

REVIEW ARTICLE

Out of the Frying Pan and into the Fire, or Genuinely Broadening Access to Psychological Therapy in the NHS?

A Review of Samantha Callan and Benjamin Fry, *Completing the Revolutions: Commissioning effective talking therapies*,
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This is a review article in two halves. The first half examines the current situation with 'Talking Therapies' in the UK National Health Service (NHS), identifying existing problems with the Improving Access to Psychological Therapies (IAPT) system, and describing outcome studies that evaluate the provision of service. The second half offers potential solutions to these problems that are innovative, creative and potentially ruthless.

Overall, this report can be seen as an attempt to redress the imbalance in the provision of psychological therapies in the NHS. The first chapter starts by providing a background to the current government initiatives on the provision of mental health services in the NHS. Two main policies are described. The first is Payment by Outcome (PbO) (also confusingly referred to as Payment by Results (PbR)) that effectively states that payment to the provider will be withheld until the client has reached a specified level of recovery. This is already in place in some government departments, such as the Justice Department. The second is the development of service provision by suitably qualified providers who may work outside of the NHS. This is known as Any Qualified Provider (AQP) service provision. Both these initiatives have been earmarked for the provision of mental health services, and in particular the 'Talking Therapies'.

The next chapter reviews the existing provision of 'Talking Therapies', examining the private and voluntary sectors. It points out that there are eight times as many therapists available in this sector as there are in the NHS, but most clients are excluded from these sectors because they are charged a fee. With the exception of cost, it notes that these sectors are often conveniently positioned, flexible and individually focused; all of which are important factors in a survey of an individual's choice of therapy. This flexibility is seen as largely due to their independence from National Institute of Clinical Excellence (NICE) guidelines.

The report then goes on to describe the main provider of 'Talking Therapies' in the NHS; the Improving Access to Psychological Therapies (IAPT) to which the vast majority of resources from the government are given. In contrast to the Independent and Voluntary sectors, IAPT is bound into the NICE guidelines that were developed largely for practitioners of physical medicine. The NICE guidelines focus on Anxiety and Depression and recommend almost exclusively CBT, virtually to the exclusion of any other form of therapy. The report points out the irony that 70 per cent of people that use the service have a diagnosis of Mixed Anxiety and Depression (which glories

1 Freely available online at: <http://www.centreforsocialjustice.org.uk/client/media/Talking%20Therapies%20Paper.pdf> (retrieved 20 May 2012)

under the acronym of MAD) for which there are no NICE guidelines. The report comments that while other modalities of therapy may not adhere to NICE guidelines in general, they do adhere strictly to the safety and ethical aspects of the guidelines. The final part of this chapter makes the point that in spite of the apparent importance of NICE guidelines, many of the most important and research-led and influential NHS Trusts, such as the Tavistock and Portman Trust and the Maudsley, all use non-NICE recommended forms of psychotherapy.

The following chapter examines the meaning of 'recovery', and goes on to describe it in terms of psychometric measures when outcome scores move from being in the clinical range (referred to as 'caseness') to that of the non-clinical population. Nearly all the NHS trusts and 50 per cent of voluntary organisations use this somewhat restricted definition. The report comments on the fact that most people present with multiple issues, and goes on to identify problems in working with single NICE guideline presentations out of context. It gives two case studies that exemplify this, suggesting that a more flexible approach such as that offered by the independent sector could be more effective. The authors then go on to review how risk is understood by NICE, and how psychological therapies are treated in the same way as invasive surgery and medication; arguing that once-weekly talking therapy carries less risk than more directly invasive procedures. They discuss how risk can be construed in terms of the modality used, the individual therapist and the individual client and his or her choices. They note that a person who is out of work has a much broader access to psychological therapies because the Department of Work and Pensions operates an AQP scheme, while someone in work who visits their GP is likely to only be referred into a NICE-guidelined service.

Current commissioning practice is the focus of the next chapter. The report describes the forms of interventions offered by the 88 per cent of accredited therapists who do not work in the NHS. It notes that by being accredited, therapists already comply with a set of highly rigorous ethical and risk-management standards, and challenges the Government spending £100 million on training a NICE-compliant workforce that replaces the accredited one. It also recognises the vast unused capacity available to the NHS in the independent and voluntary sector.

Having identified the main problems with the current system, the next chapter describes the current state of PbO. It looks at how 'outcome-based partnerships' could be developed, particularly in the light of recent therapist-variable research that shows that there is a considerable variation in the outcomes associated with some therapists compared with others; these differences being much greater than differences between therapy modalities. In PbO 'high-achieving' therapists would be rewarded for their outcomes and 'low-achieving' therapists would potentially not be rewarded at all. In other words, the responsibility for recovery would appear to lie firmly in the hands of the therapist. The authors suggest a Darwinian scenario of survival of the fittest, whereby only 'effective' therapists will be fully remunerated.

The final chapter compares therapy services. The authors describe a study that examines the effectiveness of first-wave IAPT services. Using an 'intention to treat' model which evaluates the progress of clients from referral to final outcome; of those referred into the service only an astonishing 18 per cent were deemed to have achieved recovery. Given the original 50 per cent target, this is less than impressive.

Another study carried out by the Artemis Trust compared an IAPT service, a voluntary organisation and primary care counseling. The average cost per 'recovery' of a client was £2,052 for IAPT,

£1,289 for the voluntary organisation and £866 for the primary care counselling services that IAPT has largely replaced.

The report then goes on to make a series of recommendations. The first is that the Department of Health develops tariffs for the implementation of 'pure PbO'. This means that unless a client achieves recovery, as defined by moving out of 'caseness', then therapist remuneration is minimal or even non-existent. This is my main concern, as it appears to be counter to the basic principles of psychotherapy. It places the responsibility of recovery with the therapist and not the client, or even the collaborative relationship. It appears to be firmly placed in a medical model of therapy where the therapist is expert and 'treats' the client. However, one wonders how medical doctors would respond if they were only paid if their clients got better; I imagine there would be a forthright response to this initiative!

How would PbO be reflected in the unconscious processes of the therapeutic relationship if the client knows that their therapist will only get paid if they (the client) recover? This could compound directly some clients' need to look after others at the expense of themselves, and to 'get better' to care for their therapist. At the other end of the spectrum, a client may not recover 'at' their therapist in order to punish them, or simply not recover in order to remain engaged with their therapist. At the risk of being cynical, I also wonder whether the therapist and client could collude with the process of recovery for financial gain.

The binary nature of 'caseness' is also worrying. Would the therapist only be paid if the outcome measure was one point away from 'recovery'? Is the measure of recovery only going to be seen in terms of caseness on single measure? Does this mean that only clients who fit caseness will be offered the service, and if not, how will the therapist be remunerated if the client is already out of caseness?

The next recommendation seems straightforward. There should be clear guidelines on AQP and these are simply to employ only accredited therapists from the main accrediting bodies such as BACP, UKCP and BPS which have risk management and ethical frameworks firmly in place to address the safety issues that are so important in the NICE guidelines.

The report recognises the danger of therapists only wanting to work with clients who present with non-complex difficulties, i.e. cherry picking, and recommends that measures be used that assess clients levels of complexity. They recommend the HoNOS – PbR, which has a long and robust track record in the NHS. However, I wonder whether this is enough, and whether there is room for some form of secondary assessment to be available to ensure that if more complexity is unearthed, the tariff can be renegotiated. Much work will need to be done to establish a system of tariffs that reflect the complexity of presentation. Even if they do present initially with low HoNOS scores, I am also concerned that some clients will present with difficulties from which they are not likely to recover (i.e. move higher up the HoNOS scale), who will need management and support over a period of time in order that they do not deteriorate. Where does this fit with the recovery model, and what sort of input might they expect? If they did need to be referred on, would the therapist be paid for this service?

The next recommendation is that one provider is responsible for the local provision, along with the administration of outcome forms and evaluation, and they should subcontract the service to local therapists. This would make sense and address the potential difficulty of outcome-averse therapists struggling with the completion and compilation of forms (although CORE-net would

assist here). I wonder whether these organisations could offer some support to those therapists who are associated with low numbers of clients recovering in order to mollify the Darwinian approach mentioned in the report.

This report has much to commend it. It gives a thorough review of the almost absurd state of existing provision and its reliance on the NICE guidelines. I would have welcomed more comment on the use of randomised control trials (RCTs) and how they can introduce confounds into the outcome research. Alongside this, I think more criticism is needed of the use of NICE in mediating a largely non-medical 'treatment' (a powerful critique of this can be found in Guy et al., 2012). Many of the studies that support NICE guidelines for CBT are efficacy studies where experimental and ideal conditions are strictly adhered to, such as specificity of presenting problem (have you ever worked with someone who is solely depressed?) alongside specificity of intervention. There are also few effectiveness studies taken into account that evaluate the usefulness of the intervention in the real world where people have multiple, complex difficulties that require a flexible and sophisticated approach within a safe therapeutic relationship. This is also referred to as Practice Based Evidence. I welcome the long overdue inclusion of Therapist Effect Research which probably accounts for why, when one form of therapy is compared with another, there is little or no difference.

I do have difficulty with the PbO recommendations as they stand, but recognise that this is partly imposed by the Department of Health policy and that much work needs to be done to refine them. I also recognise that this is a business model, and like it or not the provision of therapy is big business. I think it would be a shame if most of this report 'baby' were thrown out with the PbO bathwater. I feel sure there could be a way of addressing this issue so that clients could feel more empowered and responsible for their recovery. I wonder whether individual 'Patient Health Budgets', over which clients have control to pay for the therapist of their choice, could be implemented along with transparency of therapist outcomes in order to facilitate this choice. This way, therapists would be held to account as well as rewarded for good practice. Individual therapist outcome data would also be aggregated so that a single 'non recovery' would not be so potentially financially punitive. Another possibility may be to place the PbO financial risk with the provider organisation rather than solely with the individual therapist. This may go some way to addressing the unconscious processes acted out in the therapeutic relationship mentioned above. As independent therapists there has always been the 'money' side of the relationship that needs to be negotiated and worked with (or not...) by the therapist and the client. Is PbO merely an extension of this, or is it a complete departure? Again much room for some (very) lively debate!

References

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