor access among these groups, including people from BME communities.

- To make sure counselling is available in all schools.

For CCGs

- To commission more culturally appropriate services and engage with their local community to find out what the needs of their local BME communities are in relation to talking treatments. Services should be commissioned once providers have demonstrated there is sufficient diversity and cultural appropriateness within the service wishing to be commissioned.
- To commission more early intervention and specialist psychological therapies so children and young people, older people and people with severe mental illness, people who are homeless and people with co-occurring substance dependencies are able to access services. This can be achieved by working closely with the Health and Wellbeing Board to actively encourage involvement from BME communities and other excluded groups such as homeless people with the Joint Strategic Needs Assessment process to help inform the CCG's commissioning process.
- To raise awareness of psychological therapies via schools, faith groups and other community networks, better publicise self-referral routes and make education staff and GPs aware of the benefits talking therapies can bring to children and young people, older people and people with severe mental illness or from BME communities.

For providers and services

- To meaningfully engage with all diverse communities to learn and collate information about their individual needs and tailor services appropriately, including by varying methods of delivery to ensure they are accessible.
- For services to explicitly demonstrate how they meet the cultural diversity needs of their local community and provide services which are tailored to these local needs.

Experiences from the voluntary sector: local Minds

- CBT and counselling are the most common IAPT-funded therapies available through local Minds.
- Over 50 per cent of local Minds report the people they have seen are dissatisfied with waiting times in the local area.
- Over a third of local Minds feel IAPT services do not currently meet the needs of BME communities.
- Almost half of local Minds felt there has been a reduction in access to non-IAPT psychological therapies.

‘Our funding for psychological therapies was removed in 2010 but we get many referrals from IAPT as CBT does not suit everyone or every issue.’

Local Mind

Our research with voluntary sector providers showed real variation in the practice of commissioning psychological therapies with voluntary sector providers. For example, some local Minds 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. Some are also being funded to deliver a range of non-IAPT therapies to meet local need.

However, other local Minds reported concerns with the implementation of their local IAPT programme and with rising waiting times for services provided by the CCG (previously Primary Care Trust) therefore exerting more pressure on voluntary sector psychological therapies. Numerous voluntary sector services are not receiving IAPT funds but have still seen their referrals rise sharply and waiting times for therapy increase as a result of the programme generating higher demand and awareness locally. The majority (50 per cent) of local Minds reported that people are dissatisfied with waiting times for psychological therapies. There is a clear need for

commissioners to invest more in psychological therapies as well as to allow providers to innovate.

‘The local service is promoting themselves as an IAPT service but is clearly not working to NICE guidelines. Anecdotally people are waiting 5-6 months for an assessment of need, with a subsequent 3-4 month wait for first intervention. Little or no support is offered other than “we’ll be in touch with you soon” – leading to additional frustration and anxiety.’

Local Mind

Some local Minds told us that commissioners in the newly formed CCGs were either new to mental health or did not fully understand the significant benefits of psychological therapies and had subsequently de-prioritised commissioning talking therapies in their area. Almost half (48 per cent) felt there had been a reduction in access to other psychological therapies which are not part of the IAPT programme.

‘Our local IAPT service has many positive aspects. They use locations in deprived communities. They have Champions amongst staff to ensure that BME and other groups are having needs met. They support our LGBT and BME work. They use our premises and support Mind’s members.’

Local Mind

Recommendations

For CCGS

- To commission from a wide range of providers of psychological therapies, including from the voluntary and community sector, and better enable them to compete for psychological therapy contracts on a level playing field with other providers.

- To take account of the structure and service models which already exist in the local community when working with voluntary sector providers of psychological therapies.
- To actively work with the voluntary sector to adopt best practice and allow for a commissioning model which encourages innovation and understands the needs of the local community.

TalkingSpace

This has put me back on the right track, I am really grateful. I didn't think this would work but it's been really good!

TalkingSpace is the Oxfordshire Improving Access to Psychological Therapies (IAPT) service. In 2008, Oxfordshire Mind ran the pilot phase for the IAPT service and had built up capacity and experience which Oxford Health NHS Foundation Trust were keen to make best use of in developing the service.

Oxford Health NHS Trust and Oxfordshire Mind bid in partnership and were successful following a competitive tender process in 2009. Since then the partnership has grown rapidly, focussing on CBT delivered by professional, trained and qualified staff.

The achievements and benefits of the partnership means the service is offering a high quality but high volume service which copes with 8,000 referrals per year and 6,000 people completing a course of treatment. The recovery rates are at 48 per cent and 92 per cent patient satisfaction. Over 100 people have moved off sick pay and benefits per year and

they have trained 56 staff to deliver NICE-recommended talking treatments.

This service suited my needs. It was very convenient because I didn't have to travel. It's revolutionised my life.

The TalkingSpace partnership has added value through inspiring great ideas and more creative processes. Benefits for people in the community include a more co-ordinated and integrated pathway with a service ethos which is inclusive and prioritises enablement. In addition, commissioners have commented on the benefits of working with Oxford Health Trust as the 'lead contractor' but benefitting from the expertise of Oxfordshire Mind within a single, and more cost effective contract.

Although so many gains have been made by TalkingSpace, there is much more to be done. The ambition for the service in the coming year is to reach more people, helping more people towards recovery and improving their offer to older adults, BME communities and people with physical health problems.

City and Hackney Primary Care Psychotherapy Consultation Service

The City and Hackney Primary Care Psychotherapy Consultation Service is a well established, but innovative service, designed to deliver a service directly to people which GPs can also access for advice and support, throughout the London Boroughs of Hackney and the City. The service provides primary care interventions, including psychodynamically informed therapies for a range of complex chronic cases who would otherwise fall between the gaps due to a lack of specialist care for more complex patients. They include:

- those with medically unexplained symptoms
- those with personality difficulties/disorder but not managed by local services
- those with psychiatric morbidity but not managed by, or recently discharged from, psychiatric services.

The service model is innovative in four key respects:

1. The service caters for patients with complex conditions and offers an addition to IAPT provision and, where appropriate, a bridge to secondary care services.
2. The service provides a care model for patients with physical and emotional difficulties, specifically for people with medically unexplained symptoms and long-term conditions.

3. The service is rooted in local GP services and delivers support to GPs through consultation and training.
4. Partnership working with other providers in health and social care sectors.

The treatment provided is based on a multi-model approach which is consistent with NICE guidelines and evidence-based practice, working with individuals, families and groups, utilising:

- Brief dynamic approaches, including Dynamic Interpersonal Therapy and Mentalisation Based Therapy
- CBT and CBT-informed approaches such as Mindfulness
- Group approaches including psycho-education
- Family and couple therapy.

GP satisfaction is high with 92 per cent stating the service they received helped them deal more effectively with their patients. Questionnaires posted to patients one month after discharge also found a high level of satisfaction – 73 per cent reporting being satisfied with the service either 'most of the time' or 'at all times'.

Centre for Mental Health is currently undertaking an assessment of the service and will be reporting its findings in early 2014.

Relate North East

Relate North East delivers Couple Therapy for Depression, having been commissioned in a one year pilot initiative. Since November 2012, over 150 referrals have been made. For the local commissioner, provision of the service is an important way of safeguarding that an appropriate range of services are available to those with mental health issues.

For the Relate North East centre, the IAPT funding allows the centre to:

- provide relationship support in a different way
- help people on a journey to recovery from depression
- expand the social profile of clients.

Most people access the service after being referred from their GP for an initial IAPT assessment, where a consideration is made as to whether their relationship could be a cause of their mental health issues, and whether they are diagnosed as having depression. This is an important step in assessing whether people are ready for couple counselling for depression.

Many of the people seeking couple therapy for depression had not previously identified that

problems in the relationship itself may be one of the root causes of their depression. As one counsellor put it: "...these are problems that they've swept under the carpet for ages."

Counsellors identify couple therapy for depression delivered through IAPT as being innovative as it 'takes a holistic view of their depression – a holistic view of illness that improves their chance of recovery'. It is also a service that objectively explores problems in the relationship – for some this means that couples will part and for those that do, the person who has depression is referred back to the IAPT service to assess whether further intervention is necessary. Early results are positive in signifying that the intervention successfully treated depression.

Relate North East is committed to working with local commissioners to ensure that a genuine choice of interventions is available, and the Centre is eager to work with commissioners at the local and national level to ensure the implementation of higher standards in the quality of delivery across all providers and to improve reporting structures.

Reduction in other types of psychological therapies

An important component of the IAPT programme originally was to 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, including personality disorders. However, government reports since IAPT's introduction indicate that approximately 14 per cent of new IAPT services have actually replaced rather than added to existing services. While overall investment in psychological therapies has doubled, existing services, which are not part of IAPT, have seen their funding cut by over five per cent (IAPT, 2012).

The survey of therapists conducted by the British Psychoanalytic Council and the UK Council for Psychotherapy between November and December 2011, found that:

- 97 per cent of members reported that posts and services were being downgraded
- 63 per cent reported cuts in the number of psychotherapy posts in the NHS
- 68 per cent reported that they are being relied upon to deal with increasingly complex cases
- 48 per cent noted decreases in the number of psychotherapy services commissioned, with only 5 per cent reporting increases

We are concerned that unless the decline in existing therapies which are not part of the IAPT initiative is reversed, the NHS runs the risk of replacing the diverse and rich choice of other types of psychological therapies which are currently available through alternative providers. It is crucial that alternative psychological therapies alongside CBT, are available within the IAPT programme, so people with a diverse range of mental health problems can receive the help they need.

IAPT services have helped people to recover in around half of cases and around 40 per cent of the rest show worthwhile improvement³³. However, not everyone is suitable for every type of psychological therapy. Attention needs to be

given to people who do not fully recover through IAPT services and drop out of the programme, but who still need further support.

'In real terms there has been a reduction in access as funding for non-IAPT therapies has been shrunk and no new investment. I have recently started to talk to a new IAPT manager about future joint working. However there is no new funding for us.'

Local Mind

Recommendations

For Government and NHS England

- To reverse the decline in overall funding for mental health services, to enable greater access to other types of therapy as well as IAPT-funded psychological therapies.
- To ensure national frameworks, such as the NHS Mandate and CCG Outcomes Indicator Set, make explicit that psychological therapy outcome measures refer to non-IAPT and IAPT services, to incentivise availability of a wide range of psychological therapies.

For CCGs

- To sustain local provision of non-IAPT psychological therapies, which provide an important additional resource in supporting people with mental health problems.
- To encourage GP practices to invest in high quality psychologically trained practitioners to work alongside GPs in practice settings.
- To work with existing services to support providers in collating information on clinical outcomes and cost efficiencies to help commissioners better understand the impact and cost-benefit of therapy provision to inform long-term decisions about service development and ensure continuous improvement in commissioning.

Funding

There is a welcome cross-party commitment to mental health and the value of talking therapies. This has been evidenced by the commitment to parity of esteem for mental health in the Health and Social Care Act 2012. It has also been shown by significant investment in IAPT for adults and children by both the current and the last government.

While these are welcome steps to address the challenge of poor mental health, overall investment in mental health services is actually going in the wrong direction.

We know that poor mental health accounts for almost a quarter of total illness in the NHS. Yet currently it only receives 13 per cent of NHS funding. And within mental health spending talking therapies still only accounts for 6.6 per cent of overall spending.

Even though we understand that financial resources are scarce within the NHS, mental health must be seen as a priority area with increased funding to meet rising demand, and to address the historical lack of funding in mental health compared to physical health.

Looking ahead it is clear that a greatly improved funding settlement for mental health is necessary to expand capacity for the delivery of psychological therapies in the NHS. This makes economic, as well as moral, sense as increasing psychological therapy provision saves the nation more than it costs³⁴.

To deliver greater choice, improved access, and reduced waiting times all require an expanded therapy workforce capable of delivering a range of high-quality therapeutic interventions and rigorously assessing their outcomes. We welcome the funding commitments in the 2013 comprehensive spending review to expand access to IAPT and particularly to children and young people, but urge the Government to commit to further funding to address the issues identified in this report.

'We have just retendered for the IAPT service in Hampshire and won across the whole county (in partnership with the local NHS trust). Our targets are challenging with the new contract as we are being asked to do more for the same financial envelope.'

Local Mind

Recommendations

For Government and NHS England

- To reverse the decline in overall funding for mental health services and commit further investment to psychological therapies to ensure services everywhere in England can meet the rising demand for mental health support.

For CCGs

- To address the funding imbalance between mental and physical health and to ensure adequate investment in commissioning psychological therapies.

Workforce

While the increase in the availability of psychological therapies to people through the IAPT programme has been beneficial, the training and provision of up to 6,000 new CBT practitioners combined with the tendency in some local areas to cut pre-existing non-IAPT services, has led to many experienced therapists trained in other therapies losing their jobs.

However, it will not be possible to offer everyone a full choice of NICE-recommended therapies until the IAPT workforce is sufficiently diversified and re-balanced to deliver the full range of therapies. This requires funding and access to training in each therapy type, and guidance for the commissioning of IAPT training states that training in both CBT and other types of therapies should be made available³⁵. Initially IAPT focused its training efforts on CBT. However, we note that in the last two years there has been a re-balancing with as many people being trained in non-CBT high intensity therapies as in CBT. The IAPT Three Year Report also reflects this re-balancing with 30 per cent of IAPT high intensity therapists reporting that they deliver therapies other than CBT. Yet 99 per cent of IAPT's training spend has been spent on CBT, with the other four recommended therapy types sharing 1 per cent³⁶.

GPs and other primary care providers will also need greater knowledge of the various recommended psychological therapies in order both to make the most appropriate referrals and to provide high quality information about the range of treatment options to people that they can make well-informed choices.

'My experience of GPs is that they do not have the skills to detect or ask about mental health issues. I had many GP appointments over the years for stress related physical problems to no avail. When they finally referred me for therapy after a serious incident, I had deteriorated too much and the waiting list was too long. In the months before I got treatment I deteriorated and ended up in hospital. Since then I have had therapy and found it very beneficial.'

Mind survey respondent

Recommendations

For Government and NHS England

- To ensure the IAPT programme re-prioritises its training focus in order to deliver a more balanced workforce that can deliver universal access to the complete range of NICE-recommended psychological therapies.
- Existing counsellors and therapists in the NHS should be offered top-up training in the IAPT therapies.
- Primary care practitioners should be targeted for top-up training in order to improve the decision-making at each point in the treatment path.

Monitoring NICE and the research base for psychological therapies

Many psychological therapies have a strong evidence base and are NICE-approved first-line treatments. However, many other 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.

In mental health, NICE guidelines focus on using Randomised Controlled Trial (RCT) data to establish the most efficacious treatment for diagnosable health conditions. However, we know that outside of trial conditions most people present with co-morbid mental health conditions, often linked with physical conditions too.

Therefore, alongside RCTs, NICE must continue to invest resources into developing a wide range of quantitative and qualitative evidence for the efficacy and effectiveness of counselling and psychotherapy.

It is unacceptable that research funding into mental health represents only 5 per cent of overall research spending in health³⁷. In the context of parity of esteem we need to see a significant increase in funding so more research can be conducted into what works best for people with mental health problems.

Recommendations

For NICE

- To take forward the review of its approach to guideline development in mental health which means considering a more flexible approach, valuing a wider range of evidence types alongside RCTs, in developing future clinical guidelines. We would welcome further discussions with NICE about how the evidence base for psychological therapies can be broadened.
- To urgently establish a review group which brings experts together from across the psychological therapy profession and is led by an independent chair.

For Government and NHS England

- To support investment in high quality research into psychological therapies. This would include encouraging funding bodies to invest in future research to address gaps in the evidence base and identify innovative methods for analysing evidence from a range of research methods and studies.

Conclusion

The We need to talk coalition recognises the progress the Government has made within psychological therapy provision in England. In particular, we welcome the commitment to improving the IAPT programme, especially in attempting to address access and waiting times through the NHS Mandate and the Government's commitment to parity of esteem for mental health.

However, the promises made by the IAPT programme have still not come to fruition and this report demonstrates that waiting times, equity of access and choice of therapies are still far from adequate within IAPT and wider psychological therapy services for people with mental health problems.

For the Government to achieve its own parity of esteem duty, urgent action is needed to continue to expand and improve psychological therapy provision in the UK. It is not enough to pledge equality for people with mental health problems when in reality local services are dealing with an ever increasing demand for psychological therapies.

Action now will mean we can reduce waiting times and ensure more people getting the right therapy at the right time.

Appendix

In our survey, a total of 1,639 people with mental health problems responded that they had received or been on a waiting list for psychological therapies in the last 2 years. However, the response rates for each

subsequent question varied, as the table below outlines. For each statistic, we have therefore calculated the percentage or fraction of people stating a particular answer, out of the total respondents for that question.

Statistic	Question response rate
One in 10 people have been waiting over a year to receive treatment	1,430
Over half have been waiting over three months to receive treatment	1,430
Around 13 per cent of people are still waiting for their first assessment for psychological therapy	1,407
58 per cent of people weren't offered choice in the type of therapies they received	1,008
75 per cent of people were not given a choice in where they received their treatment	972
Half felt the number of sessions weren't enough	931
43 per cent of people did not have the different psychological therapies explained to them at the time of referral	1,030
13 per cent of people had full choice in the therapy they received	1,008
Half of people were offered a choice of appointment time	967
Three quarters of people were not offered a choice of treatment location	972
11 per cent of all respondents said they had to pay privately available because their choice of therapy wasn't available	235*
*the response rate is so low because this question was only asked of those who first answered yes to 'whether they had to pay privately for treatment'	
40 per cent of people had to request psychological therapies rather than being offered them	1,459
One in ten people, after being assessed, were not offered psychological therapies	1,407
Only one in ten people felt their cultural needs were taken into account by the service they were offered, though most others said this didn't matter to them	962*
*68 per cent of people said this issue didn't matter to them	
Of people with schizophrenia, bipolar disorder or personality disorder:	
• Less than 30 per cent of people referred to psychological therapies accessed these within three months	350*
• One in five people have waited for more than a year to access psychological therapies	350
• Over half had no choice of therapy service	237
• Only around a third of people who had accessed therapy felt they'd had as many sessions as they needed	227
*these response rates are so low because they are based on a sub-set of respondents who said they had schizophrenia, bipolar disorder or personality disorder	

Glossary of terms

Cognitive Behavioural Therapy (CBT)

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.

Counselling

Counselling provides a regular time and space to talk about issues and explore difficult feelings with a trained professional. This can help to deal with specific problems, either in the past or present and help to cope with a crisis, improve relationships, or develop better ways of living.

Dynamic Interpersonal Therapy

This is a new form of therapy that has been developed for the treatment of depression. The therapy aims to help understand the connection between what is happening in someone's relationships and the depressive symptoms being experienced, by identifying unconscious and repetitive patterns of relating to others.

IAPT Step 1

This is part of the IAPT model of therapy. Step 1 is based on low intensity interventions which are such as self-guided, group therapy or computer based cognitive behavioural therapy.

IAPT Step 2

If step 1 doesn't work, then people are moved to step 2 therapy. This is a higher intensity intervention and includes more in-depth CBT and counselling, often on a one-to-one basis with a trained practitioner, and could last for longer than step 1.

Medically Unexplained Symptoms

The NHS terms medically unexplained symptoms when doctors cannot find any disease or problem with the body that would otherwise account for the symptoms such as dizziness or aches and pains. This doesn't mean the symptoms do not exist but that more needs to be done to explore the cause of the symptoms, including looking at the person's mental wellbeing. Medically unexplained symptoms are surprisingly common, accounting for a fifth of all GP consultations in the UK

Mentalisation based theory

This teaches greater awareness of how thoughts can impact actions. It also teaches how to separate thoughts and actions. Mentalisation-based therapy is based on the belief that early problems stopped someone from learning how to understand their own and others' thoughts and feelings. The treatment can take up to 18 months and can be individual and group therapy.

Psychoanalysis

This therapy suggests that because so much of what goes on in someone's mind is hidden and unconscious, it can be difficult to understand one's reactions and behaviours. It also suggests that early experiences of love, loss, sexuality and death can all contribute to emotional conflicts and determine how someone relates to others later in life.

Psychodynamic therapy

This is based on the idea that the past has an impact on someone's experiences and feelings in the present. The therapist usually aims to be as neutral as possible, giving little information about themselves. This makes it more likely that important relationships (past or present) will be reflected in the relationship between the person and therapist. This helps to give an important insight for the person and the therapist to help work through difficulties.

Psychotherapy

The purpose of psychotherapy is help someone understand their feelings and behaviour better and to change their behaviour or the way they think about things. Sessions usually take place once a week, and making this regular commitment gives someone a better chance of finding out why they are having difficulties.

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