quintessence

access to populational mental health knowledge

Volume 2, Number 3, March 2010

England's innovative program to make psychotherapy more accessible

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Relevance

Anxiety and depressive disorders are the most frequently occurring mental disorders within the population and it is estimated that less than half of people consulting a health care professional receive adequate treatment. To remedy this situation, the Improving Access to Psychological Therapies (IAPT) program, a governmental initiative implemented in England since 2005, seeks to improve the accessibility of evidence-based psychotherapy in treating these disorders [1, 2].

Psychotherapy: a NICE-recommended treatment

Psychological treatments targeted by the IAPT program are based on National Institute for Health and Clinical Excellence (NICE) clinical practice guidelines[3]. The IAPT program is composed of two main psychological intervention categories: low intensity and high intensity interventions. An example of such interventions in each category are included in Table 1 for the stepped care model regarding major depression.

Table 1: NICE-recommended psychological interventions for major depression

Treatment intensity	Recommended psychological interventions
Low intensity	Supported self-management, computerized cognitive behavioural therapy, structured physical activity group.
High intensity	Cognitive behavioural therapy, interpersonal therapy, behavioural activation and behavioural couples therapy.

IAPT training program

Success of the IAPT program rests on a widespread training initiative to build a workforce specialized in psychotherapy in view of progressively increasing access to primary mental health services in NICE-compliant therapies. Many studies have clearly demonstrated that time constraints, consultation quota requirements and a lack of training or information sessions create barriers to the implementation of new evidence-based practice guidelines[4].

To successfully integrate NICE-recommended therapies in primary care, the IAPT program emphasizes the necessity of training care providers and freeing them from their professional duties during that time. To ensure its success, the program received the equivalent of over 285 million Canadian dollars in funding for 2008 to 2011. Two types of training have been developed for the IAPT program.

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1. **High-intensity** intervention training offered two days a week for one year. This course is designed for clinical psychologists, psychotherapists and care providers with experience in mental health, in view of developing skills in cognitive behavioural therapy. High-intensity trainees will obtain accreditation from the British Association of Behavioural and Cognitive Psychotherapies (BABCP).
2. **Low-intensity** intervention training offered one day a week for one year. Trainees selected for this course must have a degree in psychology or life and work experience in the field of mental health. The purpose of this course is to develop skills in supported self-management and low-intensity psychological interventions.

In addition to the training of care providers, Primary Care Trusts (PCTs) adhering to the IAPT program must collaborate closely with communities and local support services (employment services, organizations offering support for debt or relationship issues) to provide integrated care centred on individuals and their family.

Performance indicators

The British government, in collaboration with Strategic Health Authorities (SHAs), is currently working on the development of performance indicators to assess IAPT implementation in primary care settings. Three goals have been targeted so far:

1. Increasing IAPT program implementation in PCTs every year;
2. Producing a skilled workforce: the training program is set to deliver 3600 therapists with the skills required to provide adequate psychotherapy services;
3. Expanding access to NICE guideline-concordant services: 900 000 more people to access treatment by 2011; half of those completing the program will move to the recovery phase and 25 000 fewer people will be on paid sick leave from work.

These targets will be used as a basis to identify more specific indicators that will help assess the accessibility of services (decrease in waiting times and access to adequate treatment), equity of access, population coverage, effectiveness (improvement of health status and well-being of individuals), acceptability and quality of care.

Preliminary results

Good recovery rates (52%) in people who had been afflicted with an anxiety and/or depressive disorder for over six months

Two demonstration sites in Doncaster and Newham participated in the first phase of the IAPT program over the course of 13 months (2006-2007). An initial evaluation published in July 2008 presented promising results[5]:

- The program helped assess and treat an impressive number of people (over 5500 patients were referred, 3500 of whom completed treatment);
- Both sites were able to monitor post-treatment status of patients in 99% of Doncaster cases and 88% of Newham cases;
- Both sites saw good recovery rates (52%) in people who had been afflicted with an anxiety and/or depressive disorder for over six months;
- The employment rate rose by an average of 5% among the treated population;
- An estimated one in five people using the new services referred themselves to the service, demonstrating that the program facilitates access to psychotherapy.

Conclusion

Over the last decade, a number of initiatives have been developed to reduce the human, social and economic burden associated with anxiety and depressive disorders. Several countries have developed clinical guidelines to improve the quality of primary mental health care. Although these new guidelines have very limited integration in primary care settings, national initiatives such as the IAPT program provide hope that change is possible.

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