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Choice of therapies in IAPT:

An overview of the availability and client profile of step 3 therapies

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The National Audit of Psychological Therapies (NAPT) was initiated in 2008 to incorporate data from England and Wales across NHS-funded services providing psychological therapies, including: primary and secondary care, small and large services, IAPT and non-IAPT services. The second round of NAPT was published in November 2013 (Royal College of Psychiatrists, 2013), and was based on data collected 18 to 24 months after the baseline audit to determine whether performance across services had improved.

Using data collected as part of the second round of NAPT, this report aimed to answer two questions which had not previously been addressed in the audits:

1) To what extent does choice of therapy exist within the IAPT programme?

2) Are clients accessing the different psychological therapies in IAPT comparable in terms of their demographic profile, diagnosis and number of sessions attended?

Key findings

Despite CBT, counselling, IPT, couples therapy and psychodynamic psychotherapy all being NICE-recommended interventions for the treatment of depression in adults, only one of the 114 IAPT services included in this analysis offered all five therapies. This suggests that the IAPT programme has so far failed in its intention to provide a choice of the full range of evidence-based therapies for clients with depression across England.

There was an indication that for clients of some services, a level of choice exists, particularly between counselling and CBT, but the availability of IPT, psychodynamic psychotherapy and couples therapy collectively across services in England is low.

There were some differences in the client profiles between counselling and CBT, with female and ‘older’ clients being proportionally more likely to undertake counselling compared to CBT, suggesting that these therapies may be meeting the needs of different groups. Further investigation of these factors may help services target more accurately the therapies towards the client groups that that find them most acceptable.

Finally, the average number of sessions was significantly lower for counselling compared to the other four therapies and it would be useful to know whether this was an indication of counselling being more efficient than other therapies, or whether this is a product of other factors, such as clients being less distressed at intake.

INTRODUCTION

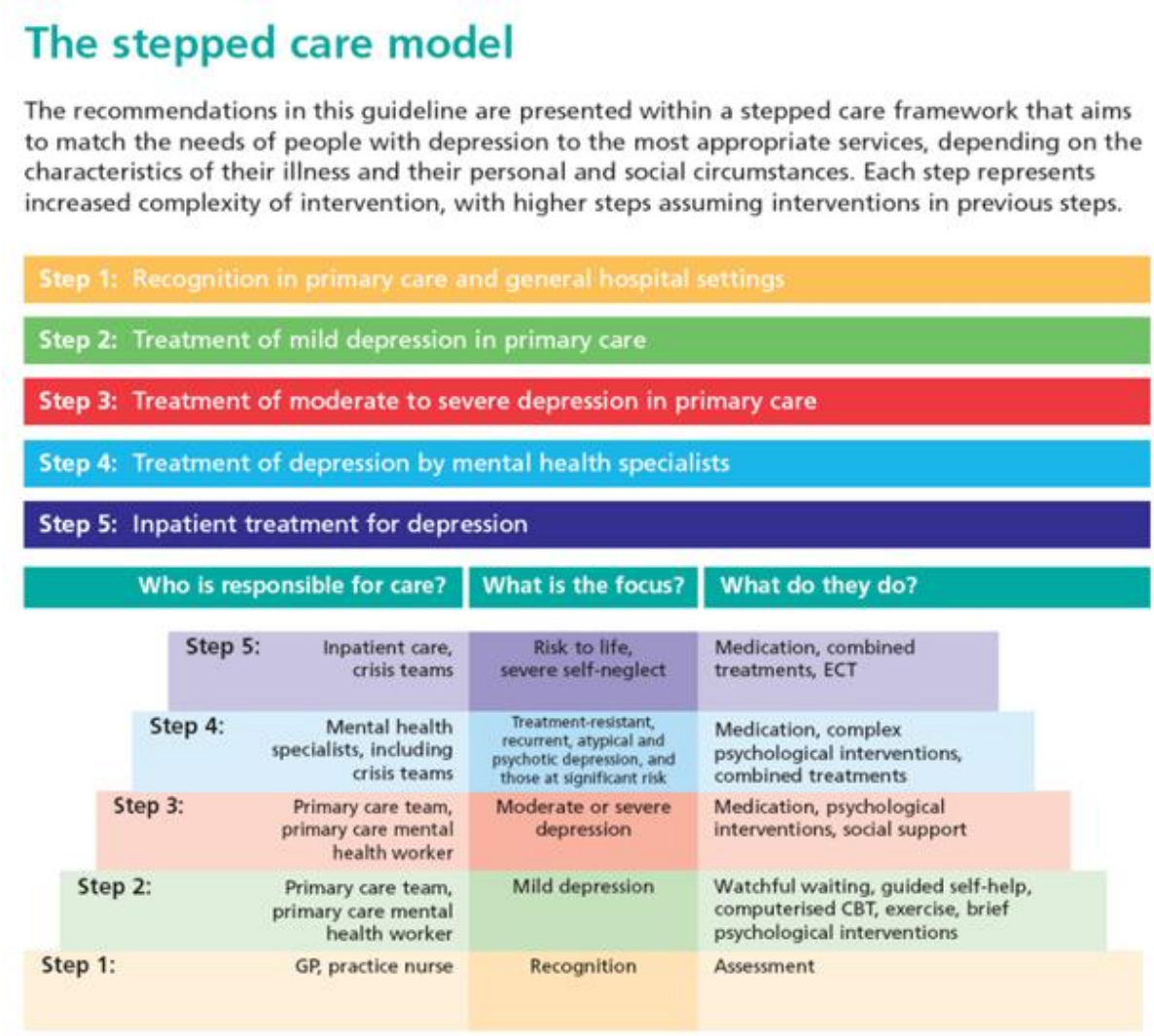
The prevalence of common mental disorders (CMDs), such as depression and anxiety, in UK adults is estimated to be almost 1 in 5 (McManus, Meltzer, Brugha, Bebbington & Jenkins, 2009; Evans, Macrory & Randall, 2015). Globally, depressive disorders are the second leading direct cause of disability and distress, with major depressive disorder (MDD) also contributing to the burden arising from suicide and ischemic heart disease (Ferrari et al., 2013). Indeed, in 2013/2014 a total of 1,241,000 cases of work-related illnesses were recorded, of which 487,000 cases (39%) were of work-related stress, depression or anxiety, resulting in a loss of 11.3 million working days in Great Britain alone (HSE, 2014).

The Depression Report (CEPMHPG, 2006) recognised the significant disease burden caused by depression and anxiety disorders, whilst at the same time highlighting the chronic underfunding of treatments for such disorders, particularly when compared with funding allocated for the treatment of biomedical diseases, such as cancer. Following this report, the UK Government initially invested over £300 million in psychological therapies for people with anxiety and depression in the form of the Improving Access to Psychological Therapies (IAPT) programme, with an additional £400 million allocated to the programme up to 2014/2015 (DH, 2012).

Initiated in England in 2008, the IAPT programme aimed to enable access to a range of evidence-based psychological therapies recommended by the National Institute for Health and Care Excellence (NICE), with a particular emphasis on the treatment of depression and anxiety-related disorders. IAPT aims to treat at least 15% of the total number of people in England estimated to have a CMD (Department of Health (DH), 2012) annually.

IAPT employ a stepped care model for the treatment of CMDs. For example, in the stepped care model for depression (Figure 1), step 1 marks the 'recognition, assessment and initial management of depressive symptoms', usually by a GP or practice nurse. If symptoms persist service users are then 'stepped up' to higher level interventions, of varying lengths and intensities, commensurate with the severity and complexity of their needs. Step 2 treatments include brief low-intensity psychological interventions such as guided self-help, computerised cognitive behavioural therapy (cCBT) and group-based CBT, whereas step 3 treatments include high-intensity psychological interventions, such as CBT and counselling. The majority of service users are expected to undergo lower step interventions prior to receiving a higher level intervention (Care Services Improvement Partnership (CSIP), 2007).

FIGURE 1: STEPPED CARE MODEL FOR THE TREATMENT OF DEPRESSION



Source: CSIP (2007) *IAPT Outline Service Specification* (p. 3)

An initial priority for the IAPT programme was to develop a workforce capable of providing CBT for the treatment of anxiety and depression at step 3, as recommended by NICE (CG113: NICE, 2011; CG90: NICE, 2009). However, the clinical guideline for depression (CG90: NICE, 2009) also recommends four additional high-intensity psychological therapies to be used in cases where CBT proves ineffective or where a service user expresses a preference for a treatment other than CBT. These, often "second line" treatments, are: counselling, interpersonal psychotherapy (IPT), brief psychodynamic psychotherapy and behavioural couples counselling. In 2009, the IAPT programme commissioned the roll-out of these additional NICE-recommended therapies and specific competence-based models, together with curricula that set national standards for the training of therapists in these modalities, were developed. The intention was for IAPT to provide the full range of NICE-recommended psychological therapies and for clients to have a choice of therapies when accessing these services (DH, 2011), although the extent to which this has become a reality is yet to be determined; hence, the rationale for the current study.

KEY IAPT REPORTS

To date, there have been three major evaluations of the IAPT programme (Glover, Webb & Evison, 2010; Gyani, Shafran, Layard & Clark, 2011; DH, 2012). Glover and colleagues (2010) evaluated the first wave of the programme (2008/2009) to determine how successfully the commitments to accessibility, provision of NICE-recommended psychological therapies and outcome monitoring were progressing. They found that services were more frequently accessed by younger adults - just 4% of service users were aged 65 or older – and women, with almost twice as many women accessing services as men. It was also reported that service users from Asian, Black and other ethnic groups were significantly under-represented, with just over 4% of service users representing these groups. CBT and counselling were the most commonly provided forms of high-intensity therapies, with almost twice as much CBT provided as counselling. Just 1.2% of sessions were of IPT or couples therapy and there was no indication of the number of sessions of psychodynamic psychotherapy, suggesting that the availability of these therapies was low or non-existent. The median number of clinical sessions recorded for service users receiving high-intensity interventions was three; substantially lower than the recommended 16-20 sessions of CBT, IPT, psychodynamic psychotherapy or couples therapy. Recovery rates (defined here as moving from initial "caseness" on the Patient Health Questionnaire (PHQ-9: Kroenke, Spitzer & Williams, 2001) to below "caseness" at end-point) were, on average, 46.9%, slightly lower than the national target of 50% (DH, 2008). This report also found considerable between-site variability in the data.

A secondary analysis of the data collected by Glover, Webb and Evison (2010) was undertaken by Gyani and colleagues in 2011. They aimed to identify the factors associated with this between-site variability and concluded that services achieved better outcomes if they operated a stepped care model, as outlined above in figure 1. Furthermore, in both low intensity (step 2) and higher intensity (steps 3 and 4) therapies, outcomes were enhanced when service users received a NICE-recommended psychological therapy. However, almost a third of service users included in the analysis did not receive an ICD-10 (International Classification of Diseases, 10th edition) provisional diagnosis. As NICE guidelines are diagnosis-driven (i.e. different interventions are recommended for different diagnoses) it was therefore difficult to determine the extent to which service users received a NICE-recommended treatment for their particular diagnosis. Gyani and colleagues noted that recovery rates for patients with a diagnosis of depression were comparable for those who received CBT and those who received counselling but no comparable outcome data were available for the other psychological therapies recommended for depression at step 3 (IPT, couples therapy and psychodynamic psychotherapy).

In November 2012, the Department of Health released a third report, *the IAPT three-year report: the first million patients*, which provided further evaluation of the programme and identified some key challenges and recommendations for the future. Recommendations included: addressing issues of equitable access for under-represented groups; addressing patient choice by increasing information on treatment options and ensuring that treatment plans are agreed by both patient and therapist; ensuring that appropriate financial investments continue to be made in local IAPT services to expand capacity and ensure quality.

National Audit of Psychological Therapies (NAPT)

The National Audit of Psychological Therapies (NAPT) was initiated in 2008 to incorporate data from England and Wales across NHS-funded services providing psychological therapies, including: primary and secondary care, small and large services, IAPT and non-IAPT services. The audit, funded by the Healthcare Quality Improvement Partnership (HQIP), aimed to evaluate and improve the quality of treatment and care for individuals experiencing symptoms of depression and anxiety across four service standard domains: access, appropriateness, acceptability and outcomes. The first audit was published in November 2011 (Royal College of Psychiatrists, 2011), with data collected between May 2010 and February 2011. Although having a much broader remit than just to evaluate IAPT, a section of the NAPT findings were able to provide information on IAPT's progress. Findings supported those of previous IAPT evaluations with regard to equity of access for under-represented groups, lack of diagnostic data and recovery rates. It also found that 70% of patients who received a high-intensity therapy did not receive the minimum number of treatment sessions recommended by NICE. Similarly disconcerting was the high number of therapists (around 30%) delivering therapies for which they reported having undertaken no IAPT-specific training. However, it should be noted that this would not mean that such workers had not been trained to work as therapists, simply that they hadn't been trained specifically to work in the IAPT programme.

The second round of NAPT was published in November 2013 (Royal College of Psychiatrists, 2013), and was based on data collected 18 to 24 months after the baseline audit to determine whether performance across services had improved. It was found that although waiting times had improved (92% of service users were assessed within 13 weeks of their referral, compared with 85% in the baseline audit), there were still issues around equity of access for older adults, in particular, and duration of therapy. Twenty-six recommendations were made based on the findings from the second audit. Of particular relevance to the current study is recommendation 2.4:

> '*With immediate effect, service managers should ensure that all therapists, and through them all service users, understand that choice is multi-dimensional and that service users should be routinely offered choices, including location and time of appointment, type of therapy, therapist gender and access in another language' (*pp.139 – 140)

The recommendation clearly states that type of therapy should be a key aspect of choice for users of psychological therapy services.

The current study

The extent to which a choice of NICE-recommended psychological therapies for depression exists at step 3 of the IAPT programme is as yet unclear, despite the publication of a number of evaluation reports. Additionally, where choice of therapy does exist, it is not clear whether there are any differences between the clients undertaking the different therapies, in terms of demographic profile and diagnosis. Information of this nature would help to clarify the extent to which the different therapies are being used to meet the needs of different groups of clients.

Hence, this report aims to answer two questions:

1) To what extent does choice of therapy exist within the IAPT programme?
2) Are clients accessing the different psychological therapies in IAPT comparable in terms of their demographic profile, diagnosis and number of sessions attended?

METHOD

In July 2014, researchers at the British Association for Counselling and Psychotherapy (BACP) requested access to IAPT data collected as part of the second round of NAPT in order to conduct a secondary data analysis. Ethical approval to analyse the data was granted by the University of Sheffield Research Ethics Committee and a data sharing agreement was entered into by BACP, the Healthcare Quality Improvements Council (HQIP) and The Royal College of Psychiatrists who had originally been commissioned to undertake the audit.

Data were available from 114 IAPT services across England (approximately 42.5% of the total number of IAPT services) recording service location and the local context, work and training backgrounds of clinicians in the services, as well as a retrospective case record audit of those who had completed a step 2 or step 3 psychological therapy in the services between 1 July 2012 and 31 October 2012 (n=117,740). For the purposes of this report, descriptive analyses were conducted on data from the 51,190 clients who received a NICE-recommended step 3 psychological therapy (CBT, counselling, couples therapy, IPT or psychodynamic psychotherapy). Data from clients recorded as receiving 'person-centred therapy' were combined with data from clients recorded as receiving 'counselling' as it was felt that these were very similar forms of practice.

Descriptive analyses were undertaken at two levels: service level (114 IAPT services) and client level (n=51,190). At the service level, descriptive analysis was used to determine the number of step 3 therapies available in services, as well as the specific interventions offered. At the client level, descriptive analysis was used to determine the number of clients who received each of the step 3 therapies, the demographic profile of these clients (e.g. gender, age, ethnicity, the problem for which psychological therapy was offered) and number of sessions received. Data were presented in a format to enable comparisons to be made across the five step 3 therapies.

Data were analysed using the Statistics Package for the Social Sciences (SPSS) version 18.

RESULTS

SERVICE LEVEL

A total of 114 IAPT services provided data for the national audit. Service size was categorised under 3 headings – small, medium and large – depending on the number of full time equivalent (FTE) therapists employed. Small services employed less than 8 FTE therapists, medium services employed 8 – 20 FTE therapists and large services employed more than 20 FTE therapists. Of the 114 services that provided data, 6 (5.3%) were categorised as small, 35 (30.7%) as medium and 73 (64.0%) as large. Table 1 outlines the number of step 3 therapies available in IAPT services and table 2 outlines the availability of the specific step 3 therapies in these services.

TABLE 1: NUMBER OF STEP 3 THERAPIES AVAILABLE IN IAPT SERVICES

		Number of step 3 therapies available				
		1	**2**	**3**	**4**	**5**
Size of service	**Small (n=6)**	3 (50.0%)	2 (33.3%)	1 (16.7%)	0 (0.0%)	0 (0.0%)
	Medium (n=35)	7 (20.0%)	10 (28.6%)	11 (31.4%)	7 (20.0%)	0 (0.0%)
	Large (n=73)	5 (6.8%)	10 (13.7%)	24 (32.9%)	33 (45.2%)	1 (1.4%)

NOTE: Percentages are calculated as a proportion of service size e.g. of the 6 small IAPT services, 3 (50.0%) only offered one step 3 therapy.

Services were assumed to offer an intervention if at least one client entering the service had received that particular intervention.

Half of the small IAPT services (n=3, 50.0%) offered only one step 3 therapy (i.e. they offered no choice). Two (33.3%) small services offered a choice of two step 3 therapies and the remaining small service (16.7%) offered a choice of three step 3 therapies. None of the small services offered four or more step 3 therapies.

A fifth (n=7, 20.0%) of the medium IAPT services offered only one step 3 therapy. Just over a quarter (n=10, 28.6%) offered a choice of two step 3 therapies and just under a third (n=11, 31.4%) offered a choice of three step 3 therapies. A further fifth (n=7, 20.0%) offered a choice of four step 3 therapies. None of the medium services offered the full range of step 3 therapies.

A small number of large IAPT services (n=5, 6.8%) offered only one step 3 therapy. Ten (13.7%) large services offered a choice of two step 3 therapies and a further third (n=24, 32.9%) offered a choice of three step 3 therapies. Almost half of the large services (n=33, 45.2%) offered a choice of four step 3 therapies and just one large service (1.4%) offered the full range of step 3 therapies.

TABLE 2: AVAILABILITY OF SPECIFIC STEP 3 THERAPIES IN IAPT SERVICES

		Step 3 therapy				
		CBT	**Counselling**	**Psychodynamic psychotherapy**	**IPT**	**Couples Therapy**
Size of service	**Small (n=6)**	4 (66.7%)	5 (83.3%)	1 (16.7%)	0 (0.0%)	0 (0.0%)
	Medium (n=35)	32 (91.4%)	30 (85.7%)	9 (25.7%)	10 (28.6%)	7 (20.0%)
	Large (n=73)	73 (100.0%)	68 (93.2%)	5 (6.8%)	41 (56.2%)	47 (64.4%)

NOTE: Percentages are calculated as a proportion of service size e.g. of the 6 small IAPT services, 4 (66.7%) offered CBT.

As mentioned previously, services were assumed to offer an intervention if at least one client entering the service had received that particular intervention.

Most small services offered counselling (n=5, 83.3%), around two-thirds (n=4, 66.7%) offered CBT and just one (16.7%) offered psychodynamic psychotherapy. None of the small services offered IPT or couples therapy.

Most medium services offered CBT (n=32, 91.4%) and counselling (n=30, 85.7%). IPT was offered by 10 (28.8%) medium services, followed by psychodynamic psychotherapy (n=9, 25.7%). Couples therapy was offered in a fifth (n=7, 20.0%) of medium services.

All large services offered CBT (n=73, 100.0%) and the vast majority also offered counselling (n=68, 93.2%). Just under two-thirds of large services offered couples therapy (n=47, 64.4%) and over half offered IPT (n=41, 56.2%) A small number of large services offered psychodynamic psychotherapy (n=5, 6.9%).

CLIENT LEVEL

Table 3 outlines the number of clients within the small, medium and large IAPT services.

TABLE 3: NUMBER OF CLIENTS WITHIN SMALL, MEDIUM AND LARGE SERVICES

		Number of clients (n)	**%**
Size of service	**Small**	478	0.9
	Medium	5749	11.2
	Large	44963	87.8
	Total	**51190**	**99.9**

NOTE: Percentages are calculated to the nearest 0.1% and so may not total 100%.

The vast majority of clients were treated within large IAPT services (n=44963, 87.8%), followed by medium services (n=5749, 11.2%) and small services (n=478, 0.9%).

Demographics - overview

Between 1 July and 31 October 2012, 51,190 clients undertook a step 3 therapy. Of these, almost two thirds (n=33,442, 65.3%) were female, just over a third (n=17,684, 34.5%) were male and gender was unknown in the remaining cases (n=64, 0.1%). The mean age of clients was 41.0 years (SD=14.0). The majority of clients were White British (n=35,827, 70.0%) or of any other White ethnicity (n=2,362, 4.6%), with Black and Minority Ethnic (BME) groups represented by 9.8% (n=5,041) of clients. Ethnicity of the remaining clients (n=7,960, 15.5%) was unknown. Clients attended an average of 7.07 treatment sessions. Tables 4 – 8 outline these findings in further detail.

Gender

Table 4: Gender and psychological therapy undertaken

	CBT	Counselling	IPT	Couples Therapy	Psychodynamic psychotherapy	Total
Female	22498 (63.5%)	10434 (69.9%)	244 (64.6%)	148 (57.8%)	118 (69.4%)	**33442 (65.3%)**
Male	12918 (36.4%)	4474 (30.0%)	133 (35.2%)	107 (41.8%)	52 (30.6%)	**17684 (34.5%)**
Unknown/ unspecified	35 (0.1%)	27 (0.2%)	1 (0.3%)	1 (0.4%)	0 (0.0%)	**64 (0.1%)**
Total	**35451 100.0%**	**14935 100.1%**	**378 100.1%**	**256 100.0%**	**170 100.0%**	**51190 (99.9%)**

Percentages have been calculated as a proportion of therapy type e.g. of the 35451 clients who undertook CBT, 22498 (63.5%) were female. Percentages have been rounded to the nearest 0.1% and so may total more than 100%.

The majority of clients undertook CBT (n=35,451, 69.3%) and less than a third undertook counselling (n=14,935, 29.2%). IPT, couples therapy and psychodynamic psychotherapy were each undertaken by less than 1% of clients.

Almost twice as many females as compared to males undertook a step 3 psychological therapy (n=33,442, 65.3% and n=17,684, 34.5% respectively). There was a statistically significant association between gender and the type of psychological therapy undertaken (χ^2 (8) = 202.1, p<.001), with a higher proportion of female clients undertaking counselling than males (69.9% and 63.5%, respectively). Conversely, male clients were proportionally more likely to undertake CBT compared to their female counterparts (36.4% and 30.0%, respectively).

AGE

TABLE 5: AGE AND PSYCHOLOGICAL THERAPY UNDERTAKEN

	CBT	Counselling	IPT	Couples Therapy	Psychodynamic psychotherapy	Total
18-24	4966 (14.0%)	1540 (10.3%)	47 (12.4%)	16 (6.3%)	24 (14.1%)	**6593 (12.9%)**
25-34	9133 (25.8%)	3084 (20.6%)	70 (18.5%)	77 (30.1%)	48 (28.2%)	**12412 (24.2%)**
35-44	8509 (24.0%)	3504 (23.5%)	99 (26.2%)	80 (31.3%)	40 (23.5%)	**12232 (23.9%)**
45-54	7296 (20.6%)	3570 (23.9%)	84 (22.2%)	52 (20.3%)	38 (22.4%)	**11040 (21.6%)**
55-64	3798 (10.7%)	2070 (13.9%)	58 (15.3%)	23 (9.0%)	15 (8.8%)	**5964 (11.7%)**
65-74	1305 (3.7%)	858 (5.7%)	13 (3.4%)	7 (2.7%)	4 (2.4%)	**2187 (4.3%)**
75-100	442 (1.2%)	307 (2.1%)	4 (1.1%)	1 (0.4%)	1 (0.6%)	**755 (1.5%)**
Unknown/ unspecified	2 (0.0%)	2 (0.0%)	3 (0.8%)	0 (0.0%)	0 (0.0%)	**7 (0.0%)**
Total	**35451 (100.0%)**	**14935 (100.0%)**	**378 (99.9%)**	**256 (100.1%)**	**170 (100.0%)**	**51190 (100.1%)**

Percentages have been calculated as a proportion of therapy type e.g. of the 35451 clients who undertook CBT, 4966 (14.0%) were aged between 18 and 24. Percentages have been rounded to the nearest 0.1% and so may total more than 100%

The majority of clients were aged between 25 and 54 years (n=35,684, 69.7%). The number of clients receiving all types of therapy declined significantly with age; only 5.7% of clients (n=2,942) were over 65 years of age. There was a statistically significant association between age and the type of psychological therapy undertaken (χ^2 (24) = 560.6, p<.001), with 'younger clients' (18-34 years) being proportionally more likely to undertake CBT than counselling (39.8% and 30.9%, respectively). Conversely, 'older clients' (45+ years) were proportionally more likely to undertake counselling than CBT (45.6% and 36.2%, respectively).

ETHNICITY

TABLE 6: ETHNICITY AND PSYCHOLOGICAL THERAPY UNDERTAKEN

	CBT	Counselling	IPT	Couples Therapy	Psychodynamic psychotherapy	Total
White British	24702 (69.7%)	10579 (70.8%)	266 (70.4%)	167 (65.2%)	113 (66.5%)	**35827 (70.0%)**
Any other White	1508 (4.3%)	778 (5.2%)	17 (4.5%)	27 (10.5%)	32 (18.8%)	**2362 (4.6%)**
Asian/Asian British Indian	628 (1.8%)	216 (1.4%)	11 (2.9%)	5 (2.0%)	1 (0.6%)	**861 (1.7%)**
Any other ethnic group	399 (1.1%)	189 (1.3%)	6 (1.6%)	3 (1.2%)	2 (1.2%)	**599 (1.2%)**
Black/Black British Caribbean	424 (1.2%)	133 (0.9%)	4 (1.1%)	4 (1.6%)	3 (1.8%)	**568 (1.1%)**
Black/Black British African	301 (0.8%)	112 (0.7%)	2 (0.5%)	0 (0.0%)	2 (1.2%)	**417 (0.8%)**
White Irish	278 (0.8%)	109 (0.7%)	3 (0.8%)	2 (0.8%)	0 (0.0%)	**392 (0.8%)**
Any other Asian background	278 (0.8%)	101 (0.7%)	3 (0.8%)	4 (1.6%)	2 (1.2%)	**388 (0.8%)**
Any other mixed background	285 (0.8%)	91 (0.6%)	4 (1.1%)	2 (0.8%)	2 (1.2%)	**384 (0.8%)**
Asian/Asian British Pakistani	242 (0.7%)	90 (0.6%)	3 (0.8%)	1 (0.4%)	3 (1.8%)	**339 (0.7%)**
Mixed White and Black Caribbean	230 (0.6%)	90 (0.6%)	2 (0.5%)	3 (1.2%)	0 (0.0%)	**325 (0.6%)**
Any other Black background	132 (0.4%)	80 (0.5%)	2 (0.5%)	2 (0.8%)	0 (0.0%)	**216 (0.4%)**
Chinese	101 (0.3%)	69 (0.5%)	0 (0.0%)	1 (0.4%)	1 (0.6%)	**172 (0.3%)**
Mixed White and Asian	116 (0.3%)	36 (0.2%)	1 (0.3%)	1 (0.4%)	1 (0.6%)	**155 (0.3%)**
Asian/Asian British Bangladeshi	106 (0.3%)	29 (0.2%)	1 (0.3%)	0 (0.0%)	1 (0.6%)	**137 (0.3%)**
Mixed White and Black African	69 (0.2%)	19 (0.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	**88 (0.2%)**
Unknown/ unspecified	5652 (15.9%)	2214 (14.8%)	53 (14.0%)	34 (13.3%)	7 (4.1%)	**7960 (15.5%)**
Total	**35451 (100.0%)**	**14935 (99.8%)**	**378 (100.1%)**	**256 (100.2%)**	**170 (100.2%)**	**51190 (99.8%)**

Percentages have been calculated as a proportion of therapy type e.g. of the 35451 clients who undertook CBT, 24702 (69.7%) were White British. Percentages have been rounded to the nearest 0.1% and so may total more than 100%

The majority of clients were of White British ethnicity (n=35,827, 70.0%), or from any other White ethnic group (n=2,362, 4.61%). All other ethnicities were represented by 5,041 (9.8%) clients. Ethnicity of the remaining 7,960 (15.5%) clients was unknown.

TABLE 7: PROBLEM FOR WHICH PSYCHOLOGICAL THERAPY WAS OFFERED

	CBT	Counselling	IPT	Couples Therapy	Psychodynamic psychotherapy	Total
Depression	5728 (16.2%)	3359 (22.5%)	88 (23.3%)	60 (23.4%)	68 (40.0%)	**9303 (18.2%)**
Mixed anxiety and depression	4917 (13.9%)	2807 (18.8%)	84 (22.2%)	44 (17.2%)	11 (6.5%)	**7863 (15.4%)**
Generalised anxiety disorder	2681 (7.6%)	892 (6.0%)	19 (5.0%)	22 (8.6%)	5 (2.9%)	**3619 (7.1%)**
Other diagnosis (non-anxiety or depression)	450 (1.3%)	651 (4.4%)	1 (0.3%)	2 (0.8%)	10 (5.9%)	**1114 (2.2%)**
Panic disorder (with or without agoraphobia)	706 (2.0%)	119 (0.8%)	32 (8.5%)	0 (0.0%)	2 (1.2%)	**859 (1.7%)**
Post-traumatic stress disorder (PTSD)	702 (2.0%)	102 (0.7%)	3 (0.8%)	0 (0.0%)	5 (2.9%)	**812 (1.6%)**
Obsessive compulsive disorder (OCD)	732 (2.1%)	50 (0.3%)	4 (1.1%)	1 (0.4%)	0 (0.0%)	**787 (1.5%)**
Other anxiety/mood disorder	473 (1.3%)	284 (1.9%)	1 (0.3%)	2 (0.8%)	20 (11.8%)	**780 (1.5%)**
Social phobias	329 (0.9%)	18 (0.1%)	2 (0.5%)	1 (0.4%)	0 (0.0%)	**350 (0.7%)**
Specific (isolated) phobias	280 (0.8%)	49 (0.3%)	2 (0.5%)	0 (0.0%)	0 (0.0%)	**331 (0.6%)**
Body dysmorphic disorder (BDD)	4 (0.0%)	1 (0.0%)	1 (0.3%)	0 (0.0%)	0 (0.0%)	**6 (0.0%)**
Not known/cannot determine	18449 (52.0%)	6603 (44.2%)	141 (37.3%)	124 (48.4%)	49 (28.8%)	**25366 (49.6%)**
Total	**35451 (100.1%)**	**14935 (100.0%)**	**378 (100.1%)**	**256 (100.0%)**	**170 (100.0%)**	**51190 (100.1%)**

Percentages have been calculated as a proportion of therapy type e.g. of the 35451 individuals who received CBT, 5728 (16.2%) were being treated for depression. Percentages have been rounded to the nearest 0.1% and so may total more than 100%

In almost half of cases (n=25,366, 49.6%), the problem for which psychological therapy was offered was unknown/undetermined. In cases where this information was available, depression was the most common problem for which psychological therapy was offered (n=9,303, 18.2%), followed by mixed anxiety and depression (n=7,863, 15.4%), and generalised anxiety disorder (n=3,619, 7.1%). All other problems accounted for less than 2.5% of cases each.

A greater proportion of counselling clients presented with depression as compared to CBT clients (22.5% and 16.2%, respectively). This was also true for clients presenting with mixed anxiety and depression (18.8% of counselling clients as opposed to 13.9% of CBT clients) and clients presenting with more generic diagnoses, such as 'other diagnosis (non-anxiety or depression)' and 'other anxiety/mood disorder' as compared to CBT clients (4.4% vs. 1.3%; 1.9% vs. 1.3%, respectively).

Conversely, a greater proportion of CBT clients presented with specific anxiety disorders such as panic disorder, PTSD and OCD compared to counselling clients (2.0% vs. 0.8%, 2.0% vs. 0.7%, 2.1% vs. 0.3%, respectively).

TABLE 8: NUMBER OF SESSIONS ATTENDED AND PSYCHOLOGICAL THERAPY UNDERTAKEN

	CBT (%)	Counselling (%)	IPT (%)	Couples therapy (%)	Psychodynamic psychotherapy (%)	Total (%)
1-5	15981 (45.1)	7583 (50.8)	127 (33.6)	80 (31.3)	65 (38.2)	**23836 (46.6)**
6-10	8561 (24.1)	4494 (30.1)	85 (22.5)	69 (27.0)	55 (32.4)	**13264 (25.9)**
11-15	4967 (14.0)	1591 (10.7)	54 (14.3)	38 (14.8)	17 (10.0)	**6667 (13.0)**
16-20	2691 (7.6)	546 (3.7)	68 (18.0)	34 (13.3)	16 (9.4)	**3355 (6.6)**
21-25	1119 (3.2)	214 (1.4)	24 (6.3)	14 (5.5)	2 (1.2)	**1373 (2.7)**
26+	504 (1.4)	161 (1.1)	19 (5.0)	13 (5.1)	8 (4.7)	**705 (1.4)**
Unknown	1628 (4.6)	346 (2.3)	1 (0.3)	8 (3.1)	7 (4.1)	**1990 (3.9)**
Total	**35451**	**14935**	**378**	**256**	**170**	**51190**

Percentages have been calculated as a proportion of therapy type e.g. of the 35451 individuals who undertook CBT, 15981 (45.1%) attended between 1 and 5 treatment sessions. Percentages have been rounded to the nearest 0.1% and so may total more than 100%.

TABLE 9: MEAN NUMBER OF SESSIONS ATTENDED AND PSYCHOLOGICAL THERAPY UNDERTAKEN

Psychological therapy undertaken	Mean number of treatment sessions
CBT	7.3 (SD=6.6)
Counselling	6.3 (SD=5.8)
IPT	11.1 (SD=10.3)
Couples therapy	10.4 (SD=9.6)
Psychodynamic psychotherapy	9.7 (SD=13.3)

The most common number of treatment sessions attended was between 1 and 10 for all psychological therapies (n=37,100, 72.5%). Very few clients (n=2,078, 4.1%) received more than 20 sessions of any one psychological therapy. It was unknown in 1,990 (3.9%) cases how many treatment sessions were undertaken. The average number of treatment sessions across all clients was 7.1 (SD=6.5).

On average, clients who undertook counselling received the fewest number of sessions (mean = 6.3) with 80.9% of counselling clients attending up to 10 sessions, compared to clients undertaking psychodynamic psychotherapy (70.6%), CBT (69.2%), couples therapy (59.3%), and IPT (56.1%).

Although sample sizes were small, IPT, couples therapy and psychodynamic psychotherapy had higher mean numbers of treatment sessions (11.1, 10.4 and 9.7 respectively) compared to counselling (6.3) and CBT (7.3).

DISCUSSION

This secondary analysis of data collected as part of the second round of the National Audit of Psychological Therapies (NAPT) has highlighted issues not previously reported on, relating to the availability of NICE-recommended step 3 therapies in IAPT services across England, together with a client profile of the different therapies, and average number of sessions completed. Large variations in sample sizes between the step 3 psychological therapies make direct comparisons difficult, particularly in the cases of IPT, couples therapy and psychodynamic psychotherapy, where sample sizes are very small. However, CBT and counselling can be more readily compared as the sample sizes for these therapies are relatively large. Hence, this discussion tends to focus on a comparison of these latter 2 therapies.

CHOICE OF STEP 3 THERAPIES

Despite CBT, counselling, IPT, couples therapy and psychodynamic psychotherapy all being NICE-recommended interventions for the treatment of depression in adults, only one of the 114 IAPT services included in this analysis offered all five therapies. In general, choice of therapy was more limited in small and medium IAPT services, whereas larger services offered a wider range of therapies. The majority of clients in this sample (n= 44,963, 87.8%) were seen in large IAPT services where greater availability of therapies existed. However, the majority of all IAPT services (regardless of size), offered three or fewer therapies (n=73, 64.0%) suggesting a limited choice of therapies exists quite widely across England.

Across all services, CBT (n=109, 95.6%) and counselling (n=103, 90.4%) were the most commonly available therapies, followed by couples therapy (n=54, 47.4%) and IPT (n=51, 44.7%). Psychodynamic psychotherapy was the therapy least often available across all services (n=15, 13.2%). IPT and couples therapy were not offered by any small IAPT services, limiting the types of therapy available in these services to CBT, counselling and psychodynamic psychotherapy. There was wide variation in the availability of the step 3 psychological therapies, for example, in large IAPT services IPT was available in 6.8% of services, whereas CBT was available in 100% of services. These findings are perhaps unsurprising given that the proportion of therapists in IAPT trained to deliver the four non-CBT NICE-recommended therapies in 2014 was just 18% collectively, in comparison with the 82% trained to deliver high-intensity CBT (NHS England, 2015). It is also noteworthy that around a fifth of the IAPT workforce, mostly counsellors, have not undergone specialist training in an IAPT-approved, NICE-recommended therapy (NHS England, 2015), which may go some way to explaining why counselling is so commonly offered across IAPT services, despite the relatively low proportion of therapists trained in non-CBT NICE-recommended therapies.

Investigation into the number of clients receiving each intervention further underlines the lack of availability of certain therapies. For example, IPT, couples therapy and psychodynamic psychotherapy were only undertaken by a small proportion of clients across all services (0.7%, 0.5% and 0.3% respectively) whereas CBT was undertaken by over two-thirds (69.3%) of clients, with the remaining 29.2% undertaking counselling. These findings are not dissimilar to previous reports (Glover et al., 2010; DoH, 2012) suggesting that the availability of the full range of NICE-recommended therapies across IAPT did not significantly differ between 2008 and 2012.

DEMOGRAPHICS

In line with findings from previous evaluations (Glover et al., 2010; Royal College of Psychiatrists, 2011), approximately two-thirds of clients in the present study were female and the remaining third were male. This finding is unsurprising given that national data suggests significantly more women than men experience, and are diagnosed with, CMDs (McManus et al., 2009). However, the present study suggests that a greater proportion of CBT clients were male compared to counselling clients, whereas the opposite was true for female clients, who were proportionately over-represented in counselling compared to CBT.

Despite estimates that between 11.9% and 14.8% of UK adults aged 65 or over are experiencing mental ill-health at any one time (Evans et al., 2015), older adults accounted for just 5.7% of clients who undertook a step 3 therapy in the present study. This under-representation of older adults in IAPT is in line with findings from previous evaluations (Glover et al., 2010; Royal College of Psychiatrists, 2011), suggesting that psychological therapy services need to be more accessible for older people. There were differences between the client profiles of CBT and counselling in terms of age, with the proportional uptake of CBT declining with increasing age, and the proportional uptake of counselling increasing with increasing age.

Ethnicity data were unknown for 15.5% of the sample, making it difficult to draw firm conclusions from the data. Clients from Black and Minority Ethnic (BME) groups were somewhat under-represented in the present sample (9.8%) compared to the wider UK population, where 14.0% are from BME groups (ONS, 2012). However, this marks an increase in access from these groups as compared to earlier reports (e.g. Glover et al. 2010) where just over 4% of clients were from Asian, Black and other ethnic groups.

The problem for which psychological therapy was offered was unknown or undetermined in almost half of all cases, making it impossible to draw firm conclusions from the data. Where this information was available, most clients presented with depression, mixed anxiety and depression or generalised anxiety disorder. A larger proportion of counselling clients presented with depression than CBT clients, as was also the case with mixed anxiety and depression. There was also a greater proportion of counselling clients with non-specific or generic problems such as 'other diagnosis (non-anxiety or depression)', as compared to CBT. Conversely, CBT clients had a higher proportion of specific anxiety disorders such as panic disorder, PTSD and OCD, in keeping with NICE guidelines for these disorders (NICE, 2011; NICE, 2005a; NICE, 2005b), where counselling is not recommended.

On average, clients attended 7.1 treatment sessions, significantly lower than the number of sessions normally recommended for step 3 therapies (usually in the range of 15-20 sessions). There are different ways to interpret this finding. On the one hand, as has been suggested previously (Royal College of Psychiatrists, 2011), clients may not be completing their recommended course of therapy and work needs to be done to increase client retention in these therapies. The fact that the average number of sessions has moved from 3 in Glover et al's evaluation to around 7 in present study, perhaps indicates that this work is moving in the right direction. Another way to interpret the finding is that, a proportion of clients may be experiencing significant benefits in the early stages of therapy and hence may be content to terminate therapy when they are ready, rather than according to a specific therapeutic protocol.

The difference between counselling and CBT in terms of the average number of sessions attended (6.3 and 7.3, respectively) is noteworthy. This finding may reflect the fact that counsellors are used to working more briefly than step 3 CBT therapists who are trained to

work to a 15 session protocol. Further research should investigate whether the outcomes for the 2 therapies are comparable and whether there are significant differences in intake severity between counselling and CBT.

CONCLUSIONS

The fact that only one of the 114 IAPT services in the sample offered the full range of NICE recommended therapies for depression indicates that the IAPT programme has so far failed in its intention to provide a choice of the full range of evidence-based therapies for clients with depression across England. For clients of some services, a level of choice exists, particularly between counselling and CBT, but the availability of IPT, psychodynamic psychotherapy and couples therapy across services in England remains woefully low and a strong inference from the data is that there are large regional variations in the level of choice, indicative of a "postcode lottery". As CBT is recommended by NICE as a frontline therapy for depression and anxiety, and that the non-CBT therapies are recommended where clients refuse or don't respond to CBT, it follows that the majority of clients using IAPT services would receive CBT and that much smaller proportions of clients receive the non-CBT therapies. Although this trend is borne out in the data on which this study is based, analysis of the service level data indicates that the preponderance of clients receiving CBT is not simply a product of referral patterns conforming to NICE guidelines, but is also driven by there being few alternatives to CBT in some services.

Differences in the client profiles for the various therapies, particularly counselling and CBT, suggest that the therapies may be meeting the needs of different client groups and thus expanding the range of what services can provide. Counselling may be meeting the needs of an older and proportionately more female client group than CBT. Similarly, counselling tends to be accessed more frequently by clients with depression, mixed anxiety and depression and generic/non-specific problems. In contrast, CBT seems to be working with younger, proportionately more male clients and where there is a specific anxiety problem. It is unclear whether these differences are a product of client preference, or referral decisions made by professionals. However, further investigation of these factors may help services target more accurately the therapies towards the client groups that that find them most acceptable. Where there is a need to improve access for an under-represented group in IAPT, it may well be that to increase the availability of the therapy most acceptable to that group will help solve the problem; for example, introducing more CBT to encourage young male clients to use a service, or increasing the availability of counselling to encourage more older clients.

The relatively low average number of sessions completed by clients receiving step 3 therapies raises important questions. Whether this is a product of early drop-out from therapy, or clients, satisfied with the gains they have made, choosing to terminate therapy relatively early, is an open question. The fact that the average number of sessions completed for counselling clients was significantly lower than CBT and the other therapies, merits further investigation. It would be useful to know whether this was an indication of counselling being more efficient than other therapies, or indeed whether this is a product of other factors, such as clients being less distressed at intake.

RECOMMENDATIONS

- As a matter of urgency, commissioners should ensure that all five NICE recommended therapies are available across England and that choice of therapy is embedded in the IAPT model
- Additional funding should be provided to ensure that training in the four non-CBT therapies is readily available to develop an IAPT workforce that can deliver on the choice agenda
- Routine data collected in IAPT should be used to further investigate the effectiveness and acceptability of the five therapies in relation to different client groups, to develop clear referral pathways and ensure the therapies are targeted to produce maximum benefit
- Routine outcome data should be used to investigate whether counselling's lower average number of sessions is indicative of greater efficiency than CBT, or whether this finding is a product of type of presenting problem and/or intake severity.

LIMITATIONS

There are a number of limitations to be considered when interpreting the evidence presented in this report. Results are based on a secondary analysis of data collected as part of NAPT. Hence, researchers at BACP were not able to influence the design of the data collection. Data for the study relied on therapists to classify the variables, such as the intervention they delivered. No doubt there was a degree of variation in how respondents interpreted the different categories and this lack of standardised coding could have led to inconsistencies. Similarly, there may have been errors in data inputting.

Data were available from less than half of the total number of IAPT services in operation across England, limiting the extent to which findings can be generalised. Furthermore, data were collected in 2012 and hence, may not be fully representative of the current state of IAPT in terms of client choice of type of therapy. However, it should be noted that the composition of the IAPT workforce in 2014 was broadly similar to that of the workforce in 2012 (NHS England, 2015), suggesting that little has changed in terms of proportion non-CBT therapists trained to deliver the NICE-recommended step 3 therapies or degree of choice of therapies available in IAPT.

Moreover, the study conflates the availability of therapies with usage of therapies, and it is conceivable that these could be different. For example, it is possible, although unlikely, that services made available more therapies than were taken up by clients. If a therapy were available, but nobody made use of it, then it would not show up in the data on which the study is based.

Additionally, significant amounts of missing data in relation to some variables mean that a number of findings should be treated with caution, particularly with regard to the ethnic profile of the clients, as well as the problem for which therapy was offered.

Nevertheless, the study is based on a large dataset collected as part of a rigorous national audit and can be seen as providing useful evidence as to the availability and client profile of step 3 therapies in IAPT.

REFERENCES

APA (1994) *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, 4th edition. Washington: American Psychiatric Press.

CEPMHPG (2006) *The Depression Report: a new deal for depression and anxiety disorders*. The London School of Economics and Political Science.

CSIP (2007) *IAPT Outline Service Specification*. Available at: http://www.iapt.nhs.uk/silo/files/iapt-outline-service-specification.pdf

Department of Health (2008) *IAPT Implementation Plan: National Guidelines for Regional Delivery*. Available at: http://www.iapt.nhs.uk/silo/files/implementation-plan-national-guidelines-for-regional-delivery.pdf

Department of Health (2011) *Talking therapies: a four year plan of action*. Available at: http://www.iapt.nhs.uk/silo/files/talking-therapies-a-four-year-plan-of-action.pdf

Department of Health (2012) *IAPT three*-year *report. The first million patients.* Available at: http://www.iapt.nhs.uk/silo/files/iapt-3-year-report.pdf

Evans, J., Macrory, I. & Randall, C. (2015). *Measuring national well-being: life in the UK, 2015*. Office for National Statistics.

Ferrari, A. J., Charlson, F. J., Norman, R. E., Patten, S. B., Freedman, G., Murray, C. J. L., Vos, T. & Whiteford, H. A. (2013). Burden of Depressive Disorders by Country, Sex, Age, and Year: Findings from the Global Burden of Disease Study 2010. *PLOS Medicine, 10*(11), e1001547

Glover, G., Webb, M., & Evison, F. (2010). *Improving Access to Psychological Therapies: A review of the progress made by sites in the first roll-out year.* North East Public Health Observatory

Gyani, A., Shafran, R., Layard, R., & Clark, D. M. (2011). *Enhancing Recovery Rates in IAPT Services: Lessons from analysis of the Year One data*. Available at http://www.iapt.nhs.uk/silo/files/enhancing-recovery-rates--iapt-year-one-report.pdf

Health and Safety Executive (2014). *Stress-related and Psychological Disorders in Great Britain 2014*. Available at: http://www.hse.gov.uk/statistics/causdis/stress/stress.pdf

Kroenke, K., Spitzer, R. L. & Williams, J. B. (2001). The PHQ-9: validity of a brief depression measure. *Journal of General Internal Medicine, 16*(9), 606-613.

McManus, S., Meltzer H, Brugha T, Bebbington P. & Jenkins, R. *(eds).* (2009). *Adult Psychiatric Morbidity in England, 2007: Results of a Household Survey.* The NHS Information Centre for Health and Social Care.

NHS England (2015) *2014 Adult IAPT Workforce Census Report.* Available at: http://www.iapt.nhs.uk/silo/files/2014-adult-iapt-workforce-census-report.pdf

NICE (2004) *Depression: management of depression in primary and secondary care.* NICE clinical guideline 23. [NICE guideline]

NICE (2005) *Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care.* NICE clinical guideline 26. Available at: http://www.nice.org.uk/guidance/cg26. [NICE guideline]

NICE (2005) *Obsessive compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder*. NICE clinical guideline 31. Available at: https://www.nice.org.uk/guidance/cg31. [NICE guideline]

NICE (2009) *Depression: the treatment and management of depression in adults (update).* NICE clinical guideline 90. Available at: http://www.nice.org.uk/guidance/cg90. [NICE guideline]

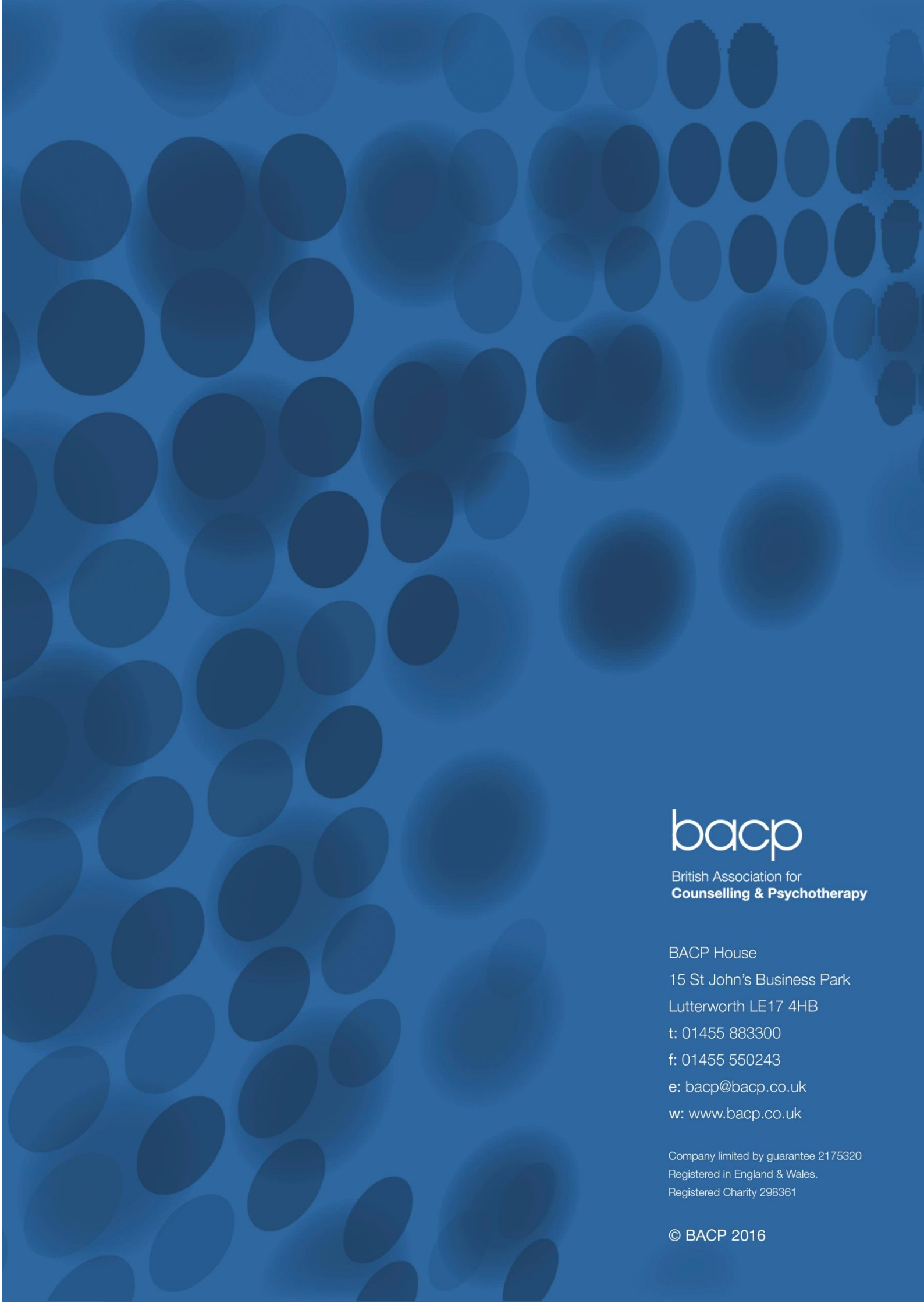
NICE (2011) *Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: management in primary, secondary and community care*. NICE clinical guideline 113. Available at: http://www.nice.org.uk/guidance/cg113. [NICE guideline]

Office for National Statistics (2011). Census data. Available at: http://www.ons.gov.uk/ons/guide-method/census/2011/census-data/index.html

Office for National Statistics (2012). *Ethnicity and National Identity in England and Wales in 2011.* Available at: http://www.ons.gov.uk/ons/dcp171776_290558.pdf

Royal College of Psychiatrists (2011): *National Audit of Psychological Therapies for Anxiety and Depression*, *National Report 2011*.

Royal College of Psychiatrists (2013). *Report of the Second Round of the National Audit of Psychological Therapies (NAPT) 2013*. London: Healthcare Quality Improvement Partnership.



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