



Psychological therapies and parity of esteem: from commitment to reality

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British Association for
Counselling & Psychotherapy

Foreword

For 25 years I worked with children and families in the deprived mining valleys of South Wales, which struggle with unemployment, community breakdown, alcoholism, drug abuse, violence, school drop-out and teenage pregnancy. My patch covered most of the parliamentary constituency of Nye Bevan, the father of the NHS. I wonder what he would think of the NHS's answers to its current problems?

The NHS was born on 5 July 1948 out of Nye Bevan's ideal that good healthcare should be available to all, yet mental health has always been the 'poor cousin' of physical healthcare. Less focus, less money, less management time and energy. Less awareness, less understanding, less research. Less care, in every sense.

There's a bias in our society, deep-rooted, long-standing and institutionalised, that mental ill health isn't really ill health at all. I'm sure most of us have heard these biases overtly or read them in the newspapers, and even more often felt their unspoken presence. Those of us who work with mental ill health, or have lived or familial experience of it, know the truth – and feel the injustice of it every day.

Over the course of my career, social attitudes have started to soften. Awareness, sympathy and understanding have begun to increase. NHS treatment of, and for, those with poor mental health has improved. The journey towards 'parity of esteem for mental and physical health' began long before the phrase was coined. But it's a long journey, which we should expect to measure in decades, even as we push for it to happen in days, months and years. On such a journey, the Government's formal commitment to 'parity of esteem' is a significant and welcome milestone, and I fervently hope it acts as a catalyst to accelerate progress.

As the UK's leading professional body for counselling and psychotherapy, BACP is interested in what needs to happen to ensure that people who access, or could benefit from, psychological therapy no longer suffer as a result of disparity.

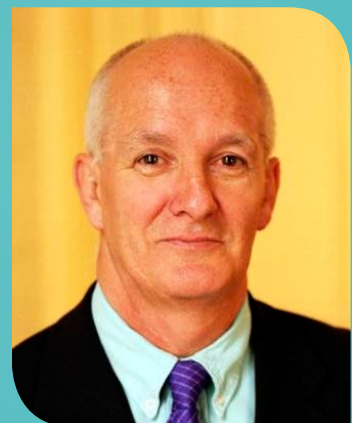
This report focuses on the NHS in England, but its recommendations make sense for all of us, across the four nations.

I offer my sincere thanks to all those who have helped produce this report. On behalf of our members, and of the broad base of supporters who have engaged with us, our message to all those involved in the funding, commissioning and delivery of psychological therapies in the NHS, is simple:

'You will not meet your commitment to parity of esteem for mental health without a significant increase in the quantity and quality of the provision of psychological therapies. If you are serious, this is what you must do.'

Dr Michael Shooter CBE

President, British Association for Counselling and Psychotherapy



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About BACP

The British Association for Counselling and Psychotherapy (BACP) is the leading and largest professional body for counselling and psychotherapy in the UK, with over 41,000 members working to the highest professional standards in a range of settings.

BACP is recognised by legislators, national and international organisations and the public as the voice of counselling and psychotherapy in the UK.

Acknowledgements

Many individuals and organisations contributed to the production of this report. We thank you all and in particular the health and social care external stakeholders, service users and BACP members who contributed to the consultation process.

Introduction

Disparity between the treatment of physical and mental health has long been an issue in health and social care provision and it is to be welcomed that in recent years the UK's mainstream political parties have started to take action on the issue of parity and the need to close the gap in funding between mental and physical health services.

The Coalition Government enshrined in law a commitment to parity of esteem for mental and physical health in the Health and Social Care Act 2012. In January 2014 it published the policy paper *Closing the Gap: priorities for essential change in mental health* (Department of Health, 2014a), which sets out 25 priorities for change in how children and adults with mental health problems are supported and cared for. In October 2014 the Deputy Prime Minister the Rt Hon Nick Clegg MP announced new waiting time standards in an attempt to bring treatment for mental health problems in line with physical health. Thus by April 2015 95% of patients accessing talking therapies through the Improving Access to Psychological Therapies (IAPT) programme should receive treatment within a maximum of 18 weeks, the same target as that for physical health conditions (Department of Health, 2014b).

The Labour Party too is committed to parity of esteem for physical and mental health conditions, including a commitment to change the NHS constitution to give people a right to psychological therapies (Labour Party, undated). Their proposal for 'whole-person care' is to integrate health and social care to create a single service that can meet a person's physical, mental health and social care needs.

Commitments to the principle of parity have been made by all three main political parties, and whichever party (or parties) is elected to government in May 2015 will be responsible for delivering parity of esteem.

Importantly, the commitment to parity of esteem for England has resulted in passionate debate about how to bring it about, and these debates are reflected in several reports and recommendations. In 2013 the Royal College of Psychiatrists, commissioned by the Department of Health, published *Whole-Person Care: from rhetoric to reality*, setting out a vision of parity of esteem (Royal College of Psychiatrists, 2013a). The British Medical Association (BMA) has made recommendations about recognising the importance of physical

'In terms of whether mental health should have parity of esteem with other forms of health care, yes it should, and we have legislated to make that the case.'

**Rt Hon David Cameron MP, Prime Minister
(Hansard, 19 March 2014, col.774)**

'It's time for us bring mental health out of the shadows and to give people with mental health conditions the support they need and deserve.'

Nick Clegg MP, Deputy Prime Minister (2014)

"Mental health is the biggest unaddressed health challenge of our age."

**Ed Miliband MP, Leader of the
Opposition (2012)**

health in mental health and intellectual disability and achieving parity of outcomes (BMA, 2014). The We Need To Talk coalition has campaigned for equity of access to mental and physical health services for all those who need them.

Scope of the report

This report, by the British Association for Counselling and Psychotherapy (BACP), looks at how to make parity of esteem a reality in relation to NHS psychological therapy services. It includes the views of service users in need of, or in receipt of, psychological therapy, as well as the practitioners and organisations involved in its delivery.

Psychological therapy is effective for people with common mental health disorders – depression, generalised anxiety disorder, phobias and post-traumatic stress disorder, mixed depression and anxiety, panic disorder and obsessive-compulsive disorder (NICE, 2011) – as well as more severe mental illness, including people with multiple health needs. Some mental health problems are self-limiting, some recurrent and some chronic, and people can be mildly, moderately or seriously ill. Furthermore, mental ill health does not discriminate across class, ethnicity or culture, and may be experienced by individuals across the life course, from young children to older people.

UK-wide, the NHS is a provider, funder and commissioner of psychological therapy services. These services are delivered by counsellors contracted to work in primary care, by NHS-managed IAPT and/or counselling services, by third sector services funded to take NHS referrals and by some private sector companies under contract to the NHS. This report is on the overall provision of psychological therapy in the NHS and its contribution

to parity in the NHS in England. However the report has a specific focus on primary care, as this is the setting for the delivery of the majority of psychological therapy services and is usually the first port of call for those with psychosocial problems. Much of the information available on psychological therapies in primary care is from IAPT services, which are frequently referred to in this report, but the recommendations made are for all psychological therapy services funded and provided by the NHS, within and alongside IAPT.

That the report focuses on therapy services in England is due in part to the commitment by successive governments to the IAPT programme in England, and also because Wales, Scotland and Northern Ireland have different commitments to improving mental health. These merit detailed consideration that goes beyond the scope of this brief report, although we hope the report will support and stimulate the debate across the four nations. The concept of parity is, of course, universal.

Terminology

Throughout this report the terms 'client', 'patient' and 'service user' are used interchangeably, as are the terms 'psychological therapy', 'counselling', 'psychotherapy' and 'talking therapy'.

Recovery in mental health can be defined as both 'clinical' and 'personal'. Clinical recovery refers to an absence or reduction of symptoms to a level below the specified threshold on a clinical assessment tool; personal recovery is about an individual having meaning and quality to their life, but not necessarily having clinical recovery (Mental Health Care, 2012). In this report, where the term 'recovery' alone is used, this is to incorporate both clinical and personal dimensions in the definition.

Process

The process of creating this report began with a seminar held at the Royal College of Physicians in April 2014. Dr Mike Shooter CBE (President, BACP), Dr Clare Gerada MBE (Chair, London Primary Care Clinical Board and former Chair of the Royal College of General Practitioners), Professor Dame Sue Bailey (Chair, Children and Young People's Mental Health Coalition; former President of the Royal College of Psychiatrists), Julie Stone (Healthcare ethics and law consultant) and Paul Farmer (CEO, Mind) shared their thoughts on the topic of parity of esteem for mental health, chaired by BBC Health Correspondent Jane Dreaper.

As part of the consultation process, BACP explored a number of themes:

- access
- choice
- waiting times
- staff and services
- funding
- research.

In June 2014 BACP issued a call for evidence to a range of organisations, including commissioners, providers and professional bodies. We requested arguments, evidence and case studies relating these six themes to psychological therapies and how parity for mental health could be achieved.

We also used evidence gathered from a targeted consultation with BACP members and users of psychological therapy services that captured their experiences of mental health and psychological therapy and mental health provision. The report synthesises the contributions of more than 2,300 BACP members from across the UK, over 30 health and social care organisations across the UK and 60 users of psychological therapy services in England.

The combined findings underpin the report's recommendations for the enhanced provision of psychological therapy in the interests of parity of esteem.

Background

Prevalence of common mental health disorders

First, the statistics. Around a quarter of adults in England have had a diagnosis of a common mental health disorder (CMHD) during their life (NICE, 2011). For those under 65, mental illness accounts for nearly half of all ill health (NHS England, 2014a). Findings from the Office for National Statistics' Measuring National Well-being programme indicated that one in five people in the UK aged 16 and over has experienced anxiety and depression (Beaumont & Lofts, 2013). In 2011/12 there were 5.1 million adults in England living with depression (Health & Social Care Information Centre, 2012). This includes people experiencing a single episode of mental ill health, those suffering recurrent episodes and those with ongoing difficulties.

The impact of mental illness

The impact on individuals, families, communities and the state is – or should be – of major concern to us all. The mortality rate for people in contact

with specialist mental health services is more than three times that for the general population (Health & Social Care Information Centre, 2013). There is also an increased risk of diseases such as cancer and diabetes associated with poor mental health (Mental Health Foundation, 2011). Carers of people with mental illness face a number of issues, including financial difficulties, emotional strain due to risk of suicide of the person cared for, and a lack of specialist respite care – all of which can contribute to poorer mental and physical health (The Princess Royal Trust for Carers, undated). Family and personal relationships can be put under strain; parents coping with mental health problems can face additional difficulties (Mind, 2014a), as can their children, who may be carers themselves.

Mental illness also has an impact on wider society. A report from the London School of Economics and Political Science, *How Mental Illness Loses Out in the NHS*, reported that mental illness accounts for almost a quarter of the total disease burden in the UK, and the 'overall burden of disease includes not only suffering, but also premature death' (LSE, 2012, pp8–9) (see Table 1).

Table 1. The burden of disease in the United Kingdom (LSE, 2012)

| Condition | Percentage of overall burden of disease* due to each condition |
|--------------------------|--|
| Mental illness** | 23 |
| Cardiovascular diseases | 16 |
| Cancer | 16 |
| Respiratory diseases | 8 |
| Sense organ diseases | 7 |
| Digestive diseases | 5 |
| Musculoskeletal diseases | 4 |
| Accidents | 4 |
| Diabetes | 2 |
| Other | 15 |
| Total | 100 |

* including premature death

** includes dementia, substance abuse and personality disorder

Access

Limited provision

Access to treatment for mental health problems has historically been low, with just 24% of people with a common mental health disorder receiving treatment (NHS Information Centre, 2007). The year-on-year rise in the prescription of antidepressant medications, despite the establishment of the IAPT programme to offer more alternatives to pharmacology (Ilyas & Moncrieff, 2012), suggests that accessing psychological treatments remains difficult.

Recent years have seen an encouraging commitment by successive governments to spending on psychological therapy services for people with mental health problems through setting up and delivering the IAPT programme. This has been a welcome step towards parity of esteem between mental and physical health services. However, in terms of parity, it is important to note that IAPT targets just 15% of those meeting service criteria for depression and anxiety (Department of Health, 2012). A national programme to treat just 15% of patients with cancer or other serious physical health conditions would not be tolerated by patients, the public, healthcare providers or politicians. Nor should we tolerate a commitment to treat such a small percentage of people with distressing mental health problems.

'At the moment, IAPT is a little too much like Henry Ford's business philosophy... you can have any therapy as long as it's CBT.'

Paul Burstow MP, Minister of State for Care Services, 2010

Limited provision of psychological therapies in the NHS is compounded by the limited range of evidence-based therapies offered, which makes access – and choice – problematic. No programme is perfect and one of the major criticisms of IAPT is that it is primarily focused on delivering cognitive behavioural therapy (CBT).

Although CBT can be an effective intervention for many, it is not a panacea. The responses of practitioners and patients to our consultation frequently highlighted the difficulties in accessing other evidence-based therapeutic modalities, such as behavioural couples therapy, counselling for depression (CfD), interpersonal psychotherapy (IPT)

'Parity within mental health means recognising that different groups have more barriers when it comes to accessing talking treatments.'

Mental Health Foundation, BACP Call for Evidence

'I have to travel for 45 minutes [to access the psychology service], and as a single parent who works almost full time, this is only possible because I have a car. I wish there was a service available in my local town.'

Service user, BACP Consultation

and short-term psychodynamic psychotherapy, all of which are recommended by NICE as treatments for depression.

This issue is discussed more fully in the section 'Choice' but is included here as access not only to therapy but also to a range of evidence-based therapies is an important indicator of progress on the road to parity of esteem.

'The only thing which seems to get any traction at all [are] the "countable" therapies like CBT: psychoanalysis or longer-term psychological therapies [are] really difficult to access.'

East London NHS Foundation Trust, BACP Call for Evidence

Stigma

There is widespread recognition that a major barrier to individuals accessing talking therapy services is the stigma attached to mental ill health and mental health services. This was reflected in the consultation, as was the need to challenge these stereotypes. National initiatives like *Time to Change* are helping to change attitudes, but negative attitudes and stigma result in isolation and discrimination and can deter people with mental health problems from seeking help for their condition or even admitting to having problems (Clement *et al*, 2014).

'Feel more comfortable saying I've got a hospital appointment rather than I'm seeing my counsellor.'

Service user, BACP Consultation

Case study

Access to psychological therapies for older adults

The facts

The prevalence rate of depression is estimated to be 8.7% among adults aged 65 and over in England and Wales (McDougal *et al*, 2007). Depression is associated with increased mortality and disability in older people (British Medical Journal, 2011).

Co-morbid physical health problems and dementia can make it difficult to identify depression and anxiety in older adults (Department of Health, 2009), meaning that the condition is often under-diagnosed and under-treated (British Medical Journal, 2011).



The IAPT response

In 2010, the Government announced the extension of the IAPT programme to address the needs of people over 65 with depression or anxiety, suggesting that services may need to adopt a flexible approach to psychological therapy provision for older people (Department of Health, 2009).

Continued concerns

While this has been a step in the right direction, responses to our parity of esteem consultation suggest that more needs to be done to reach older adults in need of therapy:

- 42% of BACP members reported difficulties with access to psychological therapies for older people
- *'There is good evidence that CBT is as effective in older clients... [They] remain under-represented in CBT treatment populations.'* (Old Age Faculty, Royal College of Psychiatrists, BACP Call for Evidence)

- *'For older people, NHS focus is on dementia... This means less focus on other mental illnesses in the elderly, eg depression, which are often treatable using psychological therapies and medications if picked up.'* (Northumberland, Tyne & Wear NHS Trust, BACP Call for Evidence)

Improving access

- *'There also needs to be recognition that there are some issues which are likely to affect older people... there is a body of expertise around working with this group... staff also have to avoid making assumptions about older people.'* (Organisational respondent, BACP Call for Evidence)
- *'There are also practical barriers presented by mobility and sensory restrictions of older people. Access for older people could therefore be improved by developing and enhancing multiple access routes, including outreach services, and creating a more flexible approach to when and where therapy sessions could be delivered.'* (Mental Health Foundation, BACP Call for Evidence)

Specific population groups

The accessibility of mental health services can be particularly difficult for some sections of society, as a result of differences in cultural and socioeconomic contexts and prevalence of mental illness across ethnic groups in society (Mental Health Foundation, undated). The Department of Health has highlighted this as a key measure of IAPT's success, stating, 'We will know we are achieving equality and human rights objectives when the proportion of patients using IAPT services is in line with both prevalence and the community profile' (Department of Health, 2011; p5). The IAPT programme has taken steps to improve access for specific groups such as older people, children and young people, veterans and people from black and minority ethnic (BME) communities (Department of Health, 2008). This is to be welcomed but there is much more to be done to enable whole-person care in this field.

'A significant barrier is represented by a national shortage of psychological interventions offered in alternative languages to English. This can make it particularly difficult to engage BME communities as although an interpreter can be arranged this often takes time, slows down the process and can put some people off accessing services due to cultural barriers regarding using interpreters.'

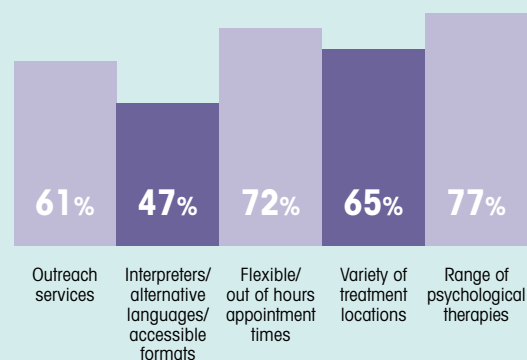
**Self Help Services,
BACP Call for Evidence**

Our consultation demonstrated high levels of concern about people with specific difficulties such as deaf and hearing impaired clients, people with eating disorders and alcohol or drug dependence, and specific social groups, such as veterans, homeless people and members of the LGBT community. Problems in accessing IAPT services were also highlighted for people with complex or multiple presentations, with long-term conditions and with severe and enduring mental illness. Identified levels of need were high; identified levels of provision were low.

'Our work has shown us that many homeless people are denied the mental health support that they need, because psychological therapies are only available to those who fit a narrow diagnostic criteria.'

**St Mungo's Broadway,
BACP Call for Evidence**

Methods for improving access in primary care services (BACP Members Consultation)



'Too much jargon, red tape, communication breakdown and lack of Deaf awareness means that Deaf BSL users rarely can access appropriate therapies in a timely fashion.'

BACP member working in further/higher education, BACP Consultation

Increasing access

In our consultation, BACP members supported the methods we suggested (see infographic above) for improving access to psychological therapy in primary care. This could be achieved in a number of ways. Joint Strategic Needs Assessments (JSNA) compiled by Health and Wellbeing Boards should identify the needs of the local community, and CCGs should ensure that adequate psychological therapy services are available to meet the assessed needs of their local population and specific population groups. This should go some way to ensuring parity of provision for all people with mental health problems who could benefit from talking therapies and specifically those who face particular barriers in accessing existing psychological therapy services.

Commissioners may need to collaborate with or commission more third sector psychological therapy services in order to achieve greater access. For example, voluntary and community sector services can be an access point for black and minority ethnic communities to early assessment and can provide interventions that are experienced as less stigmatising and more culturally sensitive (Afuwape *et al*, 2010). However, we would argue that all NHS psychological therapy services have a responsibility to work together to ensure the parity principle extends equally to all minority and hard-to-reach groups.

‘IAPT services delivered within the third sector are flexible and creative in how they offer access.’

**Self Help Services,
BACP Call for Evidence**

‘Sessions are only every two weeks, for 45 minutes in length and for only four to six sessions – totally inadequate for some clients.’

BACP member working in an NHS IAPT service, BACP Consultation

Duration of treatment

Finally, the responses to our call for evidence raised concerns not only about the difficulties in accessing a choice of therapies and accessing any psychological therapies at all but also about the difficulties in accessing therapy for more than a limited number of sessions. Responses emphasised the need to focus instead on optimum length of therapy to bring about recovery.

Duration of therapy is often determined by service specifications; sometimes this includes the imposition of treatment limits that are below the recommended minimum: ‘One commissioner will not pay for any patient receiving more than two sessions... there are many who will pay only up to a maximum of six sessions for any one patient’ (Hansard, 10 October 2013; col 184). It’s worrying to note that half of patients who complete therapy feel that the number of sessions received is insufficient (Mind, 2013).

‘Clients with relatively straightforward anxiety/depression are offered 12–20 sessions of “brief” CBT, while all other issues are offered just six to 12 sessions of counselling. Consequently, survivors of childhood sexual abuse, for example, are excluded from our service not by lack of experience or training but by an imposed limit on the number of sessions available to do more complex work in.’

BACP member working in an NHS IAPT service, BACP Consultation

The Health and Social Care Information Centre has stated that for psychological treatment to be effective an appropriate number of sessions should be provided (2014a).

The IAPT programme suggests that more than one course of treatment may be required for some patients (NHS England, 2014b) and there is also evidence that clinical recovery rates improve with more sessions (Clark, 2011). While many patients experience mental health problems episodically, time-limited treatments may not be appropriate for those who need longer-term treatment or who suffer recurrent episodes of poor mental health. Some patients will recover with less than the full number of sessions recommended by NICE and others will require the full amount (HSCIC, 2014a) – or even more.

The rationing of health care is always contentious, but for people with mental health problems this is an important parity principle. As Lord Stone of Blackheath has stated: ‘Can noble Lords imagine, for drugs for a physical illness or chemotherapy, being told, “When you’ve had a maximum of 20 of these injections or radiotherapy sessions, you’re on your own, mate”? Why should that be so for treatment for mental illnesses?’ (Hansard, 10 October 2013; col 188).

Recommendations for access

Population-led service design

- Psychological therapy service provision should meet the mental health needs of the local population, including hard-to-reach groups.
- CCGs can achieve this through effective use of the Joint Strategic Needs Assessment (JSNA), good practice guides and partnership working with local providers.

Recovery determining length of therapy

- CCGs should ensure that the number of sessions of psychological therapy a person receives is determined by need, and by progress towards clinical and personal recovery.

Waiting times

'Far too many people of all ages wait too long to get the mental health services they need. The longer they wait for support, the more likely it is their condition gets worse.'

Department of Health, 2014a, p12

An inevitable consequence of difficulties in accessing NHS psychological therapy services are the long waiting times. Long waiting times were identified as a barrier to individuals accessing services by 48% of respondents in our service user survey. Waiting times reported by service users, BACP members, IAPT (HSCIC, 2014a) and in National Audit of Psychological Therapies (NAPT) service data (Royal College of Psychiatrists, 2013b) vary, and the variation in waiting times across services (HSCIC, 2014b) will have an impact on individual experiences of accessing therapy.

Impact of waiting times

Waiting for mental health treatment, as with physical health treatment, can lead to deterioration in an individual's condition. The We Need to Talk coalition found that, while waiting for psychological therapy services, 67% of people experienced a worsening of symptoms, 67% experienced suicidal thoughts, 40% harmed themselves and 16% attempted suicide (Mind, 2014b). An organisational respondent to our Call for Evidence stated: 'The delays in treatment provision can turn a straightforward issue into a much more complex thing, as social and occupational function deteriorate and financial and other stressors increase.'

Waiting times can also have an impact on the effectiveness of therapy. A primary care counsellor responding to our BACP member consultation reported: 'My clients regularly wait in excess of 16 weeks and often are angry or less interested when finally contacted, heightening initial anxiety and increasing no-shows [to appointments].'

'Elderly patients... [are] waiting for therapies for months and months.'

**Organisational respondent,
BACP Call for Evidence**

'Approximate 12-month waiting list for psychotherapeutic assessment followed by an 18-month waiting list for therapy.'

**Organisational respondent,
BACP Call for Evidence**

Waiting time targets

The NHS Constitution for England stipulates clear targets for access to physical health services, including two weeks for an urgent cancer referral and 18 weeks for routine surgery following a GP referral (Department of Health, 2013).

In response to the long waits for psychological therapies, the Government's *Achieving Better Access to Mental Health Services by 2020* commitment sets targets for 75% of referrals to the IAPT programme to be treated within six weeks and 95% to be treated within 18 weeks, to be reached by 2015/16 (Department of Health, 2014b).

This is a welcome step towards putting mental health on a par with physical health in terms of targets but the commitment could be more ambitious. The IAPT programme itself has previously aimed to achieve waiting times of no more than 28 days from referral (IAPT, 2012), and in 2013/14 61% of IAPT patients received treatment within 28 days and 89% within 90 days (HSCIC, 2014a). The We Need to Talk demand for access to therapy for all within 28 days remains a realistic – and important – target for which to aim.

Of equal importance to consistency in targets for waiting times is consistency in their application. The waiting times stipulated in *Achieving Better Access to Mental Health Services by 2020* only apply to IAPT services, not to all psychological therapy provision in the NHS, reflecting a lack of parity across and within mental health services. However waiting time targets can only be achieved if appropriate funding and other additional resources are given to psychological therapy services.

'My most recent experience involved having to wait over two years for sessions with a psychologist... Whilst waiting for psychology appointments I did endure another crisis.'

Service user, BACP Consultation

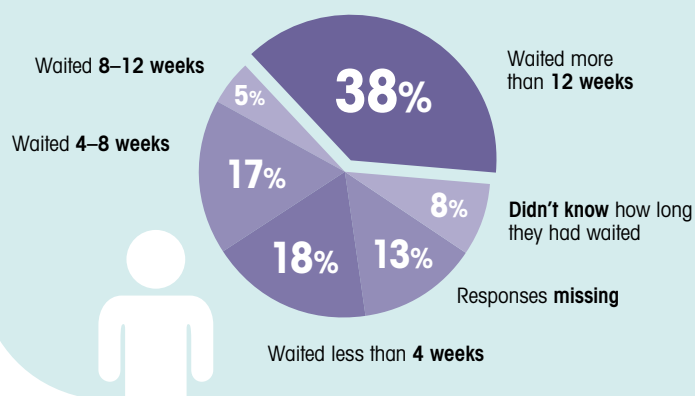
In the BACP members consultation **68% believed that** the first psychological therapy session should be provided within four weeks or less following GP referral.

Publication of waiting times

One of the main drivers for the improvement in waiting times is the publication of waiting time figures. The IAPT programme is to be applauded for publishing its waiting times, although, with the demise of the National Audit of Psychological Therapies, this is not currently the case for other psychological therapy services in the NHS. There is difficulty in getting data on non-IAPT services and this information needs to be available across NHS services.

Seventy eight per cent of respondents to the BACP member survey agreed that waiting times for psychological therapies should be recorded and reported.

Service user experiences – waiting times before starting psychological therapy (BACP Consultation)



Recommendations for waiting times

28 days from referral to therapy

- All people referred to NHS psychological therapy services should begin treatment within 28 days of referral and assessment.

Publication of waiting times

- The Health & Social Care Information Centre should publish data on all NHS psychological therapy services' waiting times from referral to assessment and treatment.



Choice

'[Parity should mean that] people with mental health problems will be given the same level of choice and control over their care, including discussions about choice of treatment and access to personal budgets.'

Royal College of Psychiatrists, 2013a

Patients' right to choice

Patient choice in the NHS has been a major political initiative for successive governments, underpinned by the philosophy of patient-centred care. In 2003, *Building on the Best: choice responsiveness and equity in the NHS* (Department of Health, 2003) was published, outlining plans to build more personal choice and patient empowerment into the NHS. From 2006 all patients requiring hospital treatment for physical health conditions have been able to choose from a list of hospitals based on their priorities and what is important to them (NHS Choices, 2013).

Policy on choice has tended to focus on people with physical health problems or those accessing secondary care. It was not until April 2014 that the Coalition Government extended to people receiving outpatient treatment for a mental health condition the right to choose their consultant or specialist, and choice of the mental health provider for their NHS care and treatment in England (NHS England, 2014c). Even so, most psychological therapy provision takes place in primary care and community settings, rather than outpatient secondary care settings, so this right to choose excludes most people seeking talking therapies.

As mentioned above, choice requires access and is therefore an important parity point in relation to psychological therapies. Choice requires first, a choice of therapy as an intervention (as opposed to antidepressant medication, for example), and second, choice between a range of available evidence-based therapies. In treating both physical and mental health conditions it is essential to take account of patient preferences and also give alternative options where a particular course of treatment is unsuccessful.

'Patients also want psychological therapies rather than medications as they are more palatable with fewer associated harms.'

**Devon Partnership NHS Trust,
BACP Call for Evidence**

'Talking treatments are low on the priority list – "take the pills and you'll be fine".'

Service user, BACP Consultation

Choice between psychological therapy and medication

With regard to choice between psychological therapy and medication, of all those receiving treatment in the NHS for common mental health disorders, only one in seven receive psychological therapy and the majority of people are prescribed medication (NICE, 2011). This is despite most patients saying they would prefer talking therapy and over half of patients opting for counselling rather than antidepressant medication when given the choice (Digna *et al*, 2004). According to We Need to Talk, around one third of people had to ask for therapy rather than being offered it (Mind, 2014b).

Providing patients with a choice of treatment options improves engagement with services (Laugharne & Priebe, 2006) and reduces the likelihood of premature drop-out from treatment (Rokke *et al*, 1999). In addition, patient preference is a determining factor in adherence to treatment (Raue *et al*, 2009). The Royal College of Psychiatrists and the Royal College of General Practitioners (2008) have argued that 'an active preference by individuals for the method used is associated with better outcomes'. Patients whose preferences are not considered when decisions are made about their treatment can also become frustrated, which can contribute to lower rates of adherence to therapy (World Health Organisation, 2003).

Choice between psychological therapies

As highlighted in consultations, there is no requirement for commissioners or providers to deliver the full range of NICE-recommended therapies in IAPT.

'There is no driver in the system to ensure that patients have a meaningful and clinically appropriate choice of interventions'

**Tavistock Centre for Couple Relationships,
BACP Call for Evidence**

Only one in five service user respondents to our survey had been offered a choice of therapy. Table 2 demonstrates the dominance of CBT in IAPT services.

Service user
choices they
would like to
be offered
(BACP
Consultation)

80%

Appointment
location

90%

Appointment
time



Table 2. Appointments attended for therapy interventions delivered in IAPT, 2013–14 (HSCIC, 2014c)

| Type of therapy | Number | Percentage of total |
|---|-----------|---------------------|
| Cognitive behavioural therapy (CBT) | 1,145,957 | 69.5 |
| Counselling for depression | 458,435 | 27.8 |
| Interpersonal psychotherapy (IPT) | 28,911 | 1.8 |
| Couple therapy for depression | 11,583 | 0.7 |
| Brief dynamic interpersonal therapy (DIT) | 4,662 | 0.3 |

Non-IAPT NHS psychological therapy services are staffed by therapists who have been trained in a range of modalities, so choice of therapy can be provided more easily to meet the local population and patient needs. However, to reduce variability in access and increase choice of a range of therapies, all NHS psychological therapy services should work collaboratively.

Informed choice

A further aspect of choice, and one to which physical health services have paid attention in recent years, is the quality of information available to enable people to make an informed decision about their preferred type of treatment or therapy. Our consultation indicated that three-quarters of service users would like information to help them choose the type of therapy they prefer. The IAPT programme states that patients 'should be given enough information to make an informed choice about which treatment best meets their needs' (IAPT, 2014). The information is only useful, however, if there is a range of therapies from which to choose.

Types of choice

Choice is not only about the types of treatment available; it is also about the where, when, with whom and how – such as in what language – the treatment is provided. The NHS promised that by 2005 every patient would be able to choose a convenient date and time of hospital appointment and elective admission, although, again, this does not apply to psychological therapy services, which are largely provided in primary care (NHS Choices, 2013). This is an important parity point: people with mental health problems should be able to access high quality services that work for them. For example, it is self-evident that bilingual or multi-lingual patients may have better outcomes if therapy is provided in their first language yet over a third of patients for whom access to therapy in another language is important do not have this choice (Royal College of Psychiatrists, 2013b). In the second National Audit of Psychological Therapies, choice about a therapist's gender (which is available to patients consulting a GP) was offered to less than half of patients (Royal College of Psychiatrists, 2013b). The service users we consulted also felt strongly that services should improve choice of time and location of appointments.

Services users' reported difficulties accessing psychological therapy:

- 48% having to wait for treatment
- 22% appointment location
- 17% appointment time

BACP Consultation

'An important part of improving choice of therapy for older people is by taking into consideration the time and location of therapy.'

**Mental Health Foundation,
BACP Call for Evidence**

Although the IAPT programme and other NHS counselling services work hard to provide choice and access, there is much more to be done to achieve parity with physical health services. The following sections of this report focus on services and staff, funding and research, and make recommendations for resolving some of these problems of access, choice and waiting times in order to make parity of esteem a reality.

Recommendations for choice

Choice extended to psychological therapies

- A choice of evidence-based psychological therapies should be provided by the NHS and enshrined in the NHS Constitution.
- Patient choice should be facilitated by the provision of high quality information about the range of evidence-based therapies.

Patient-led delivery

- Psychological therapy services should be sufficiently resourced so that people can choose how, when, where and with whom they access therapy.



Services and staff

‘We tend to view physical and mental health treatment in separate silos in health services.’

NHS England, 2014a

If psychological therapy services are to be available to all those who need them, this requires training and systemic change, so that patients receive the most appropriate diagnoses and referrals and can easily navigate a seamless treatment path. It also necessitates making the most effective use of existing skilled and well-trained staff to deliver the most cost-effective therapeutic interventions. Parity of provision is not enough; we also need parity of quality.

This issue extends beyond primary care and mental health settings. In England, for example, approximately 15 million people have a long-term physical condition (King's Fund/Centre for Mental Health, 2012), and nearly a third of these will have a co-morbid mental health problem such as depression or anxiety disorder (London School of Economics, 2012). Psychological mindedness, an understanding of the whole person approach, is essential to good quality care across physical and mental health services.

People with physical conditions recover more quickly and are better able to manage their disabilities and symptoms if they have good mental health (Ardino & Knapp, 2013). Offering talking therapy to people with long-term conditions can improve patient outcomes and achieve long-term cost savings (Department of Health, 2011). The prevalence of co-morbidities demonstrates that practitioners working in health and social care in community, primary and secondary care settings need to be well trained in the psychological aspects of physical ill health and the impact of poor mental health on physical health.

81% of BACP members agreed that all healthcare staff should receive training to enhance their skills in identifying common mental health problems.

78% of BACP members agreed that training for all healthcare staff should incorporate elements of both physical and mental health to ensure practitioners have an understanding of how the two are linked.

BACP Consultation

Training

The need to think differently about training, and to include knowledge and understanding of the whole person, is reflected in ongoing debate and recent reports. Thus the Government Mandate to Health Education England states that all health professionals need to have an understanding of mental health conditions (Department of Health, 2014c), while the Chief Medical Officer has stated: ‘There should be a period of specific mental health training in GP training’ (Davies, 2014; p314). The British Medical Association (2014) report *Recognising the Importance of Physical Health in Mental Health and Intellectual Disability* states that mental health training for student doctors is limited and needs to improve. The Royal College of Nursing has also called for better education in mental health issues for both GPs and primary mental health care workers (Royal College of Nursing, undated).

‘Integrated, multi-disciplinary education... perhaps one may even dare ask for a new breed of worker?’

**Royal College of Nursing,
BACP Call for Evidence**

Mental health needs to be part of the core training for all health and social care professionals and an integral part of their continuous professional development. In turn, of course, mental health specialists, including psychological therapists, should incorporate core knowledge of physical healthcare in their training.

Importantly, training for both physical and mental health specialists should cover the interdependencies between the two, as well as how to identify and refer patients with co-morbidities. The dividend from a whole person approach is that better mental health can itself improve physical health outcomes and vice versa.

Such an approach to staff training can help break down the silos between mental and physical care and primary and secondary services. This can help to ensure that the NHS delivers patient-centred, co-ordinated care, which, as NHS England states, is key to reducing disparity between mental and physical health (NHS England, undated).

‘We do experience, at times, a clear divide still between GP, nurse professionals and therapeutic teams. This needs to be shifted so that GPs and other medical professionals respect the work that therapeutic staff provide and vice versa in order to offer the best service to clients.’

**Self Help Services,
BACP Call for Evidence**

Quality of services

For there to be parity of esteem, the same high quality of services should be provided in both mental and physical health sectors. The NHS should ensure that all services it funds and provides are delivered by appropriately trained practitioners. To ensure NHS psychological therapy services are being delivered by qualified practitioners, the NHS should employ therapists who are on the Accredited Voluntary Register and meet the Centre for Workforce Intelligence definition of minimum training and experience for a psychological therapist in the NHS (Centre for Workforce Intelligence, 2013).

Guidance

Co-ordinated and integrated care can be promoted by ensuring this is reflected in clinical guidance. The Royal College of Psychiatrists (2013a) suggests that all NICE guidance should be developed with co-opted mental health experts to ensure the mental health aspects of conditions are included. This should be extended to stipulate that these co-opted mental health experts should be from community, primary care and secondary care sectors and should be experienced in working with various levels of symptom severity. This would result in guidance that ensures services at all levels work with each other so the needs of the whole patient are supported.

Recommendations for staff and services

Training for healthcare clinicians

- All healthcare clinicians should be trained to understand both mental and physical health and their inter-dependencies.
- Healthcare practitioners who prescribe and refer people for treatment should have an understanding of psychological therapies and knowledge of local provision.

Professional standards

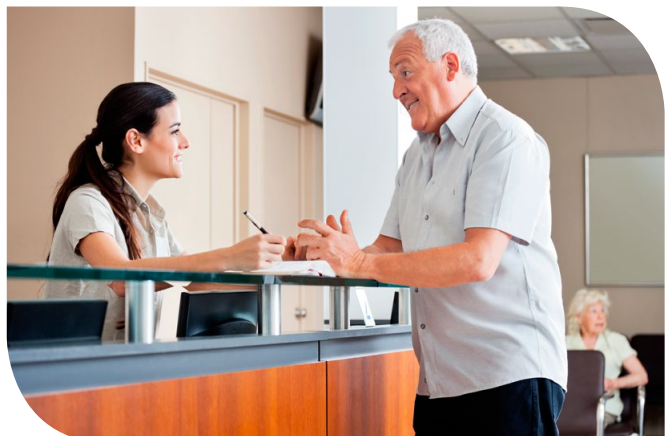
- The NHS should ensure that all the psychological therapies it provides and funds are delivered by practitioners with appropriate training and professional registration.

Collaborative development of guidance

- Guidance, such as guidelines from the National Institute for Health and Care Excellence (NICE), should be developed with input from mental and physical care health professionals in both primary and secondary care to ensure it reflects the whole care pathway.

‘There are barriers in the system to integration which include primary care, secondary care split and the secondary mental health and secondary physical health split. These barriers need to be reduced.’

**Royal College of Psychiatrists,
BACP Call for Evidence**



Funding

‘Funding decisions must be supported by a thorough assessment of their potential impact on parity.’

Mental Health Policy Group, 2014

Despite the challenges of rising NHS costs at a time of austerity, the disparity between spending on mental and physical health services – and the human suffering that results – must be redressed. Mental ill health is costly in emotional, physical, social and economic terms for individuals, families, communities and the state. Funding to address mental health problems, including the provision of effective psychological therapies, should reflect the burden of disease in society.

‘Our service is strained by capacity – the availability of counsellors to take on more clients, and number of counsellors trained to do intake assessments.’

BACP member, BACP Consultation

Disease burden

Fundamentally, the principles guiding decision-making about funding should be the same for both physical and mental health: funding should be directed to best effect for people and populations and should be proportionate to their physical and mental health needs. Mental illness accounts for 23% of the disease burden in the UK yet spending on treating mental health by CCGs in England varies between 6.5% and 18% of their budgets (Campbell, 2014). While there has been an increase in funding for psychological therapies, in 2011/12 it accounted for just seven per cent of investment in mental health services for working age adults in England (Mental Health Strategies, 2012).

‘Finance so often dictates what is offered to our clients.’

BACP member, BACP Consultation

Mental illness costs the UK an estimated £105 billion per year in healthcare, benefits and lost productivity (Centre for Mental Health, 2010). ‘Depression and anxiety make it difficult or impossible to work, and drive people onto incapacity benefits’ (The Centre for Economic Performance’s Mental Health Policy Group, 2006). There are huge individual, social and economic benefits from the prevention and early treatment of mental ill health. Despite this, only a little over one per cent of local authorities’ public health budgets in England is spent on mental health prevention (Mind, 2014c), while significantly more is spent on the prevention of physical ill health (Department for Communities and Local Government, 2014).

‘Parity of funding across the board will help as increased staff numbers will allow better care to be provided.’

**Organisational respondent,
BACP Call for Evidence**

Collaborative funding

More sophisticated and collaborative funding arrangements need to be designed and implemented at both national and local level to address this emotional, social and financial impact. At a national level, for example, there should be collaborative funding of psychological therapy services between the Department of Health and the Department for Work and Pensions, as psychological therapy can reduce the burden of ill health and thus the economic burden of incapacity benefit across the country (Centre for Economic Performance’s Mental Health Policy Group, 2006). Likewise, local authorities should work with their co-terminous CCGs to resource psychological support for their communities across the different age and social groups. Access to psychological therapy for those with dementia, for example, can delay the need for a care home placement by an average of 18 months, potentially saving £44,000 per person in social care spending (Fujiwara & Dolan, 2014). Such a whole system approach should be facilitated by Health and Wellbeing Boards. Responses to our call for evidence highlighted the benefits of a longer-term, collaborative approach to budgeting.



74% of BACP members agreed that services would benefit from having annual budgets replaced by longer-term budgets (BACP Consultation)

Recommendations for funding

Funding proportionate to disease burden

- CCGs, with direction from NHS England, should allocate funds proportionate to the burden of mental health problems in their locality.

Collaborative funding

- National and local governments should introduce collaborative funding across public services with long-term budgets.



Research

'It is well established that the scale of mental health research is not proportionate to the burden of disease.'

Medical Research Council, 2010

A lack of parity between mental health and physical health is equally apparent in research funding. Although mental health problems account for 23% of the disease burden in the UK, the proportion of health research spending on mental health is much less – just 5.5% in 2009/10 (UK Clinical Research Collaboration, 2012). Within that, less than 15% is spent on researching psychological treatments (Holmes *et al*, 2014).

Funding for research

There is limited commercial appeal in researching psychological therapies (Roth & Fonagy, 2006) and charitable donations for mental health research are low, perhaps reflecting social attitudes towards mental ill health (Medical Research Council, 2010). Academic institutions are unlikely to have the large research budgets required to fund the much needed trials of psychological therapy, with the result that there is relatively little research about psychological therapies compared with pharmaceutical research or research into major physical illnesses such as cancer and diabetes. There exists a systemic gap whereby few organisations have the responsibility, means or incentive to fund high quality efficacy research.

As it is not provided by the market, the Government must take responsibility for ensuring that research is carried out in proportion to need, and should allocate a greater than proportionate share of its own research funds to psychological therapy research to redress the lack of monies provided by other research funding bodies. The government departments for health and social care should strengthen ties between organisations such as NICE, academic institutions, research funders and professional bodies, as well as service users, to identify and prioritise areas for further research into psychological therapies.

'Given the in-depth research that the not-for-profit sector can do and the networks they have, they should be brought into discussions about psychological therapies and how they can be a viable option for all.'

**Mental Health Providers Forum,
BACP Call for Evidence**

Multi-morbidities

Research into the co-dependent relationship between physical health and mental health is important due to the impact mental health and physical health have on each other. The presence of co-morbid mental health problems can lead to a delay in seeking help for other health conditions (Prince *et al*, 2007), while people with long-term physical conditions may avoid disclosing mental health problems to their doctor due to the attached social stigma. Such delays can reduce the chance of a co-morbid illness being detected and diagnosed.

While the mechanisms underlying the relationship between mental and physical health are complex and not fully understood, we know that a combination of biological, social, environmental and behavioural factors are involved. The psychological burden that chronic and life-limiting physical conditions can place on people is another possible mechanism underpinning the relationship between mental and physical disorders.

To advance our understanding of the relationships between mental health and physical health, the disparity between the scale of research on multi-morbidities and the burden of multi-morbid disease needs to be addressed (British Medical Association, 2014).

'We need more funding into psychological therapies for mental illness as well as into the relationship between physical and mental illnesses.'

**Northumberland, Tyne and Wear
NHS Trust, BACP Call for Evidence**

Recommendations for research

Identify and prioritise psychological therapy research

- Government departments for health and social care should strengthen links between organisations such as NICE, academic institutions, research funders, professional bodies, and service providers and users to identify and prioritise areas for research into psychological therapies.

Proportionate research funding

- Funding allocated to research should be proportionate to the burden of disease relating to mental health problems in the UK.

Researching the whole-person

- All research should recognise and consider the impact of the interdependencies between their field (housing, long-term conditions etc) and mental health.



38% of BACP members think all health research should consider and report on the impact of physical health on mental health and vice versa (BACP Consultation)



Conclusion

Disparity between the treatment of physical and mental health has long been an issue in health and social care provision. The impact of poor mental health on individuals, families, communities and the state is – or should be – of major concern to us all.

This brief report, drawing on a wide-ranging consultation, looks at the contribution psychological therapies can make in bringing about parity.

The report makes recommendations to bring about essential change. BACP is committed to working to make these recommendations a reality.

'Being human means we have hearts and minds... We need to give our hearts and minds to delivering parity for all those people we are privileged to work with across health, social care, justice and education.'

Professor Dame Sue Bailey, personal correspondence, 24 October 2014

Recommendations

BACP makes the following recommendations for achieving parity of esteem in relation to NHS psychological therapy services.

Access

Population-led service design

- Psychological therapy service provision should meet the mental health needs of the local population, including hard-to-reach groups.
- Clinical Commissioning Groups (CCGs) can achieve this through effective use of the Joint Strategic Needs Assessment (JSNA), good practice guides and partnership working with local providers.

Recovery determining length of therapy

- CCGs should ensure that the number of sessions of psychological therapy a person receives is determined by need and by progress towards clinical and personal recovery.

Waiting times

28 days from referral to therapy

- All people referred to NHS psychological therapy services should begin treatment within 28 days of referral and assessment.

Publication of waiting times

- The Health & Social Care Information Centre should publish data on all NHS psychological therapy services' waiting times from referral to assessment and treatment.

Choice

Choice extended to psychological therapies

- A choice of evidence-based psychological therapies should be provided by the NHS and enshrined in the NHS Constitution.
- Patient choice should be facilitated by the provision of high quality information about the range of evidence-based therapies.

Patient-led delivery

- Psychological therapy services should be sufficiently resourced so that people can choose how, when, where and with whom they access therapy.

Staff and services

Training for healthcare clinicians

- All healthcare clinicians should be trained to understand both mental and physical health and their interdependencies.
- Healthcare practitioners who prescribe and refer people for treatment should have an understanding of psychological therapies and knowledge of local provision.

Professional standards

- The NHS should ensure that all the psychological therapies it provides and funds are delivered by practitioners with appropriate training and professional registration.

Collaborative development of guidance

- Guidance, such as guidelines from the National Institute for Health and Care Excellence (NICE), should be developed with input from mental and physical healthcare professionals in both primary and secondary care to ensure it reflects the whole care pathway.

Funding

Funding proportionate to disease burden

- CCGs, with direction from NHS England, should allocate funds proportionate to the burden of mental health problems in their locality.

Collaborative funding

- National and local governments should introduce collaborative funding across public services, with long-term budgets.

Research

Identify and prioritise psychological therapy research

- Government departments for health and social care should strengthen links between organisations such as NICE, academic institutions, research funders, professional bodies and service providers and users to identify and prioritise areas for research into psychological therapies.

Proportionate research funding

- Funding allocated to research should be proportionate to the burden of disease relating to mental health problems in the UK.

Researching the whole-person

- All research should recognise and consider the impact of the interdependencies between their field (housing, long-term conditions etc) and mental health.

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