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Improving Access to Psychological Therapies



Looking Towards 2010: Where have we got to? How do we sustain development?

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IAPT Progress to Date

- Manifesto commitment
- Demonstration Sites
- Pathfinder Sites
- CSR Settlement
- National Materials
- Year One Courses and Services

Demonstration Sites

(Newham & Doncaster. For LSE report: www.iapt.nhs.uk)

- Awarded £1.5- £2 million per annum to increase access to psychological treatments
- Initially different service models (especially high vs low intensity mix)
- Somewhat different patient populations
- Session by session outcome monitoring
- Experiment with self-referral

Demonstration Sites (Newham & Doncaster)

- Excellent data completeness (99% in Doncaster, 88% Newham).
- Large numbers treated (approx 3,500 in first year). Use of Low intensity important.
- Outcomes broadly in line with NICE Guidance for those who engaged with treatment (52% recover). Employment benefits. Maintenance of gains.
- When compared with GP referrals, self- referrals were as severe, tended to have had their anxiety disorder or depression for longer, and had BME rates that were more representative of the community.
- Outcome does not differ by ethnic status or referral route
 - White 50%
 - Black 54%
 - Asian 67%

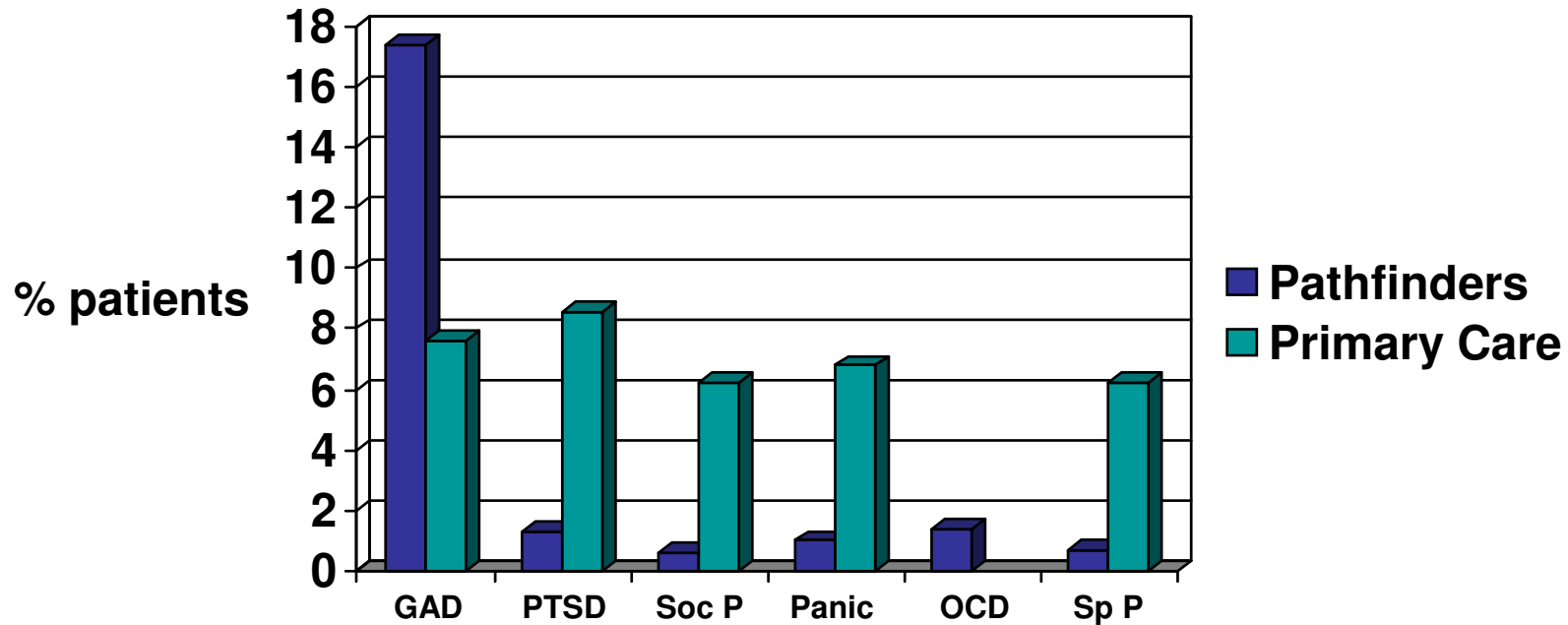
Pathfinders (see www.nhs.iapt.uk)

- 11 across country. More modest funding (approx £200k). Additional focus on particular groups (older people, children, BME, medically unexplained symptoms)
- High patient satisfaction ratings
- 5 weeks to initial assessment (10% dissatisfied)
- Recorded outcomes also broadly in line with NICE (49% recover)

BUT

- Variable data completeness (mean 55%, range 18%-95%)
- Very little self-referral (1%)
- Depression and worry (GAD) services. Poor coverage of other anxiety disorders even they have lower natural recovery rates and CBT tends to be more effective.

Rates of Anxiety Disorders in Pathfinders vs Primary Care



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Features of Secretary of State's October 2008 Announcement

- Extra 900,000 patients treated
- 450,000 will recover
- Self-referral. Equitable access

Support Materials from National Team

All available on IAPT website (www.iapt.nhs.uk)

- National Implementation Plan
- Commissioning Toolkit
- Outcomes Toolkit
- Clinical Supervision Principles & Guidance
- National Curricula
- Commissioning IAPT services for the whole community
- Other workforce & teaching materials
- Discussion group

National Plan for Roll-Out

Year One

- At least 20 PCTs selected as expansion sites
- Training providers selected and courses started
- At least trainees

Years Two & Three

- Large increase in trainee numbers and expansion sites
- At least 50% national coverage

Subsequent 2-3 years

- Complete national coverage

Year One: What has actually happened?

- Excellent choice of training providers
- Strong support from SHAs (despite almost impossibly tight timetable)
- Over-achievement in sites (35 versus 20)
- Over-achievement in trainee numbers (> 1100 versus 730)
- London trainees 25% from BME groups
- Learning the lessons of year one

Selection and Placement of Trainees

- Need for clarity over non-graduate route into high intensity training (at selection)
- Recruiting all relevant professional groups for high intensity training (getting AfC grades right)
- Ensuring PCTs have one third trained workforce and the appropriate service model.

What are the courses teaching?

- National CBT based Curricula (high & low)
- Emphasis on quality (after training the trainees are expected to get results in NICE trial database with comparable patients).
- Different from existing courses
 - Number of teaching days
 - Depression and anxiety disorders. Stepped care. Job links.
 - Trainees guaranteed relevant cases
 - NOT generic CBT. For High teach at least one evidence based CBT for each disorder. For low teach innovative delivery methods/coach role. (guided self-help, computerized CBT, problem-solving, behavioural activation, medication compliance, sign-posting. Includes telephone delivery).
 - Nationally provided materials (low)
 - High level of supervision (course & service)

Characteristics of a good therapist

- Positivity
- Low hostility
- Believes in the treatment
- Respect for minority cultures
- Flexibility
- Gets good outcomes

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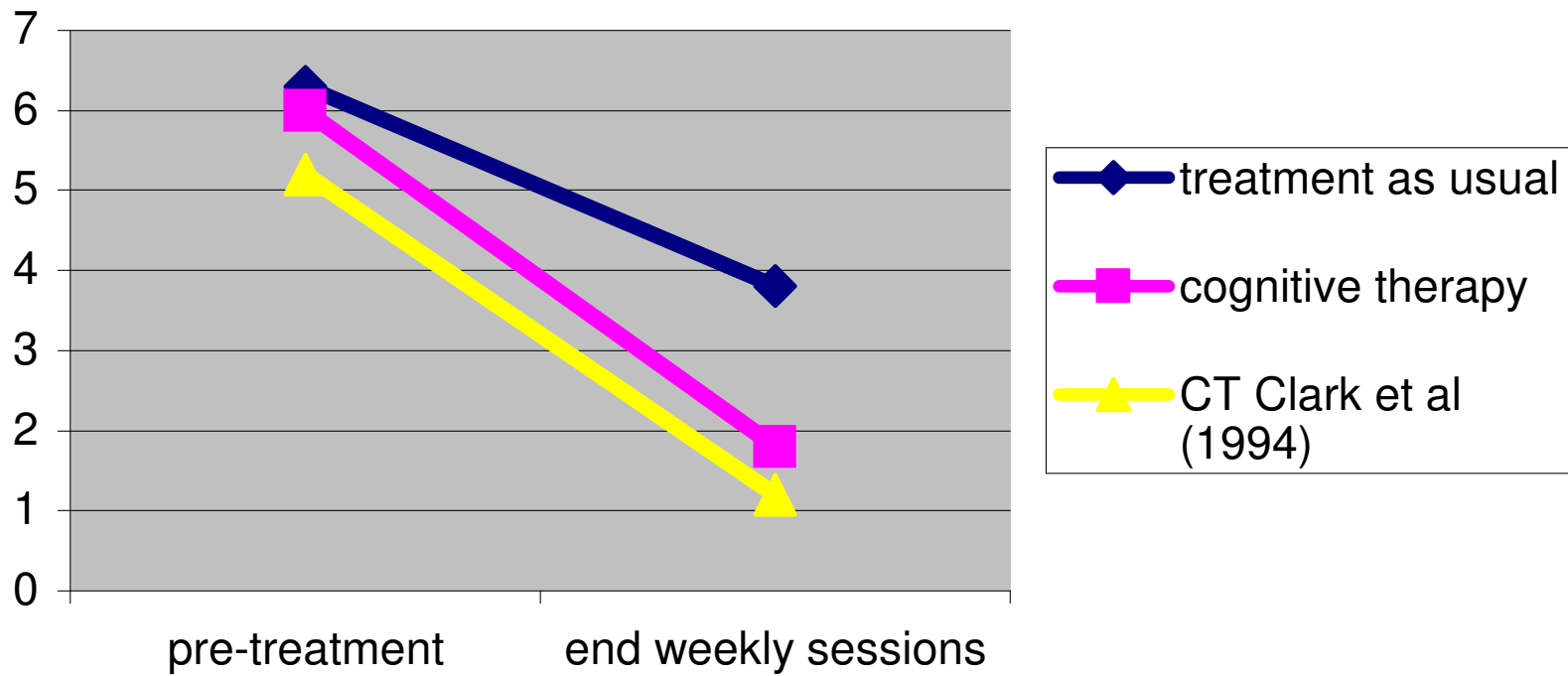
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Can we train therapists?

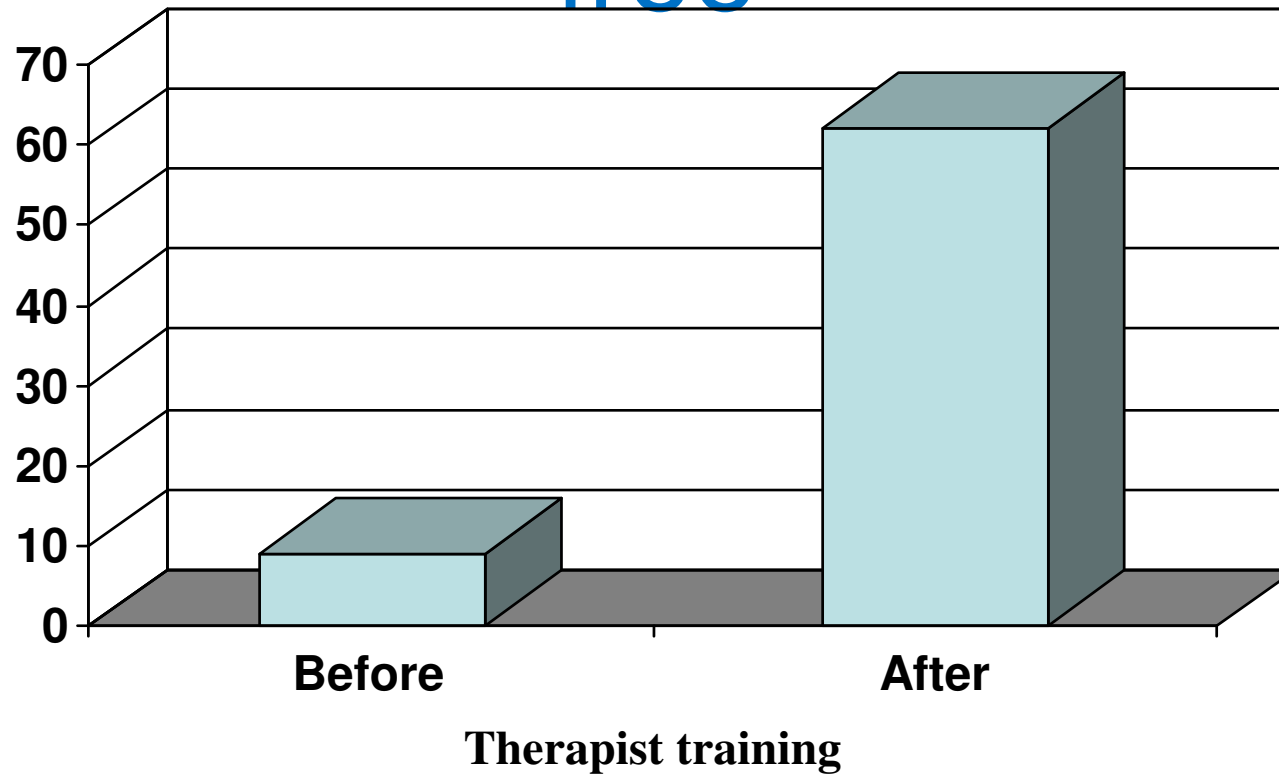
Grey, Salkovskis, Quigley, Ehlers & Clark (2008)

- Panic disorder in primary care
- 7 therapists (person-centred, REBT, systemic, integrative)
- Study in 3 phases (baseline, train, post-baseline)
- Training comprises: 3 day workshop, weekly supervision for 6 months, 1 day workshop, continued supervision)

Panic related distress/disability (0-8) patient rated



% Patients who become panic free

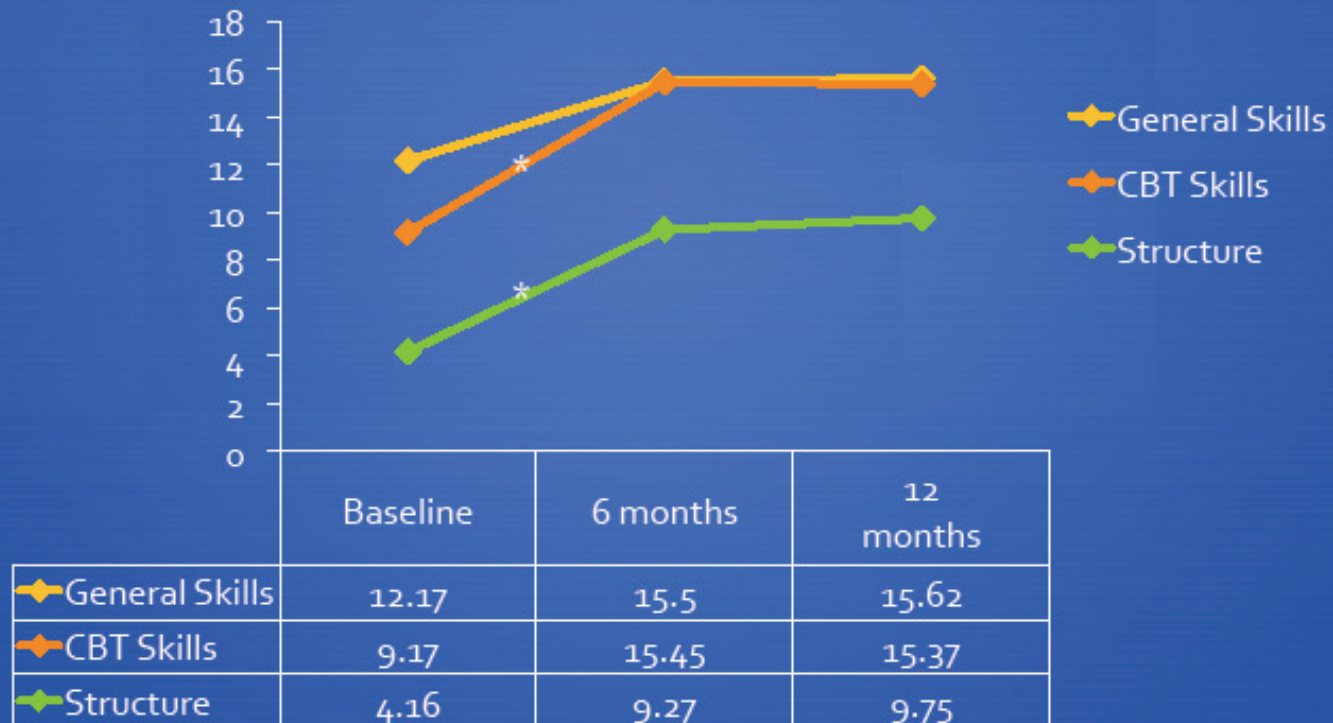


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CTRS Unpacked



Service Model (1)

- Stepped care (when appropriate)
 - Best chance of good outcome with minimum patient burden. Increases volume.
 - Regular systematic review and prompt step-up if patient has **not recovered**.
 - Describe high and low intensity as different to avoid demoralization and drop-out.
- Single integrated service (to avoid undue delays between steps). Blurs traditional boundary between primary and secondary care.
- Multiple Providers (statutory, private & voluntary sector) but one service.

Service Model (2)

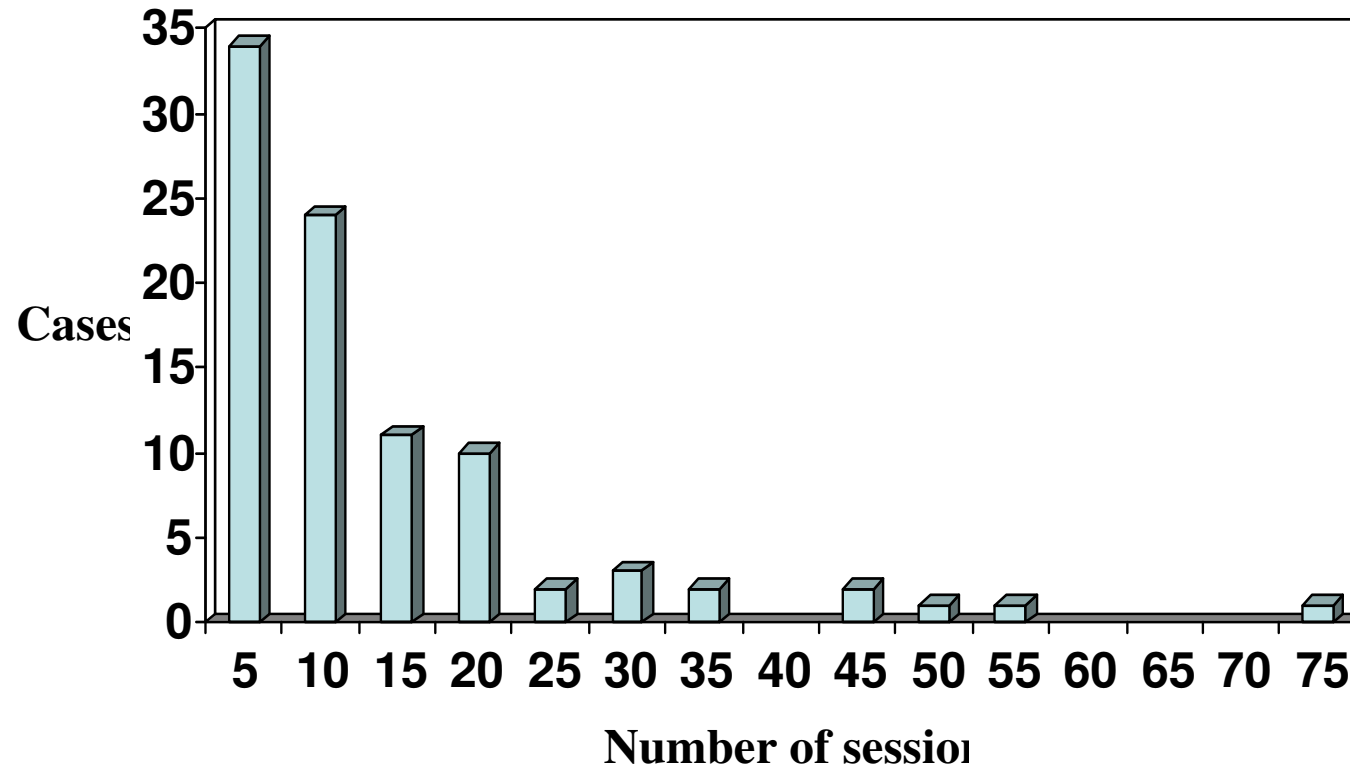
- Close link to employment advisors.
- Serving a population in the long-term so emphasis on relapse prevention (therapy blueprints, follow-up session).
- Patients receive appropriate dose of therapy (not arbitrary limit of 6 sessions. Out of office behavioural experiments when indicated).
- Session by session outcome monitoring for ALL patients in the service (using IAPT Outcomes Toolkit).
- IT system that enables therapists and service director to have prompt access to outcome data and generates service reports.

Omagh Bomb Therapy Series

(Gillespie, Duffy, Hackmann & Clark, 2002, Behav Res & Ther, 40, 345)

- PTSD following car bomb. No exclusion criteria.
- Session by session outcome measures
- Pre-treatment to posttreatment effect size (2.47) comparable to RCTs.
- Outcome measures (86% complete)
- Median number of sessions = 8
- Co-morbidity does NOT predict outcome (but co-morbid cases have more treatment sessions: 10 vs 5).

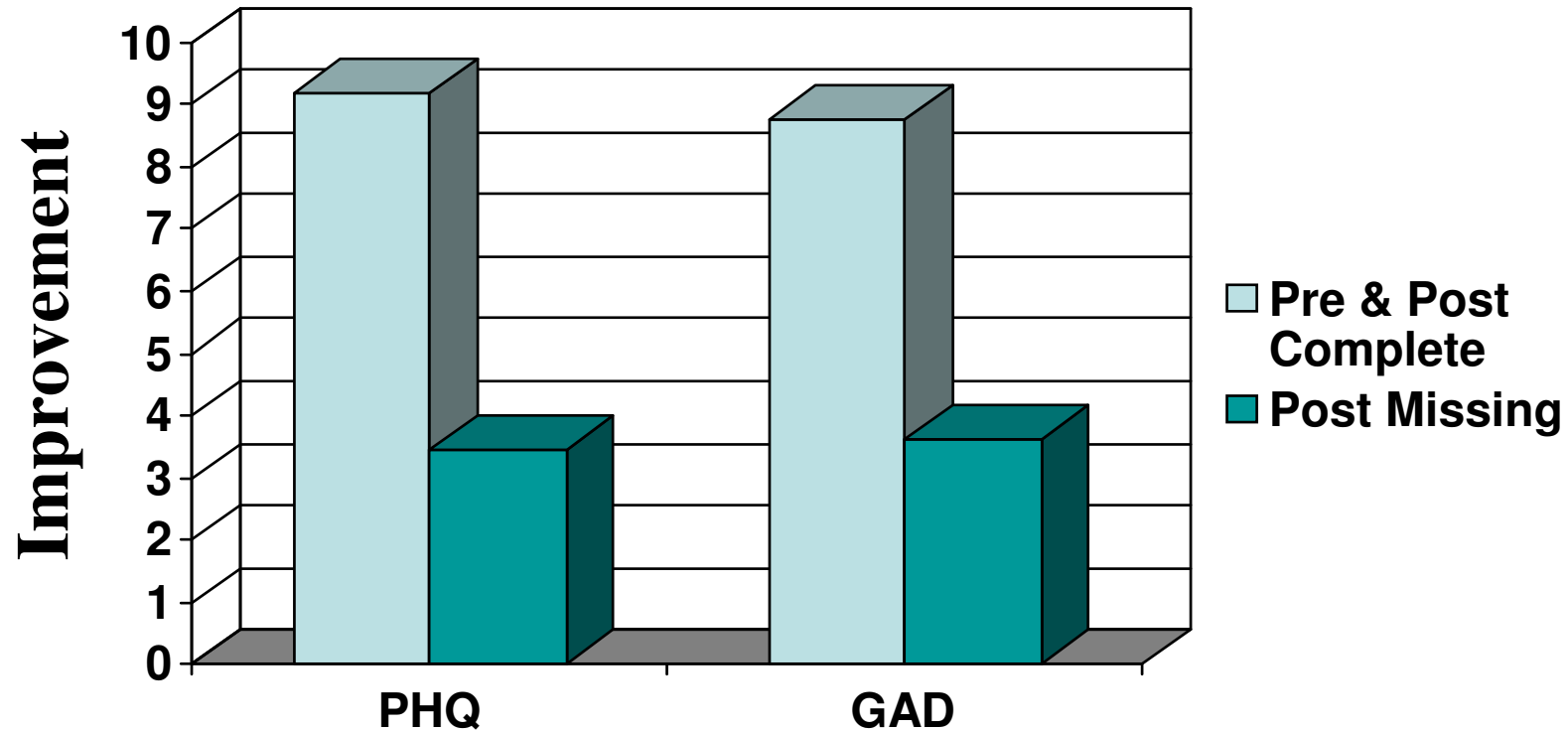
Number of treatment sessions



Service Model (2)

- Close link to employment advisors.
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Why getting complete data matters



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Looking to the Future

Increasing equitable access

- Self-referral
 - (BME groups, London Bombings Screen & Treat programme)
- Voluntary sector, community groups
- Service website
- Extended opening hours (not just office hours)
- GP lead /champion
- Multiple venues
- Monitoring access by gender, BME, postcode, diagnosis, medication.

What Treatments should be offered?

- NICE Recommended
- CBT suitable for all conditions covered by IAPT (depression and all anxiety disorders)
- High intensity CBT indicated for all.
- Low intensity indicated for (mild/moderate) depression, GAD & panic. Not PTSD.
- In depression (but not anxiety disorders), NICE also recommends IPT (all severities), counselling & couples therapy (mild/moderate only).
- Statement of Intent commitment.

Choice of treatment within NICE

Type of treatment, how delivered and by whom.

- Patient at centre.
- Empowering.
- May increase take up of treatment.
- Needs to be fairly informed.
- Second treatments (need for research)

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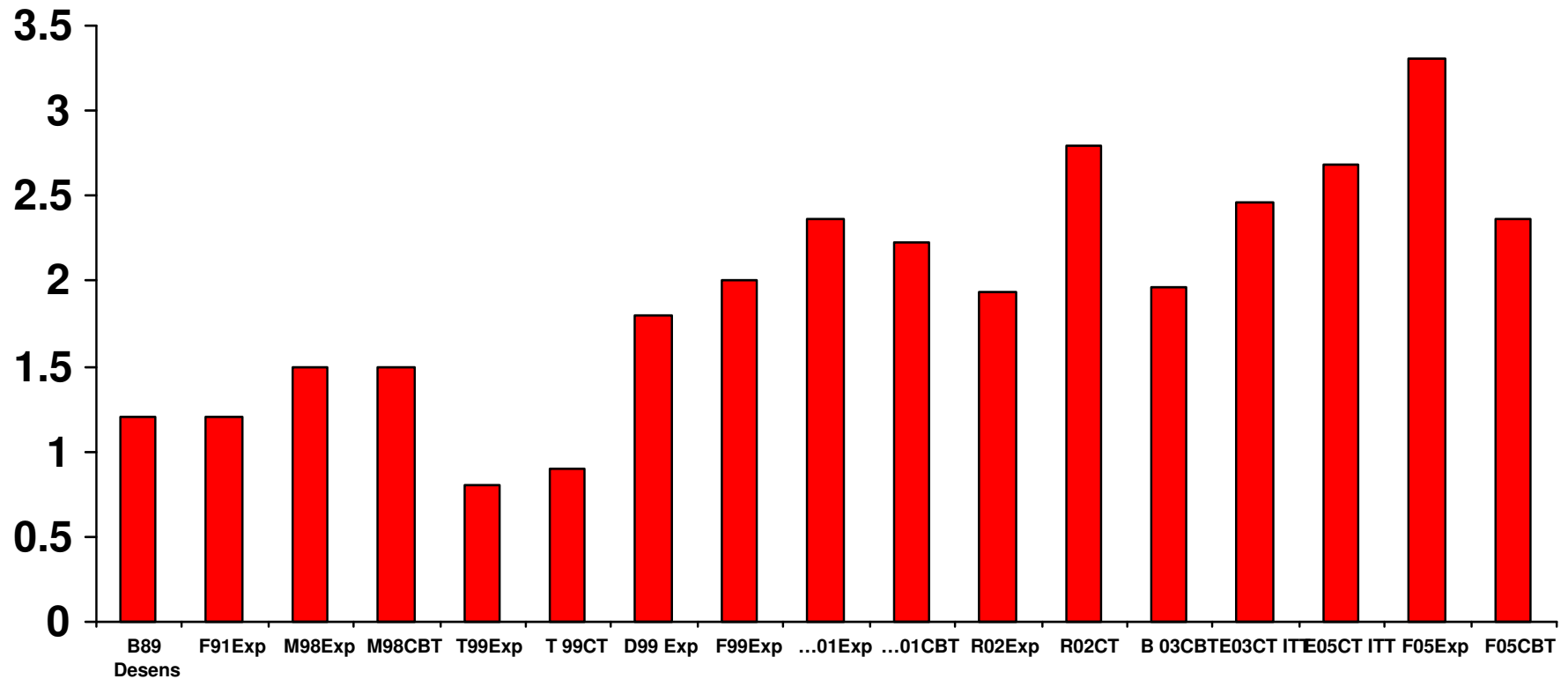
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NHS

Realizing the full potential of outcome monitoring

- Improve outcomes (Lambert)
- Test our ideas/prejudices
- Spot our limitations
 - *Therapy innovation*
 - *CPD/specialization*
- Ticket to commissioners and to NICE

Pre-post effect sizes for trauma-focused CBT treatments by year of publication (PTSD symptoms - patient self-report)



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Sustaining the momentum

- “Fierce urgency of now”
- Demonstrate access and outcomes.
- Become much more user centric.
- Mainstream IAPT within the NHS
- Coherent care pathways for all.
- Create services that people want to work in.
 - Supervision, CPD, objective criteria for excellence, improving on your elders.

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Thank You